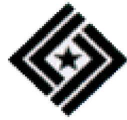

OSHA INSTRUCTION

U.S. DEPARTMENT OF LABOR — Occupational Safety and Health Administration

DIRECTIVE NUMBER: CPL 03-00-016	**EFFECTIVE DATE:** April 5, 2012

SUBJECT: National Emphasis Program – Nursing and Residential Care Facilities (NAICS 623110, 623210 and 623311)

ABSTRACT

Purpose: This Instruction implements a National Emphasis Program (NEP) for programmed inspections of nursing and residential care facilities [NAICS 623110, 623210, and 623311 (formerly SIC codes 8051-Skilled Nursing Care Facilities, 8052-Intermediate Care Facilities, and 8059-Nursing and Residential Care Facilities, Not Elsewhere Classified)].

Scope: OSHA-wide.

References: OSHA Instruction CPL 02-00-150, *Field Operations Manual*, April 22, 2011.

OSHA Instruction CPL 02-00-144, *Ergonomic Hazard Alert Letter Follow-up Policy*, April 11, 2007.

OSHA Instruction CPL 02-01-052, *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents*, September 8, 2011.

OSHA Instruction CPL 02-00-106, *Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis*, February 9, 1996.

OSHA Instruction CPL 02-02-069, *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens Standard*, November 27, 2001.

Cancellations: None.

State Impact: Notice of Intent and Adoption Required, See Section VI.

Action Offices: National, Regional, Area Offices and State Plan Offices.

Originating Office: Office of Health Enforcement

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By and Under the Authority of

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Executive Summary

OSHA Instruction, National Emphasis Program for Programmed Inspections of Nursing and Residential Care Facilities, NAICS 623110, 623210 and 623311 (formerly SIC codes 8051-Skilled Nursing Care Facilities, 8052-Intermediate Care Facilities, and 8059-Nursing and Residential Care Facilities, Not Elsewhere Classified), sets forth policy and procedures for targeting and conducting programmed inspections in this industry. The specific hazards being addressed include ergonomic stressors in patient lifting, bloodborne pathogens, tuberculosis, workplace violence, and slips, trips and falls.

Key terms are defined, the targeting lists are described, scheduling and inspection procedures are provided, and information on Integrated Management Infromation System (IMIS)/OSHA Information System (OIS) coding is given. There are five appendices that provide additional information: a quick reference for compliance safety and health officers (CSHOs); a release and consent form; a list of resources available to CSHOs and employers; a sample alleged violation description (AVD) for resident handling hazards; and a sample AVD for MRSA exposure.

Significant Changes

There are no significant changes compared to the earlier program (i.e., 2002 NEP, which concluded in 2003), except that this new NEP also addresses workplace violence.

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I. Purpose.

This Instruction describes policies and procedures for targeting and enforcement efforts to reduce occupational illness and injury in nursing and residential care facilities in North American Industrial Classification Sytem (NAICS) codes 623110, 623210 and 623311 (formerly Standard Industrial Classification (SIC) codes 8051-Skilled Nursing Care Facilities, 8052-Intermediate Care Facilities, and 8059-Nursing and Residential Care Facilities, Not Elsewhere Classified).

II. Scope.

This Instruction applies OSHA-wide.

III. References. (see additional references at Appendix C)

A. 45 CFR Subtitle A, Subchapter C, Part 164 -- Security and Privacy, Subpart E - *Privacy of Individually Identifiable Health Information*, Section 164.512.

B. Bureau of Labor Statistics (BLS), Table 1. Incidence Rates of Nonfatal Occupational Injuries and Illnesses by Industry and Selected Case Types, 2010.

C. OSHA Instruction CPL 02-00-025, *Scheduling System for Programmed Inspections*, January 4, 1995.

D. OSHA Instruction CPL 02-02-069, *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens*, November 27, 2001.

E. OSHA Instruction CPL 02-00-106, *Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis*, February 9, 1996.

F. OSHA Instruction CPL 02-00-135, *Recordkeeping Policies and Procedures Manual (RKM)*, December 30, 2004.

G. OSHA Instruction CPL 02-00-144, *Ergonomic Hazard Alert Letter Follow-up Policy*, April 11, 2007.

H. OSHA Instruction CPL 02-00-150, *Field Operations Manual (FOM)*, April 22, 2011, and subsequent changes.

I. OSHA Instruction CPL 02-02-038, *Inspection Procedures for the Hazard Communication Standard*, March 20, 1998.

J. OSHA Instruction CPL 02-02-072, *Rule of Agency Practice and Procedure Concerning OSHA Access to Employee Medical Records*, August 22, 2007.

K. OSHA Instruction CPL 02-01-052, *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents*, September 8, 2011.

L. OSHA Instruction CPL 04-00-001, *Procedures for Approval of Local Emphasis Programs* (LEPs), November 10, 1999.

M. OSHA Instruction CSP 03-02-002, *OSHA Strategic Partnership Program for Worker Safety and Health*, December 9, 2004.

N. OSHA Notice 11-03 (CPL 02), Site-Specific Targeting 2011 (SST-11), September 9, 2011, and successive annual notices.

O. OSHA Instruction STD 01-01-013, *Fall Protection in General Industry*, April 16, 1984.

IV. Cancellations.

None.

V. Action Offices.

A. Responsible Office.
Directorate of Enforcement Programs (DEP), Office of Health Enforcement.

B. Action Office.
National, Regional, Area Offices and State Plan Offices.

C. Information Offices.
OSHA Directorate of Training and Education, Consultation Project Managers, Voluntary Protection Program (VPP) Managers, Partnership Coordinators, Compliance Assistance Coordinator, and Compliance Assistance Specialists.

VI. Federal Program Change. Notice of Intent and Adoption Required.

This Instruction describes a Federal program change which establishes a National Emphasis Program (NEP) to reduce occupational illness and injury in nursing and residential care facilities (NAICS codes 623110, 623210 and 623311) with specific emphasis on ergonomic stressors relating to resident handling, exposure to blood and other potentially infectious materials, exposure to tuberculosis, workplace violence, and slips, trips, and falls. Because the seriousness and prevalence of the hazards in these facilities are nationwide, States are required to participate in this national emphasis effort. Targeting will focus on establishments in NAICS codes 623110, 623210, and 623311, with a DART rate at or above 10.0. The NEP contemplates at least three (3) inspections per year, per State or field office.

The State's notice of intent, due within 60 days, must indicate whether the State's emphasis program will be identical to or different from the Federal program. If a State is already implementing an emphasis program in this area, or if it adopts a new initiative in response to this Federal program change, its implementing policies and procedures are expected to be at least as effective as those in this instruction.

If a State adopts or maintains an emphasis program on nursing and residential care facilities which differs from the Federal program, the State must identify the differences and may either post its different procedures on its State Plan's website and provide the link to OSHA, or provide an electronic copy to OSHA with information on how the public may obtain a copy. If the State's emphasis program is identical to the Federal, it must provide the date of adoption to OSHA. State adoption must be accomplished within six months, with posting or submission of documentation within 60 days thereafter. OSHA will provide summary information on the State's response to this instruction on its website.

The OSHA Office of Statistical Analysis will provide targeting lists to States upon request. States may make appropriate additions and deletions to this list as discussed in Section XII but should not delete public sector establishments within their jurisdiction. States must code any inspections (programmed or unprogrammed) and related compliance assistance activity conducted under this NEP as directed in Section XVI.

VII. Expiration.

This Instruction will expire three (3) years from the date of issuance. Upon the expiration or replacement of this Instruction, inspection cycles already underway shall be completed as provided in XII.B.3.

VIII. Significant Changes.

There are no significant changes compared to the earlier program (i.e., 2002 NEP, which concluded in 2003), except that this new NEP also addresses workplace violence.

IX. Application.

This instruction applies to all general industry nursing and residential care facilities covered under NAICS codes 623110, 623210 and 623311.

X. Background.

Nursing and residential care facilities continue to have one of the highest rates of injury and illness among industries for which nationwide days away, restricted work activity and job transfer (DART) injury and illness rates were calculated for Calendar Year 2010 (CY 2010). According to data from the Bureau of Labor Statistics (BLS), the national average DART rate for private industry for CY 2010 was 1.8. Nursing and residential care facilities (i.e., employers within NAICS 6231, 6232 and 6233) experienced average

DART rates of 5.6, 3.9 and 4.7, respectively, despite the availability of feasible controls which have been identified to address hazards within this industry. The sectors within the chosen NAICS codes which ordinarily provide medical/nursing care to residents (i.e., NAICS codes 623110, 623210 and 623311) will be the establishments chosen for inspection under this NEP.

Note: BLS data for NAICS 6232 contain data for establishments within NAICS 623210, which will be a focus sector for this NEP, and for NAICS 623220 (i.e., residential mental health and substance abuse facilities; settings that do not ordinarily include medical services). The latter, NAICS 623220, will NOT be a focus of this NEP. Data separating the two sectors in NAICS 6232 are currently unavailable. Additionally, BLS data for NAICS 6233 contains data for establishments that fall within NAICS 623311, which will be a focus sector for this NEP, and also for NAICS 623312 (i.e., assisted-living facilities without on-site nursing care facilities), which will NOT be a focus of this NEP. Data separating the two sectors in NAICS 6233 are also currently unavailable.

Because of the large number of establishments in this industry that reported high rates in the OSHA Data Initiative survey, higher DART and DAFWII rates are generally used to select a limited number (e.g., 300 for the SST-11) of the highest rated establishments in this SIC Code. The Agency is initiating this NEP to supplement the annual Site Specific Targeting (SST) inspections in an effort to identify and address hazards in additional facilities within this industry. In so doing, OSHA will be able to initiate inspections in nursing and residential care settings at sites that have elevated DART and DAFWII rates but do not meet the strict criteria applied for eligibility in the selection under the SST. Section XII.A of this instruction offers additional information.

This NEP will focus primarily on the hazards which are prevalent in nursing and residential care facilities, specifically, ergonomic stressors relating to resident handling; exposure to blood and other potentially infectious materials; exposure to tuberculosis; workplace violence; and slips, trips, and falls. As detailed in the FOM, when additional hazards come to the attention of the CSHO, the scope of the inspection may be expanded to include those hazards. Calendar Year (CY) 2010 data from the BLS indicate that an overwhelming proportion of the injuries within this industry were attributed to overexertion-related incidents. As an example, 48% of all reported injuries in nursing care facilities for CY 2010 were due to overexertion. Injuries from slips, trips, and falls were also very commonly reported among the nonfatal occupational injury and illness cases reported in nursing and residential care facilities. Taken together, overexertion and slips, trips, and falls accounted for 51.4% of all reported cases with days away from work within this industry for CY 2010.

OSHA enforcement data from the IMIS/OIS indicate that the most frequently cited standard in nursing and residential care facilities is 29 CFR 1910.1030, the Bloodborne Pathogens Standard. Additionally, employees working in nursing and residential care facilities have been identified by the Centers for Disease Control and Prevention (CDC) as being among the occupational groups with the highest risk for exposure to tuberculosis

(TB) due to the case rate of disease among persons ≥ 65 years of age. In CY 2009, for example, the CDC reported an overall TB case rate of 3.8 per 100,000 population across all age groups. The corresponding case rate for persons ≥ 65 years of age was 5.8 per 100,000 in 2009. [1, CDC]

Workplace violence (WPV) is a recognized hazard in nursing and residential care facilities. The National Institute for Occupational Safety and Health (NIOSH) defines WPV as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. [10, CDC] In 2010, BLS data reported approximately 2,130 assaults by persons in nursing and residential care facilities. OSHA Instruction CPL 02-01-052 **,** *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents*, directs OSHA officials [e.g., Compliance Safety and Health Officers (CSHOs)] who conduct inspections in response to programmed inspections at worksites that are in industries with high incidence of workplace violence (e.g., health care) to include investigation of incidents related to workplace violence.

This NEP addresses only enforcement-related procedures. Voluntary guidelines published by OSHA will not be used as a basis for citations issued under this NEP. The efforts set forth herein are designed to meet the Department of Labor's Strategic Plan goals (2011-2016) in addressing the requirements of safe and healthy workplaces, in high-risk industries and as identified in OSHA's Strategic Plan goal 2.1, to improve workplace safety and health through the enforcement of occupational safety and health regulations and standards.

Hazards other than those selected as the target of this Instruction are likely to exist in nursing and residential care facilities. For example, a commonly recognized hazard in these settings is the exposure to multi-drug resistant organisms (MDROs) such as methicillin-resistant *Staphlycoccus aureus* (MRSA). The CDC has identified residents of nursing care facilities among those at increased risk for colonization with MRSA and recommends that employers institute standard precautions and contact precautions to protect workers who must provide care and services to residents colonized with MRSA or other MDROs. [10, CDC] Employee exposures to hazardous chemicals, such as sanitizers, disinfectants and hazardous drugs are also among the other hazards that are commonly encountered in nursing and residential care facilities.

As detailed in the FOM (OSHA Instruction CPL 02-00-150), when additional hazards come to the attention of the compliance officer, the scope of the inspection may be expanded to include those hazards. As such, unprotected exposures to hazardous chemicals or MDROs such as MRSA should be addressed if these become known during the course of an inspection conducted under this NEP.

Outreach and training efforts in these settings should include information on commonly recognized hazards (e.g., WPV and MDRO exposures) for the purpose of advancing awareness of those hazards (See Section XIV of this NEP for some additional information).

XI. Definitions.

A. Data Initiative.

The OSHA Data Initiative is a nationwide collection of establishment-specific injury and illness data from approximately 80,000 establishments. It collects data from establishments by using the "OSHA Occupational Injury and Illness Data Collection Form." The Data Initiative is OSHA's Annual Survey Form that is referred to in 29 CFR 1904.41.

Note: The 2010 injury and illness data collected by the 2011 Data Initiative will be used in this NEP.

B. Days Away, Restricted, or Transferred (DART) Rate.

To calculate the DART, use the formula (N ÷ EH) x (200,000) where N is the number of cases involving days away and/or restricted work activity, and/or job transfer; EH is the total number of hours worked by all employees during the calendar year; and 200,000 is the base number of hours for 100 full-time equivalent employees.

For example: Employees of an establishment (XYZ Company) worked 645,089 hours at this XYZ company. There were 22 injury and illness cases involving days away and/or restricted work activity and/or job transfer from the OSHA-300 Log (total of column H plus column I). The DART rate would be (22 ÷ 645,089) x (200,000) = 6.8.

C. Establishment.

An establishment is a single physical location where business is conducted or where services are performed.

For a more detailed definition of Establishment see Chapter 2, paragraph VII.B. of CPL 02-00-135, *Recordkeeping Policies and Procedures Manual*.

XII. Program Procedures.

A. Site Selection - Targeting Source.

Establishments in NAICS 623110, 623210 and 623311 (formerly SIC codes 8051-Skilled Nursing Care Facilities, 8052-Intermediate Care Facilities, and 8059-Nursing and Residential Care Facilities, Not Elsewhere Classified) with a DART rate at or above 10.0 as indicated by CY 2010 OSHA Data Initiative (ODI) data will be the targeting source. This DART rate cut-off was used to select at

least 700 sites in the pool of facilities eligible for inspection. A list of establishments in NAICS codes 623110, 623210 and 623311 (i.e., an NEP-Specific Inspection List) will be provided by the Office of Statistical Analysis (OSA). See Section XII.B.1 below.

1. Although a list of nursing and personal care establishments may have been selected on an Area Office's (AO) Site Specific Targeting (SST) Primary Inspection list, AOs will be expected to select sites for inspection under this NEP from the Nursing Home NEP-Specific Inspection list. Residential nursing care facilities (SIC code 805) that have been randomly selected on an AO's SST-11 Primary Inspection List use a DART rate at or above 16.0, whereas the sites selected under this NEP will use a rate at or above 10.0.

   The inspection procedures outlined in the SST directive [e.g., OSHA Notice 11-03 (CPL 02) established inspection procedures for SST-11] must be followed when initiating inspections of residential nursing facilities selected from the SST list. However, if a health referral is made or a combined safety and health inspections is done at a site that was initially selected from the SST list, and the items on the referral (or combined safety and health inspection) are related to hazards targeted under this NEP (e.g., ergonomics), then the health portion of the inspection should follow the inspection procedures outlined in this NEP. Please refer to sections XIII.A.1-5 of OSHA Notice 11-03 (CPL 02) for further instructions on inspections done under SST-11.

2. Verify the SIC/NAICS codes of any site selected for inspection under this NEP. As needed, establish what activities occur at the worksite before determining the appropriate SIC/NAICS code.

   Note: Please note that in accordance with existing OSHA policy, where work performed at Federally operated worksites are similar to what is covered under this NEP and criteria for this NEP are met, an inspection must be conducted.

B. <u>Inspection Scheduling.</u>

Inspections conducted under this NEP will focus on establishments classified in the following sectors within the selected NAICS codes 623110, 623210 and 623311. Settings in these specific NAICS codes ordinarily provide medical/nursing care to residents.

1. Using the most recently available ODI data, the OSA will prepare an NEP-Specific Inspection List of establishments in the NAICS codes

623110, 623210 and 623311. The OSA will then provide to each AO a list of establishments within the Area Office's geographical jurisdiction. Each establishment on the resulting establishment list will be assigned a random number by the OSA. The National Office (NO) will make the list available on the Directorate of Enforcement Program's (DEP's) Intranet website.

2. Each AO shall inspect at least three (3) facilities each year under this NEP, unless there are fewer facilities in its jurisdiction. Inspections will be scheduled in the order called for by the random number assigned.

3. If an AO initiates an unprogrammed inspection (e.g., complaint or referral) in a facility within the covered NAICS codes, and the inspection criteria of this Instruction are met (i.e., the DART rate for 2009, 2010, or 2011 is at or above 10), then the procedures set forth in this Instruction must be followed and the inspection may be coded under this NEP.

4. Although an AO will be permitted to use the nursing home NEP code on certain inspections initiated as unprogrammed or SST activities, the Area Office would still be responsible for conducting at least 3 inspections from the list provided by the OSA.

C. Inspection Priority.

Normally, the first inspection priority for Area Offices is to conduct unprogrammed inspections, and the inspection priorities as described in the FOM (OSHA Instruction CPL 02-00-150) will be followed, with the following additional guidance:

1. Each AO shall inspect at least three (3) residential nursing care establishments each year from the nursing home NEP-Specific Inspection List unless, in view of resource considerations, the Regional Administrator has received special approval (generally in advance) from the Deputy Assistant Secretary to conduct a smaller number of inspections, or this NEP is replaced before all the establishments on the list are inspected. Approval will normally require the AO to complete all inspections in the current cycle.

2. Inspections conducted under this NEP have the same priority as inspections conducted under SST. Other than as specified in section XII.A.1 of this instruction (i.e., regarding inspections generated from SST lists), when possible, inspections conducted under this NEP will be combined with other programmed and unprogrammed inspections. This NEP may be combined with other existing initiatives, such as Local Emphasis Programs which identify targets on a different basis.

3. AO will continue to conduct other programmed inspections under national emphasis programs, or under local emphasis/initiative programs as the AO and Regional goals dictate.

D. Deletions.

1. Area Offices will be responsible for making appropriate deletions from the inspection list in accordance with CPL 02-00-025 at B.1.b.(1)(b)6.d.**Deletions**, except that the criteria for H# and S# *(note: H = health; S = safety; and # = digit of the fiscal year)* have been modified by this NEP. The coding originally was defined to determine deletion from an inspection list if the establishment had a substantially complete or focused health (H) or safety (S) inspection conducted within the previous five (5) fiscal years. This NEP provides that an establishment is deleted from the inspection list if it has received a comprehensive safety and/or health inspection within the two (2) years prior to the effective date of this NEP.

2. Additionally, establishments will be deleted if:

a. The establishment is known to be out of business, or it is determined to not be applicable to this NEP (e.g., wrong NAICS code, address cannot be confirmed, etc.). Before deleting any establishment, the AO must perform a reasonably diligent search of local business directories, the internet, or other sources). The AO should document the basis for such determinations.

b. The establishment has received a comprehensive inspection (safety and/or health) within the two (2) years prior to the effective date of this NEP, provided either that no citations were issued for hazards covered by this NEP or that a citation(s) was issued but a follow-up inspection documented tangible appropriate and effective efforts to abate the serious hazards cited or OSHA received abatement verification that the hazards have been abated. An establishment with a pending contest of a citation related to the hazards will not be deleted, but the inspection will be deferred during the contest.

c. The establishment is a public sector employer (i.e., State or local government) in a Federal OSHA state. Note: State Plan States may not automatically delete public sector facilities.

XIII. Inspection Procedures.

A. NAICS Verification.

At the opening conference the compliance safety and health officer (CSHO) will verify the establishment's NAICS code. As needed, determine the activities which occur at the workplace before determining the appropriate NAICS code. If the establishment does not fall within NAICS 623110, 623210 or 623311, the inspection will be terminated as part of this NEP.

B. Ownership.

1. Determine the corporate name of the employer as well as the name being used by the company for the local facility.

2. If the establishment chosen from the NEP-specific inspection list has changed ownership since December 31, 2009, and has been under new ownership for more than six months, recalculate the rate for the period of new ownership. If the recalculated DART rate is below 10.0, do not continue with the inspection. If it is at or above 10.0, continue with the inspection.

   When calculating the DART rate for the period of the new ownership, which may be less than a year, be sure both the number of incidents and the employee work hours are for the new ownership period.

3. If the establishment has changed ownership after December 31, 2009, and has been under new ownership for less than six months, calculate the DART rate using available records. If the CSHO is unable to calculate the DART rate because the new owner does not have records from the previous owner, continue with the inspection.

4. In establishments where the ownership has changed, CSHOs can enter into the IMIS/OIS the Dun & Bradstreet DUNS number of the new owner in the appropriate field on the Establishment Detail Screen. If the new owner does not have a new DUNS number, enter the old DUNS (see XVI.D.).

C. Recalculate DART.

1. During inspections under this Instruction, the OSHA-300 logs for the previous three years will be reviewed. The CSHO will recalculate the DART rates for all three years and record them on the OSHA-1 Form. The DART rate for 2010 (recalculated by the CSHO) will be compared to the DART rate reported by the employer in the OSHA 2011 Data Initiative data collection. A recalculation will not be performed if, for any reason, the relevant records are not readily available. CSHOs will check OSHA-

301 Forms, or equivalent, as they deem appropriate to confirm the OSHA-300 Forms.

2. If records are not available for CSHOs to make this determination, proceed with the focused safety and health inspection.

3. If upon initial review of the OSHA-300 logs, it becomes apparent that the employer has over-recorded on the log cases that are not recordable, these cases shall be removed prior to calculating the DART rate.

4. If the establishment's recalculated DART rate for 2010 is below 10.0, but the DART rate for either of the other two years being reviewed is at or above 10.0, proceed with the inspection. For example, if DART rates for 2009, 2010 and 2011 are being reviewed and the recalculated DART rate for 2010 is below 10.0, but the DART rate calculated for either 2009 or 2011 is greater than 10.0, proceed with the inspection.

5. As described in the scenario above, if the establishment's recalculated DART rate using the establishment's records is less than 10.0 for 2009, 2010 and 2011, conduct a records review for 2010 only, and then recalculate the establishment's DART rate for 2010. At the CSHO's discretion, an abbreviated walk-around for the purposes of interviewing employees may be conducted to verify that the information on the OSHA 300 is accurate. In this case, the CSHO should focus interviews on those employees most likely to have an injury (e.g., certified nursing assistants and dietary staff). Classify the inspection as a "records only" inspection and end the inspection if the rate for 2010 is still below 10.0.

   Note: The 2010 DART rate will be the basis for the initial NEP-Specific inspection list provided by the OSA. An updated NEP-Specific inspection list will be generated and provided for use with the corresponding DART rate as a reference point for each of the subsequent two years following initiation of this NEP. As an example, an establishment's injury and illness records for 2010, 2011, and 2012, would be reviewed during the second year of this NEP (i.e., inspections conducted in 2013). At that time, instead of the 2010 data, the 2011 injury and illness data provided by an ODI conducted in 2012 will become the reference point.

D. <u>Privacy.</u>

1. <u>Residents.</u>

   a. Respect for residents' privacy must be a priority during any inspection.

b. In evaluating resident handling or other hazards (e.g., BBP, tuberculosis) **DO NOT** review any resident records that include personally identifiable health information, including diagnoses, laboratory test results, etc., provided by the employer.

c. Evaluations of workplace health and safety issues in this NEP may involve assessment of resident handling. Resident handling activities may take place in resident rooms, restrooms, shower and bathing areas or other areas where the privacy of residents could be compromised. Documenting resident handling activities by videotaping or photography requires the resident's informed, written consent. Family members or guardians may give consent for those residents who are incapable of giving informed consent (see Appendix B).

2. Employees' Records.

a. If employee medical records are needed that are not specifically required by an OSHA standard (e.g., the results of medical examinations, laboratory tests, medical opinions, diagnoses, first aid records, reports from physicians or other health care providers), they must be obtained and kept in accordance with 29 CFR 1913.10, *Rules of Agency Practice and Procedure Concerning OSHA Access to Employee Medical Records,* and 29 CFR 1910.1020, *Access to Employee Exposure and Medical Records*. Medical access orders must be obtained through the Office of Occupational Medicine. See OSHA Directive CPL 02-02-072, *Rules of Agency Practice and Procedure Concerning OSHA Access to Employee Medical Records*, dated August 22, 2007, for further information and inspection guidance on obtaining medical access orders.

b. The Department of Health and Human Services' Standards for Privacy of Individually Identifiable Health Information, 45 CFR 164.512 (b)(1)(i), provides that protected health information may be disclosed to a public health authority (e.g., OSHA) which has the authority to collect or receive such information for the purpose of preventing or controlling disease, injury, or to be used in public health investigations (e.g., OSHA inspection activities to determine compliance with safety and health regulations).

NOTE: Questions regarding privacy protections should be directed to the Regional Offices (consultation on these issues is available through the OSHA

Offices of Occupational Health Nursing or Occupational Medicine in the Directorate of Technical Support and Emergency Management).

E. Prior Settlement Agreements.

1. Currently, there are no corporate-wide settlement agreements in effect for facilities in the covered NAICS codes. Prior to the start of any inspection conducted under this NEP, the AO will determine if the establishment is subject to any locally established settlement agreement. If the establishment is subject to a settlement agreement, the AO will issue appropriate instructions to the CSHO.

2. The inspection of an establishment covered by a settlement agreement may be used as a monitoring inspection as the terms of the agreement dictate. The AO will contact the Regional Office for appropriate action.

F. Recordkeeping.

Recordkeeping issues must be handled in accordance with OSHA Instructions CPL 02-00-135, *Recordkeeping Policies and Procedures Manual*, and CPL 02-02-069, *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens*, or other relevant field guidance. A partial walkthrough should be conducted to interview workers in order to verify the injury and illness experience. Any serious violations that are observed in the vicinity or brought to the attention of the CSHO must be investigated and may be cited.

G. Ergonomics: MSD Risk Factors Relating to Resident Handling.

This section provides guidance to OSHA personnel for conducting inspections in accordance with this NEP as it relates to risk factors for musculoskeletal disorders (MSDs) associated with resident handling. These inspections shall be conducted in accordance with the FOM, and other relevant OSHA reference documents.

1. Employers with Multiple Facilities. In some cases, inspections of a number of establishments operated by the same corporate entity will demonstrate effectiveness of an existing corporate-wide policy to address resident handling hazards. To maximize efficient allocation of agency resources, resident handling will be addressed during future NEP inspections of establishments operated by that employer by verifying that the establishment is implementing the corporate policy to address these hazards. This policy will apply when (1) OSHA has conducted NEP inspections of at least six of the corporation's establishments, (2) OSHA has not issued either a citation or a hazard alert letter because of resident handling hazards at any of these establishments, and (3) the CSHO verifies

that the subsequently inspected establishment is implementing the corporate policy to reduce resident handling hazards.

The AO will determine whether an establishment qualifies for this treatment based on information received from the NO and the Regional Ergonomic Coordinator (REC).

The NO will notify the RECs whenever a decision is made to issue an ergonomics citation to a nursing home corporation operating at multiple sites. Inspections of facilities owned by a corporation that received a citation that has become a final order may be conducted in accordance with the procedures in this NEP. If a corporation has a citation that is currently under contest, individual guidance will be provided.

2. Establishment Evaluation. Inspections of MSD risk factors will begin with an initial process designed to determine the extent of resident handling hazards and the manner in which they are addressed. This will be accomplished by an assessment of establishment incidence and severity rates, whether such rates are increasing or decreasing over a three-year period, and whether the establishment has implemented a process to address these hazards in a manner which can be expected to have a useful effect.

   CSHOs should ask for the maximum census of residents permitted and the current census during the inspection. Additionally, CSHOs should inquire about the degree of ambulation of the residents, as this information may provide some indication of the level of assistance given to residents or the degree of hazards that may be present.

   Note: If there is indication from injury records, or from employer or employee interviews that other sources of ergonomics-related injuries exist (e.g., MSDs related to office work, laundry, kitchen, or maintenance duties), the compliance officer must include the identified work area and affected employees in the assessment.

3. When assessing an employer's efforts to address resident handling hazards, the compliance officer should evaluate program elements, such as the following:

   a. Program Management.

      Whether there is a system for hazard identification and analysis.

      Who has the responsibility and authority for compliance with this system?

Whether employees have provided input in the development of the establishment's lifting, transferring, or repositioning procedures.

Whether there is a system for monitoring compliance with the establishment's policies and procedures and following up on deficiencies.

If there have been recent changes in policies/procedures and an evaluation of the effect they have had (positive or negative) on resident handling injuries and illnesses.

b. Program Implementation.

How resident mobility is determined?

The decision logic for using lift, transfer, or repositioning devices, and how often and under what circumstances manual lift, transfer, or reposition occurs.

Who decides how to lift, transfer, or reposition residents?

Whether there is an adequate quantity and variety of appropriate lift, transfer, or reposition assistive devices available and operational. Note that no single lift assist device is appropriate in all circumstances. Manual pump or crank devices may create additional hazards.

Whether there are adequate numbers of slings for lifting devices, appropriate types and sizes of slings specific for all residents, and appropriate quantities and types of the assistive devices (such as but not limited to slip sheets, transfer devices, repositioning devices) available within close proximity and maintained in a usable and sanitary condition.

Whether the policies and procedures are appropriate to eliminate or reduce exposure to the manual lifting, transferring, or repositioning hazards at the establishment.

c. Employee Training.

Whether employees (nursing and therapy) have been trained in the recognition of hazards associated with manual resident lifting, transferring, or repositioning, the early reporting of injuries, and

the establishment's process for abating those hazards.

Whether the employees (nursing and therapy) can demonstrate competency in performing the lift, transfer, or repositioning using the assistive device.

4. Occupational Health Management.

Whether there is a process to ensure that work-related disorders are identified and treated early to prevent the occurrence of more serious problems and whether this process includes restricted or accommodated work assignments.

After evaluating the facility's incidence and severity rates and the extent of the employer's program, a decision will be made about the need to continue the ergonomic portion of the inspection. Where there is a need to address these issues, the AO will follow OSHA instructions in determining whether to send an Ergonomic Hazard Alert Letter (EHAL), other communication, or issue citations. In all cases, the AO will notify the REC of the result of the inspection.

OSHA will contact all employers who receive an ergonomic hazard alert letter to determine whether the deficiencies identified in the letter have been addressed. Please refer to CPL 02-00-144, *Ergonomic Hazard Alert Letter Follow-up Policy,* for the process for contacting employers who received an ergonomic hazard alert letter. During this contact, OSHA will again provide information on available consultation and compliance assistance. In appropriate cases, OSHA will consider conducting another compliance inspection.

Some states (e.g., California, Alaska, Minnesota, Washington, and Oregon) have existing regulations or codes that can be applied to ergonomics-related injuries. In these cases, State or local regulations may support the 5(a)(1) element of industry recognition.

5. Citation Guidance.

Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance. When conditions indicate that a General Duty Clause citation relating to resident handling may be warranted, the Area Office will contact the REC and collaborate with the Regional Solicitor (RSOL) on the case prior to issuing a citation. Appendix D is provided only as an example of the language that may be used in an Alleged Violation Description (AVD) for resident handling-related incidents.

H. Slip, Trips, and Falls.

This section provides general guidance related to these types of hazards when conducting inspections in a nursing and personal care facility.

1. Evaluate the general work environments (e.g., kitchens, dining rooms, hallways, laundries, shower/bathing areas, points of access and egress) and document hazards likely to cause slips, trips, and falls, such as but not limited to:

   a. Slippery or wet floors, uneven floor surfaces, cluttered or obstructed work areas/passageways, poorly maintained walkways, broken equipment, or inadequate lighting.

   b. Unguarded floor openings and holes.

   c. Damaged or inadequate stairs and/or stairways.

   d. Elevated work surfaces which do not have standard guardrails.

   e. Inadequate aisles for moving residents.

   f. Improper use of ladders and/or stepstools.

2. Note any policies, procedures and/or engineering controls used to deal with wet surfaces. These would include, but are not limited to, ensuring spills are reported and immediately cleaned up, posting signs/barriers alerting employees to wet floors, keeping passageways/aisles clear of clutter, and using appropriate footgear. Where appropriate, evaluate the use of no-skid waxes or other types of coated surfaces designed to enhance surface friction.

3. Citation Guidance. Where hazards are noted, the CSHO should cite the applicable standard (relevant standards can be found in subparts D and J of 29 CFR Part 1910; there are other standards related to slips, trips, and falls).

   If employees are exposed to hazards from falling while performing various tasks including maintenance from elevated surfaces, then OSHA Instruction STD 01-01-013, *Fall Protection in General Industry*, should be reviewed to determine the applicability of 29 CFR 1910.23(c)(1), 1910.23(c)(3) and 1910.132(a).

I. Bloodborne Pathogens.

This section describes procedures for conducting inspections and preparing citations for occupational exposure to blood and other potentially infectious materials (OPIM) in nursing and residential care facilities. This is not an exhaustive list. For further detailed guidance, CSHOs should refer to OSHA Instruction CPL 02-02-069, *Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens*. In addition, outreach and educational materials are available on the Internet and other references are provided in the appendices to this document.

1. Evaluate the employer's written Exposure Control Plan (ECP) to determine if it contains all the elements required by the standard.

2. Assess the implementation of appropriate engineering and work practice controls.

    a. Determine which procedures require the use of a sharp medical device (e.g., use of a syringe for the administration of insulin) and determine whether the employer has evaluated, selected, and is using sharps with engineered sharps injury protection (SESIPs) or needleless systems.

    b. Confirm that all tasks involving sharps have been evaluated for the implementation of safer devices. For example, determine whether the employer has implemented a policy requiring use of safety-engineered needles for pre-filled syringes and single-use blood tube holders.

    c. Determine whether the employer solicited feedback from non-managerial employees responsible for direct resident care who are potentially exposed to injuries from contaminated sharps in the identification, evaluation, and selection of effective engineering and work practice controls and whether the employer documented solicitation in the ECP.

3. Ensure that proper work practices and personal protective equipment are in place.

4. Assess whether containment of regulated waste is performed properly.

5. Evaluate and document the availability of handwashing facilities. If immediate access to handwashing facilities is not feasible, ascertain whether skin cleansers are used (e.g., alcohol gels).

6. Assess the use of appropriate personal protective equipment (e.g., masks, eye protection, face shields, gowns and disposable gloves, including latex-free gloves, where appropriate).

7. Ensure that a program is in place for immediate and proper clean-up of spills, and disposal of contaminated materials, specifically for spills of blood or other body fluids.

8. Ensure that the employer has chosen an appropriate EPA-approved disinfectant to clean contaminated work surfaces and that the product is being used in accordance with the manufacturer's recommendations.

9. Determine that the employer has made available to all employees with occupational exposure to blood or OPIM the hepatitis B virus (HBV) vaccination series within 10 working days of initial assignment at no cost to the employee and that any declinations are documented.

10. Ensure that healthcare workers who have contact with residents or blood and are at ongoing risk for percutaneous injuries are offered a test for antibody to the HBV surface antigen in accordance with the U.S. Public Health Service guidelines. (See CPL 02-02-069, Section XIII.F.)

11. Investigate procedures implemented for post-exposure evaluation and follow-up following an exposure incident:

    a. Determine if establishment-specific post-exposure protocols are in place (i.e., where and when to report immediately after an exposure incident).

    b. Determine if medical attention is immediately available, including administration of a rapid HIV test, in accordance with current U.S. Public Health Service guidelines.

12. Observe whether appropriate warning labels and signs are present.

13. Determine whether employees receive training in accordance with the standard.

14. Evaluate the employer's sharps injury log. Ensure that all injuries that appear on the sharps injury log are also recorded on the OSHA-300 log. (Note: As outlined in chapter 2, paragraph II.D. of CPL 02-00-135, *Recordkeeping Policies and Procedures Manual*, an employer may use the OSHA-300 as long as the type and brand of the device causing the sharps injury is entered on the log, records are maintained in a way that segregates sharps injuries from other types of work-related injuries and

illnesses, or allows sharps injuries to be easily separated, and personal identifiers are removed from the log. However, CSHOs may suggest that employers simply use a separate sharps injury log.) A sample log is available in Appendix D of CPL 02-02-069.

15. Determine whether the log includes the required fields.

16. Ensure that employees' names are not on the log, but that a case or report number indicates an exposure incident.

17. Determine whether the employer uses the information on the sharps injury log when reviewing and updating its ECP. Failure to use this information is not a violation, but the CSHO should recommend that the information be used for these purposes.

18. Citation Guidance. If an employer is in violation of the Bloodborne Pathogens Standard, the employer will be cited in accordance with CPL 02-02-069.

J. Tuberculosis (TB).

This section provides guidance for conducting inspections and preparing citations for the occupational exposure to tuberculosis specific to nursing and residential care facilities. This is not an exhaustive list. For further detailed guidance, CSHOs should refer to OSHA Instruction CPL 02-00-106, *Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis.*

1. Determine whether the establishment has had a suspected or confirmed TB case among residents within the previous 6 months prior to the date of the opening conference: if not, do not proceed with this section of the inspection. If a case has been documented or suspected, proceed with the inspection according to the guidance document, CPL 02-00-106, referenced above.

2. Determine whether the establishment has procedures in place to promptly isolate and manage the care of a resident with suspected or confirmed TB, including an isolation room and other abatement procedures.

3. Determine whether the establishment offers tuberculin skin tests for employees responsible for resident care, specifically those described in CPL 02-00-106, referenced above.

4. Citation Guidance. The CSHO should refer to CPL 02-00-106, for enforcement procedures including citation guidance for:

a. Respiratory Protection (Note: All respiratory protection citations must be cited under 29 CFR 1910.134 - Respiratory Protection).

b. Accident prevention signs and tags, 29 CFR 1910.145.

c. Access to employee exposure and medical records, 29 CFR 1910.1020.

d. Recordkeeping, 29 CFR Part 1904.

K. Workplace Violence.

Workplace violence (WPV) is a recognized hazard in nursing and residential care facilities. NIOSH defines workplace violence as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. [10, CDC] *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents,* CPL 02-01-052, establishes agency enforcement policies and provides uniform procedures which apply when conducting inspections in response to incidents of workplace violence. OSHA Instruction, CPL 02-01-052, directs CSHOs, who conduct programmed inspections at worksites that are in industries with high incidence of workplace violence such as health and residential care facilities, to investigate for the potential or existence of this hazard.

Citation Guidance. In accordance with the FOM's general guidance on 5(a)(1) citations (see CPL 02-00-150, starting on page 4-14), and specific guidance in CPL 02-01-052, citations should focus on the specific hazard employees are exposed to, not the events that caused the incident or the lack of a particular abatement method. The workplace violence directive also contains sample language for hazard alert letters.

Some states have existing regulations or codes on workplace violence, for example, New Jersey, Rhode Island, Minnesota, Washington, and New York public sector. In these cases, State or local regulations may support the 5(a)(1) element of industry recognition.

If it is determined that the hazard may not be cited under Section 5(a)(1), but there is a State or local code that addresses this hazard and a local agency actively enforces the code, the RA shall refer this to the local enforcement agency.

L. Other Hazards.

As detailed in the CPL 02-00-150, when additional hazards come to the attention of the compliance officer, the scope of the inspection may be expanded to include those hazards. Although unprotected occupational exposures to MRSA and other

multi-drug resistant organisms or exposure to hazardous chemicals (i.e., hazard communication) are not included in the target hazards under this NEP, if these or other hazards become known during the course of an inspection conducted under this NEP, they should be investigated.

1. Methicillin-resistant *Staphylococcus aureus* (MRSA) and other multi-drug resistant organisms (MDROs).

   Nursing and residential care facilities are among the settings at increased risk of potential transmission of MRSA and other MDROs. Compliance officers are expected to investigate situations where it is determined during inspections conducted under this NEP that employees are not protected from potential transmission of MDROs such as MRSA.

   Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance. Recommendations for standard precautions and contact precautions to reduce or eliminate exposure to MRSA and other MDROs are outlined in CDC guidelines, including the *Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007.* [11, CDC] Appendix E contains information that is provided only as an example of language that may be used in an Alleged Violation Description (AVD) for unprotected occupational exposure to MRSA specific to nursing and residential care facilities.

   Note: Violations of applicable OSHA standards (e.g., PPE standards) must be documented in accordance with the FOM. In General Duty Clause citations the recognized hazard must be described in terms of the danger to which employees are exposed, e.g. the danger of being infected by MRSA, not the lack of a particular abatement method. Feasible abatement methods that are available and likely to correct the hazard must be identified.

2. Hazard Communication.

   Employee exposures to hazardous chemicals, such as sanitizers, disinfectants, and hazardous drugs may be encountered in nursing and residential care facilities. Employers are required to implement a written program that meets the requirements of the Hazard Communication standard (HCS) to provide worker training, warning labels and access to Material Safety Data Sheets (MSDSs).

   NOTE: Inspection and citation guidance are contained in OSHA Instruction, CPL 02-02-038*, Inspection Procedures for the Hazard Communication Standard.*

XIV. Outreach.

Each AO/Region/State Consultation Program Office is encouraged to develop outreach programs that will support the efforts of the Agency in meeting the Strategic Plan goals outlined in this NEP. Such programs could include letters to employers, professional associations, local unions, local safety councils, apprenticeship programs, local hospitals and occupational health clinics, and/or other industry employer organizations. OSHA Regional and Area Offices can work with Alliance Program and other OSHA cooperative program participants to provide outreach.

A. Rollout Campaign.

Speeches, training sessions, and/or news releases through the local newspapers, safety councils and/or industrial hygiene organizations can provide another avenue for dissemination of information. A news release will be prepared by the NO and made available to each Region. Additionally, the Directorate of Training and Education (DTE) has prepared training materials which will be of assistance in this outreach effort.

B. Components of Training.

For the purpose of advancing awareness and abatement of these hazards outreach and training efforts should include information on commonly recognized hazards, like patient handling, WPV, occupational exposures to bloodborne pathogens, TB, and MDROs such as MRSA. The OSHA Nursing Home eTool is designed to assist employers and employees in identifying and controlling the hazards associated with nursing homes and residential care facilities. The OSHA Hospital eTool contains information on occupational exposures to MDROs at http://www.osha.gov/SLTC/etools/hospital/hazards/mro/mro.html. *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents*, CPL 02-01-052, establishes agency enforcement policies and provides uniform procedures which apply when conducting inspections in response to incidents of WPV. OSHA's Nursing Homes and Personal Care Facilities Safety and Health Topics webpage has numerous links, including reference materials related to workplace violence, and is located at http://www.osha.gov/SLTC/nursinghome/index.html. Additional useful references and web links are listed in Appendix C of this Instruction.

C. Additional Information.

For information on participation in or resources available from OSHA's cooperative programs [including Alliance Program, Strategic Partnership Program, VPP, OSHA On-site Consultation or Safety and Health Achievement Recognition Program (SHARP)], please visit OSHA's Cooperative Program web site at http://www.osha.gov/dcsp/compliance_assistance/index_programs.html or

contact the Directorate of Cooperative and State Programs (DCSP) at 200 Constitution Avenue, NW, Room N3700, Washington, DC 20210, (202) 693-2200.

XV. Relationship to Other Programs.

A. Unprogrammed Inspections.

Unprogrammed inspections will be conducted according to the FOM CPL 02-00-150 or other guidance documents. If the occasion for an unprogrammed (e.g., complaint, fatality) inspection arises with respect to an establishment that is also in the current inspection cycle to receive a programmed inspection under this NEP, the two inspections may be conducted either concurrently or separately. See Section XVI.B. below.

B. Partnerships.

If an OSHA Strategic Partnership verification inspection is scheduled close (in time) to an inspection under this NEP, the two inspections may be conducted concurrently or separately; refer to CSP 03-02-002.

XVI. Recording and Tracking.

A. Coding Inspection Under this NEP.

1. The OSHA-1 forms must be marked as "programmed planned" in Item 24. The "NEP" box is to be checked and the value "NURSING" recorded in Item 25d. Select 'Strategic Plan Activity' and then select the value "NURSING" in Item 25f.

2. Issuance of a 5(a)(1) citation alleging ergonomic hazards or an Ergonomic Hazard Alert Letter (note: this does not include letters which are written in recognition of an employer's efforts) must be recorded in Optional Information, Item 42, using the following format:

	TYPE - ID	VALUE
• 5(a)(1) Citations:	N - 03	ERGO-CIT
• Hazard Alert Letters:	N - 03	ERGO-LTR

B. Combined with Unprogrammed Inspections.
For all unprogrammed inspections conducted in conjunction with a nursing and residential care facilities NEP inspection, the OSHA-1 forms must be marked as "unprogrammed" in Item 24 with the appropriate unprogrammed activity identified. In addition, the "NEP" box is to be checked and the value

"NURSING" recorded in item 25d. Select 'Strategic Plan Activity' and then select the value "NURSING" in Item 25f.

C. Combined with SST, other NEP, or LEP Inspections.

For all programmed inspections pursuant to other NEPs and LEPs conducted in conjunction with a nursing and residential care facilities inspection, the OSHA-1 forms must be marked as "programmed planned" in item 24. In addition, the "NEP" box is to be checked and the value "NURSING" recorded in Item 25d along with all SST, NEP and LEP IMIS/OIS codes applicable to the inspection. Select 'Strategic Plan Activity' and then select the value "NURSING" in Item 25f.

Note: When a health referral is made or a combined safety and health inspection is performed at a residential nursing care site that was initiated from the SST list, and the items on the referral are related to hazards targeted under this NEP (e.g., ergonomics), the health portion of the inspection should follow the inspection procedures outlined in this NEP and only such SST-related inspections should have the combined SST coding along with the coding under this NEP. Residential nursing care facilities selected from the SST lists and are considered to be safety-related inspections should include SST coding, but should not be considered an inspection under this NEP. The NEP coding will only apply to health-related inspections.

D. DUNS Number.

The Dun & Bradstreet Data Universal Numbering System (DUNS) number, which is a required entry for all nursing and residential care facilities inspections, must be recorded in the appropriate field on the Establishment Detail Screen. In establishments where ownership has changed, enter the DUNS number for the new owner. If, however, the new owner does not have a new DUNS number, enter the old DUNS. Since the DUNS number is site-sensitive the old number will give some useful data. The field on the Establishment Detail Screen can be accessed by pressing F5 in Item 8 to access establishment processing. Once establishment processing is completed, the DUNS number will appear in Item 9b.

XVII. Program Evaluation.

AOs will collect data and information relevant to the effectiveness of this NEP and submit it to the Regional Office. Data and information on effectiveness includes, but is not limited to: reductions in the DART rate, safety and health programs implemented, employees trained, and outreach activities.

At the end of each fiscal year (September 30), after summarizing the data and information, the Regional Office will forward the Nursing and Residential Care Facilities

NEP evaluation to the NO, Directorate of Enforcement Programs (DEP). At a minimum, the evaluation should meet the requirements of CPL 04-00-001, Section D. DEP will serve in a coordinating role, collecting information from the applicable field offices on best practices in improving safety and health in establishments in the NAICS codes covered by this NEP. After review and evaluation, the DEP will disseminate necessary information back to the field offices and to the OSHA DTE.

Appendix A

Compliance Safety and Health Officer Quick Reference for Data Collection

1. Confirm that facility employs more than 10 employees and that it is required to keep injury and illness records under 29 CFR 1904.

2. Determine duration of current ownership and proceed accordingly (See Ownership: Section XIII.B. of this Instruction).

3. Verify DART rate from OSHA-300 logs, recalculate for 2009, 2010, and 2011 (See Recalculate DART: Section XIII.C of this Instruction).

4. DART Rate = $(N \div EH) \times (200{,}000)$

   N = The number of incidents which result in a lost or restricted workday
   EH = Total number of employee work hours
   200,000 = Base for 100 full-time workers, working 40 hours per week, 50 weeks per year

5. Review OSHA-301s and supporting documents where appropriate (See Recalculate DART: Section XIII.C of this Instruction).

6. Input appropriate IMIS/OIS information.

7. Record DUNS Number (See Sections XIII.B. and XVI.D. of this Instruction).

8. Enter valid inspection type, classification, and industry code.

Appendix B

Release and Consent

I hereby consent and release to the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA), the right to use my picture and sound being videotaped or photographed during an OSHA inspection of ______________________________ (name of facility) commenced on _____________ (date). I understand that this videotape or photograph will be used solely to document employee safety and health conditions at the facility, and may be used as evidence in legal proceedings related to those conditions.

______________________________ ____________________

Signature of Resident Date

In the event that there has been a medical or legal determination that a resident cannot give informed consent to be videotaped or photographed, the following shall be used:

On behalf of ______________________________ (name of resident), I hereby grant to the U.S. Department of Labor, Occupational Safety and Health Administration, the right stated above.

______________________________ ____________________

Signature of person authorized to give informed consent on resident's behalf Date

____

Relationship to resident (spouse, child, etc.)

______________________________ ____________________

Signature of Witness Date

Appendix C

Reference Material for Nursing Home National Emphasis Program

Publications:

1. Centers for Disease Control and Prevention, *Reported Tuberculosis in the United States, 2009.* Atlanta, GA: U.S. Department of Health and Human Services, CDC, October 2010.

2. Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, *Safe Lifting and Movement of Nursing Home Residents*, USDHHS, CDC, NIOSH Pub. No. 2006-117.
http://www.cdc.gov/niosh/docs/2006-117/pdfs/2006-117.pdf

3. Association for Occupational Health Professionals (AOHP), *Beyond Getting Started: A Resource Guide for Implementing a Safe Patient Handling Program in the Acute Care Setting* (2006). AOHP-OSHA Alliance Implementation Team.
http://www.aohp.org/documents/about_aohp/BGS_Summer2011.pdf

4. Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, *Musculoskeletal Disorders and Workplace Factors*, 2nd printing, U.S. DHHS, CDC, NIOSH Pub. No. 97-141.
http://www.cdc.gov/niosh/docs/97-141/pdfs/97-141.pdf

5. *Musculoskeletal Disorders and the Workplace: Low Back and Upper Extremities,* National Academy of Sciences, Institute of Medicine (2001).

6. *Back Injury Prevention Guide in the Health Care Industry for Health Care Providers*, CalOSHA (11/97).
http://www.dir.ca.gov/dosh/dosh_publications/backinj.pdf

7. Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, *Elements of Ergonomic Programs: A Primer based on Workplace Evaluations of Musculoskeletal Disorders*, DHHS/NIOSH Pub. No. 97-117. [Note: There are links on the Ergonomics Tech Links page to the NIOSH documents]

8. OSHA Publication 3182, *Guidelines for Nursing Homes: Ergonomics for the Prevention of Musculoskeletal Disorders*.
http://www.osha.gov/ergonomics/guidelines/nursinghome/final_nh_guidelines.html

9. OSHA Publication 3148, *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers.*
https://www.osha.gov/Publications/OSHA3148/osha3148.html

10. Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. (2002). *Violence Occupational Hazards in Hospitals*. DHHS (NIOSH) Pub. No. 2002-101. http://www.cdc.gov/niosh/docs/2002-101/#5

11. Centers for Disease Control and Prevention, *Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007*, www.cdc.gov/hicpac/pdf/isolation/Isolation2007.pdf

12. OSHA Publication 3186, *Model Plans and Programs for the OSHA Bloodborne Pathogens and Hazard Communication Standards.* http://www.osha.gov/Publications/osha3186.html

13. OSHA Publication 3245, *OSHA Recordkeeping Handbook*. http://www.osha.gov/recordkeeping/handbook/index.html

14. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR): "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005," December 30, 2005/Vol. 54/No. RR-17.

15. "Occupational Injuries and Illnesses; Recording and Reporting Requirements," published in the Federal Register on January 19, 2001 (66 FR 5915).

Additional Web links:

http://www.cdc.gov/tb

http://www.cdc.gov/MMWR/preview/MMWRhtml/rr5210a1.htm

http://www.cdc.gov/mrsa

http://www.cdc.gov/ncidod/dhqp/gl_hcpersonnel.html

http://www.cdc.gov/ncidod/dhqp/gl_longterm_care.html

http://www.cdc.gov/ncidod/eid/vol7no2/nicolle.htm

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

http://www.cdc.gov/niosh/docs/2006-117

http://www.cdc.gov/niosh/topics/ergonomics

http://www.cdc.gov/niosh/topics/healthcare

http://www.cdc.gov/HAI/organisms/visa_vrsa/visa_vrsa.html

http://www.cdcnpin.org/scripts/tb/program.asp

https://www.osha.gov/SLTC/workplaceviolence/index.html

http://www.osha.gov/SLTC/healthcarefacilities/index.html

http://www.osha.gov/SLTC/nursinghome/index.html

http://www.osha.gov/SLTC/etools/hospital/index.html

http://www.osha.gov/SLTC/etools/nursinghome/index.html

http://www.osha.gov/SLTC/etools/hospital/hazards/slips/slips.html

http://www.osha.gov/SLTC/tuberculosis/index.html

http://www.osha.gov/SLTC/etools/hospital/hazards/tb/tb.html

Oregon Coalition for Healthcare Ergonomics: http://hcergo.org

Appendix D

Sample 5(a)(1) AVD for Resident Handling Hazards

NOTE: Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance. The following is provided ONLY as an example of the language that may be used in an Alleged Violation Description (AVD) for resident handling-related incidents.

The General Duty Clause.

Section 5(a)(1) of the Occupational Safety and Health Act of 1970: The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause serious physical harm to employees, in that employees were required to perform lifting tasks resulting in stressors that have caused or were likely to cause musculoskeletal disorders (MSDs):

a). Location – Address:
On or about *Date* employees were exposed to ___________ hazards which were causing or likely to cause ___________ . Employees were required to transfer non-weight bearing and partial weight bearing residents manually by lifting or partially lifting them, exposing employees to lifting-related hazards resulting in injuries and disorders such as lumbar or back strain/sprain/pain, herniated/ruptured disk, injury to the L5/S1 disc, and various shoulder injuries.

Abatement.

Feasible means of abatement include but are not limited to implementing a safe patient handling and movement policy for transferring and lifting of non-weight bearing and partial weight bearing residents. This necessitates the use of mechanical lift assist and transfer devices. *Note: AVD must be adapted to the specific circumstances noted in each inspection. The AVD above is an example that will be appropriate in some circumstances.*

Appendix E

Sample 5(a)(1) AVD for MRSA Exposure

NOTE: Refer to the FOM and other OSHA reference documents prior to proceeding with citation issuance. The following is provided ONLY as an example of the language that may be used in an Alleged Violation Description (AVD) for unprotected MRSA exposure.

General duty clause, Section 5(a)(1) – refer to the CDC guidelines: *Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, 2007*, which recommends standard precautions and contact precautions to reduce or eliminate exposure to MRSA. Abatement would include handwashing, cohorting of patients/residents, device and laundry handling.

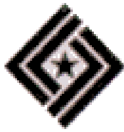
The General Duty Clause.

Section 5(a)(1) of the Occupational Safety and Health Act of 1970: The employer did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to communicable diseases:

a). Location – Address:
On or about *Date* employees were exposed to drug-resistant infections while providing care to residents with infections such as, but not limited to, Methicillin-Resistant *Staphylococcus aureus* (MRSA).

Abatement.

Feasible means of abatement include, but are not limited to: a) providing training on all routes of transmission of infections, the proper personal protective equipment to be used, and infection control practices to be utilized; b) notifying employees about status of any resident with infection prior to beginning care assignments for every shift; c) cohorting patients/residents; and d) using administrative controls, such as limiting access to patients/residents with MRSA infections by non-essential personnel.



OSHA INSTRUCTION

U.S. DEPARTMENT OF LABOR Occupational Safety and Health Administration

DIRECTIVE NUMBER: CPL 02-01-052 EFFECTIVE DATE: September 8, 2011

SUBJECT: Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents

ABSTRACT

Purpose: This instruction establishes general policy guidance and procedures for field offices to apply when conducting inspections in response to incidents of workplace violence.

Scope: OSHA-wide.

References:

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA Publication 3148, 2004.

Recommendations for Workplace Violence Prevention Programs in Late-Night Retail Establishments, OSHA Publication 3153, 2009.

Violence in the Workplace: Risk Factors and Prevention Strategies, NIOSH - Current Intelligence Bulletin 57, July 1996.

Workplace Violence Prevention Strategies and Research Needs, NIOSH Publication #2006-144, 2006.

BLS, Workplace Injuries, 2008.

OPM, Dealing with Workplace Violence: A Guide for Agency Planners; February 1998.

OSHA Instruction CPL 02-00-150 Field Operations Manual (FOM), April 22, 2011.

Annals of Epidemiology: Volume 19, Issue 2, Pages 73-142, Hospital Employee Assault Rates Before and After Enactment of the California Hospital Safety and Security Act, Casteel et al., February 2009.

Cancellations: None.

State Impact: Federal Program Change, Notice of Intent Required, Adoption Encouraged. See Section VI.

Action Offices: OSHA National, Regional, Area/District, State Plan and State Consultation Offices.

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By and Under the Authority of

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Assistant Secretary

Executive Summary

This instruction establishes OSHA general enforcement polices and procedures for field offices to apply when conducting inspections related to workplace violence. The instruction highlights the steps that should be taken in reviewing incidents of workplace violence when considering whether to initiate an inspection in industries that OSHA has identified as susceptible to this hazard. The instruction is meant to provide guidance on both how an OSHA workplace violence case is developed and which steps Area Offices should take to assist employers in addressing the issue of workplace violence.

Significant Changes

This is the first instruction on the enforcement procedures for investigations and inspections that occur as a result of workplace violence incident(s) and specifically at worksites in industries that OSHA has identified as susceptible to workplace violence. It clarifies and expands the Agency's policies and procedures in this area.

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I. Purpose.

The purpose of this instruction is to provide general policies and procedures that apply when workplace violence is identified as a hazard while conducting an inspection under a national, regional or local emphasis program and when responding to incidents of workplace violence, especially when conducting inspections at worksites in industries with a high incidence of workplace violence.

II. Scope.

This instruction applies OSHA-wide.

III. References.

A. OSHA, Publication 3148: Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, 2004.

B. OSHA, Publication 3153: Recommendations for Workplace Violence Prevention Programs in Late-Night Retail Establishments, 2009.

C NIOSH, Current Intelligence Bulletin 57: Violence in the Workplace. Risk Factors and Prevention Strategies, July 1996.

D. NIOSH Publication #2006-144, Workplace Violence Prevention Strategies and Research Needs, 2006.

E. BLS, Workplace Injuries, 2008.

F. OPM, Dealing with Workplace Violence: A Guide for Agency Planners, February 1998.

G. OSHA Instruction CPL 02-00-148, Field Operations Manual, November 9, 2009.

H. Annals of Epidemiology: Volume 19, Issue 2, Pages 73-142, Hospital Employee Assault Rates Before and After Enactment of the California Hospital Safety and Security Act, Casteel et al., February 2009.

I. Journal of Addictions Nursing: Volume 17, Number 1, Pages 13-19, *Violence Intervention Prevention*, Egell, D., Torino, T., 2006.

IV. Cancellations.

None.

V. Action Offices.

A. Responsible Office.

Directorate of Enforcement Programs, Office of Federal Agency Programs.

B. Action Offices.

National, Regional, Area Offices, State Plan States and Consultation Offices.

C. Information Offices.

OSHA National and Regional Offices.

VI. Federal Program Change

Federal Program Change, Notice of Intent Required, Adoption Encouraged. This Instruction describes a Federal program change which establishes general policy guidance and procedures for field offices to apply when conducting inspections in response to incidents of workplace violence. Workplace violence is an occupational hazard in some industries and environments which, like other safety issues, can be avoided or minimized if employers take appropriate precautions. States are strongly encouraged to adopt this Instruction for use with their general duty clause, state-specific workplace violence standard, or other applicable authority under state law. Although not required, States for the most part have authority equivalent to the Federal general duty provision of Section 5(a)(1) of the OSH Act. Where this authority exists, States should utilize it in an at least as effective manner to address hazards in the workplace associated with workplace violence.

States must submit a notice of intent indicating if the State has or will adopt policies and procedures for enforcement of workplace violence and if so, whether the State's policies and procedures are or will be identical to or different from the Federal. OSHA will post summary information on the State responses to this instruction on its website.

VII. Significant Changes.

This is the first instruction on the enforcement procedures for investigations and inspections that occur as a result of workplace violence incident(s).

VIII. Application.

This instruction applies to inspections or investigations conducted by OSHA officials (i.e., Compliance Safety and Health Officers (CSHOs) and Regional and

National Office Officials) who conduct inspections in response to a complaint of workplace violence or conduct programmed inspections at worksites that are in industries with a high incidence of workplace violence (e.g., healthcare, social service settings and late-night retail establishments). It is not intended to exclude other programmed inspections when workplace violence is uncovered and well-documented. District Supervisors, Area Directors, Regional Administrators and National Office Officials will ensure that the policies and procedures set forth in this instruction are followed. Federal Agencies Executive Order 12196, Section 1-201 and 29 CFR 1960.8 and 1960.16 require Federal agencies to follow the enforcement policies and procedures contained in this instruction.

This directive is not intended to require an OSHA response to every complaint or fatality of workplace violence or require that citations or notices be issued for every incident inspected or investigated. Instead, it provides general enforcement guidance to be applied in determining whether to make an initial response and/or cite an employer. An instance of workplace violence is presumed to be work-related if it results from an event occurring in the workplace.

Employers may be found in violation of the general duty clause if they fail to reduce or eliminate serious recognized hazards. Under this directive, inspectors should therefore gather evidence to demonstrate whether an employer recognized, either individually or through its industry, the existence of a potential workplace violence hazard affecting his or her employees. Furthermore, investigations should focus on the availability to employers of feasible means of preventing or minimizing such hazards.

IX. Background.

Workplace violence is recognized as an occupational hazard in some industries and environments which, like other safety issues, can be avoided or minimized if employers take appropriate precautions. At the same time, it continues to negatively impact the American workforce. Workplace violence has remained among the top four causes of death at work for over fifteen years, and it impacts thousands of workers and their families annually.

Research has identified factors that may increase the risk of violence at worksites. Such factors include working with the public or volatile, unstable people. Working alone or in isolated areas may also contribute to the potential for violence. Handling money and valuables, providing services and care, and working where alcohol is served may also impact the likelihood of violence. Additionally, time of day and location of work, such as working late at night or in areas with high crime rates, are also risk factors that should be considered when addressing issues of workplace violence.

Data on workplace violence provides information on the number and types of both

fatal and non-fatal incidents of workplace violence. The Bureau of Labor Statistics' (BLS) Census of Fatal Occupational Injuries (CFOI) shows an average of 590 homicides a year from 2000 through 2009, with homicides remaining one of the four most frequent work-related fatal injuries. Workplace homicides remained the number one cause of workplace death for women in 2009. While there was some fluctuation over this ten year period there was an overall decline, with the highest number of homicides occurring in 2000 (677) and the lowest number occurring in 2009 (521). During this same time period, the Department of Justice's, National Crime Victimization Survey showed an overall decline in the rate per 1,000 people of workplace nonfatal violence against employees, starting at 7.96 in 2000 and ending at 3.86 in 2009 [due to a methodological changes 2006 was not included in these calculations](Harrell, Erika. 2011. *Special Report: Workplace Violence 1993-2009*. U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics). This survey showed that from 2005 through 2009 the majority of non-fatal incidents were instigated by strangers. In addition, during the same time period, survey results showed that 19% of victims of workplace violence worked in law enforcement, 13% worked in retail and 10% worked in medical occupations.

Over the last several years, research has provided some frameworks for developing methods to prevent or minimize the likelihood of workplace violence. As more is learned about workplace violence, it has become apparent that workplace violence prevention is a concern spread across many responsible entities. In September 2006, NIOSH published "*Workplace Violence Prevention Strategies and Research Needs*" (NIOSH Publication No. 2006-144). In it, NIOSH noted that a multidisciplinary team approach to workplace violence prevention was needed: "The involvement of persons with diverse expertise and experience is especially critical due to the depth and complexity of [workplace violence] prevention. Such teamwork is crucial for planning, developing, and implementing programs..." This includes "management, union, human resources, safety and health, security, medical/psychology, legal, communications, and worker assistance."

Several studies have shown that prevention programs can reduce incidents of workplace violence (See Appendix C). By assessing their worksites, employers can identify methods for reducing the likelihood of incidents occurring. OSHA believes that a well written and implemented Workplace Violence Prevention Program, combined with engineering controls, administrative controls and training can reduce the incidence of workplace violence in both the private sector and Federal workplaces. Classifications of workplace violence have been developed to describe the relationship between the perpetrator and the target of workplace violence (Injury Prevention Research Center. 2001. *Workplace Violence: A Report to the Nation.* The University of Iowa) and are set forth in Section X. B. of this instruction.

OSHA has developed several guidance documents to assist employers, some of which are listed in Appendices A and B of this instruction. In addition, Appendix C provides research studies addressing different aspects of workplace violence prevention.

X. Key Terms and Definitions.

A. Workplace Violence.

NIOSH defines workplace violence as violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty. [Center for Disease Control and Prevention, National Institute for Occupational Health. (2002). "Occupational Hazards in Hospitals." DHHS (NIOSH) Pub. No. 2002-101. [http://www.cdc.gov/niosh/docs/2002-101/#5]

B. Types of Workplace Violence.

Classifications of workplace violence that describe the relationship between the perpetrator and the target of workplace violence are:

1. Type 1—Criminal Intent

   Violent acts by people who enter the workplace to commit a robbery or other crime—or current or former employees who enter the workplace with the intent to commit a crime.

2. Type 2—Customer/Client/Patients

   Violence directed at employees by customers, clients, patients, students, inmates or any others to whom the employer provides a service.

3. Type 3—Co-worker

   Violence against co-workers, supervisors, or managers by a current or former employee, supervisor, or manager.

4. Type 4—Personal

   Violence in the workplace by someone who does not work there, but who is known to, or has a personal relationship with, an employee.

C. OSHA-Identified High-Risk Industries.

1. Healthcare and Social Service Settings

This category covers a broad spectrum of workers who provide healthcare and social services in psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment clinics, pharmacies, community-care facilities, residential facilities and long-term care facilities. Workers in these fields include physicians, registered nurses, pharmacists, nurse practitioners, physicians' assistants, nurses' aides, therapists, technicians, public health nurses, home healthcare workers, social and welfare workers, security personnel, maintenance personnel and emergency medical care personnel.

2. Late-Night Retail Settings

This includes entities such as convenience stores, liquor stores and gas stations. Factors that put late-night retail employees at risk include the exchange of money, twenty-four hour operation, solo work, isolated worksites, the sale of alcohol and poorly-lit stores and parking areas.

D. Catastrophic Event.

The hospitalization of three or more employees resulting from a work-related incident or exposure, in general, from an incident caused by a workplace hazard.

E. Fatality.

An employee death resulting from a work-related incident or exposure, in general, from an incident caused by a workplace hazard.

XI. OSHA's Response Efforts and Outreach.

OSHA has developed guidance and recommendations on workplace violence prevention for late-night retail and healthcare settings. These resources, along with other research listed in the appendices of this instruction, can be used by Area Directors and OSHA personnel to inform employers about developing a workplace violence prevention program. Area Directors may choose to disseminate this information through stakeholder meetings, targeted training programs or presentations to employers, labor unions, trade or professional associations, educational institutions and government agencies. Regional and Area Offices can also work with Alliance Program participants to help provide outreach. OSHA's On-site Consultation Program is available on request to employers requesting help on workplace violence prevention. The Consultation Program includes an appraisal of the work practices and occupational safety and health hazards of the workplace. In addition, the service offers assistance to

employers in developing and implementing an effective safety and health program.

XII. Inspection Scope and Scheduling.

A. Scope.

This instruction is provided for initiating inspections when: (1) responding to a complaint, referral, or a fatality or catastrophic event; and (2) conducting a programmed inspection where workplace violence is identified as an issue.

1. An inspection shall be considered where there is a complaint, referral, or fatality and/or catastrophic event involving an incident of workplace violence, particularly when it stems from a workplace in industries identified by OSHA as having a potential for workplace violence. These industries include, among others, healthcare and social service settings and late-night retail establishments.

2. An inspection shall be considered during programmed inspections where there is recognition of the potential for workplace violence in that industry or where the hazard is identified as existing.

3. An inspection generally shall not be considered in response to co-worker or personal threats of violence. If an Area Director becomes aware of instances that could be classified as intimidation or bullying, they should consider referring the issue to the appropriate government entity. Referrals could be made to the local police department, the Equal Employment Opportunity Commission, the National Labor Relations Board or OSHA's Office of Whistleblower Protection. The Area Director may inform the employer if a referral is made. Area Directors should contact the National Workplace Violence Coordinator, in the Directorate of Enforcement, if they have any questions concerning referrals for these types of incidents.

B. Inspection Scheduling.

Inspections will generally be conducted in response to complaints and referrals or as part of a fatality and/or catastrophe investigation pursuant to FOM procedures *and* where reasonable grounds exist after an evaluation of the criteria set forth below.

1. Workplace Violence Complaints and Referrals.

a. Area Offices shall refer to procedures set forth in FOM

Chapter 9 (Complaint and Referral Processing) for handling complaints and referrals. Where it is determined that a complaint meets the criteria for a formal complaint or a referral is generated from one of the sources identified in the FOM as a referral agency, an on-site inspection shall be considered. Where the inspection criteria for formal complaints and referrals in the FOM are not met, non-formal complaint procedures shall be followed.

b. In addition to following procedures for formal complaints and referrals, Area Directors shall determine if reasonable grounds exist to conduct an inspection by using the following criteria. A factual screening should be conducted (i.e., talking to the source of the complaint or referral) to assess whether the criteria have been met prior to initiating an inspection.

2. Criteria for Initiating Inspections.

a. Known risk factors to consider, listed by NIOSH in its report *NIOSH Current Intelligence Bulletin #57: Violence in the Workplace: Risk Factors and Prevention Strategies* (1996). (While each of these factors shall be considered, they would not individually trigger an inspection.)

- Working with unstable or volatile persons in certain healthcare, social service or criminal justice settings.
- Working alone or in small numbers.
- Working late at night or during early morning hours.
- Working in high-crime areas.
- Guarding valuable property or possessions.
- Working in community-based settings, such as community mental health clinics, drug abuse treatment clinics, pharmacies, community-care facilities and long-term care facilities.
- Exchanging money in certain financial institutions.
- Delivering passengers, goods or services.

- Having a mobile workplace such as a taxicab.

b. Evidence of employer and/or industry recognition of the potential for workplace violence in OSHA-identified high risk industries, such as healthcare and social service settings and late night retail (See Section X, C, 1&2.).

c. Feasible abatement methods exist to address the hazard(s).

Below are four examples applying these criteria to various types of situations. The first example presents facts where OSHA would investigate, the second is a case where OSHA would not investigate and the final two are examples requiring Area Director discretion.

Example 1 – Inspection to be conducted

A patient in the psychiatric ward attacks a nurse at a local hospital.

- Known risk factor – YES

  - Working with unstable or volatile persons in healthcare.

- Industry and/or Employer Recognition – YES

  - Large body of studies on the existence of potential workplace violence in these types of healthcare settings. Previous incidents reported to employer.

- Existence of feasible means of abatement – YES

  - Large body of work on feasible means of abatement available to address workplace violence in these types of healthcare settings (e.g., having two or more employees present when unstable clients are at the facility).

Example 2 – No inspection conducted

A disgruntled acquaintance stabs an employee of a bookstore at work.

- Known risk factor – NO

  - The incident covers only some of the risk factors, and the hazard could not have been reasonably anticipated.

  - The bookstore was not in a high crime area.

- The incident occurred at 10 a.m. in a store with five employees present.

- The only employer knowledge was that the employee and acquaintance appeared to argue prior to the stabbing.

- Industry and/or Employer Recognition – NO
  - No industry history of violence at bookstores and no reason for the employer to anticipate such an incident.

- Existence of feasible means of abatement – NO
  - No known prevention measures for random acts of violence in this type of workplace setting.

Example 3 – Area Director discretion required

A shooting was reported at a local grocery store.

- Known risk factor – Unknown

Evidence to be considered:

- Is the store in a high-crime area?

- Have there been past threats or acts of violence and is there a pattern of violence against employees at the store?

- What time of day or night did the incident occur?

- How many times have police responded to disturbances at this location?

- How many employees were working at the time?

- Was the incident a robbery?

- Industry and/or Employee Recognition – Unknown
  - Answers to the above questions will help determine if the local grocery store may be considered a late-night retail establishment for which there may be industry knowledge of the potential for workplace violence.

  - Information should be gathered on any safety precautions taken by the employer and a review should be conducted of injury and

illness logs to determine whether the employer recognized the potential for violence or knew of past incidents.

- Existence of feasible means of abatement – Unknown

  - Determine if there are feasible means of abatement available to the local grocery store to eliminate or reduce the possibility of future incidents.

Example 4 – Area Director discretion required

Employees at a financial institution were shot.

- Known risk factor – YES

  - Exchange of money. However, information needs to be gathered regarding the type of workplace where the incident occurred (i.e., a stand-alone bank, a credit union in an office building, a quick loans or check cashing storefront).

  - Was the establishment in a high crime area?

  - Was the financial institution held up?

  - What were the circumstances surrounding the violent incident?

  - Was the perpetrator an acquaintance of any of the employees?

  - What interactions occurred between the perpetrator and employees?

- Industry and/or Employer Recognition – YES

  - Studies exist on the potential for armed robberies at financial institutions.

  - Were there any engineering controls in place to address incidents of workplace violence, such as bulletproof glass and buzz-in entries?

- Existence of effective abatement methods – Unknown

  - Are there feasible abatement methods available to reduce or eliminate the possibility of future incidents?

  - Feasible abatement methods would depend on the type of incident that occurred and the institution.

3. Fatality/Catastrophe.

An inspection will generally be conducted where there is a death of one or more employees or hospitalization of three or more employees. If the Area Director determines, after assessing the facts and applying the criteria above, that it is not appropriate to initiate an inspection for a workplace violence fatality, they shall document the reasons on the OSHA 36.

NOTE: CSHOs should not conduct their own inspections at the same time as other law enforcement personnel. If a CSHO arrives during a police investigation, they should stop their investigation, contact the law enforcement commander and request to be notified once the on-site police investigation is complete.

4. Programmed Inspection.

A CSHO may pursue an investigation for workplace violence during programmed inspections where there is recognition of the potential for workplace violence in that industry or where the hazard is identified as existing.

XIII. Inspection Procedures.

This section outlines procedures for conducting inspections and issuing citations or notices for workplace violence hazards. The procedures in FOM Chapter 3 (Inspection Procedures) shall be followed, except as modified below. Compliance Officers should consult any OSHA directives, appendices and other references cited in this instruction for further guidance.

Regional Workplace Violence Program Coordinators should contact the National Office Agency Workplace Violence Program Coordinator via e-mail within ten working days after any enforcement action has been taken in response to workplace violence. The e-mail should provide the name of the company/business, the inspection number(s), a list of any expected violations, the six-month date, the approximate penalty amount (if available) and the current status of the case. Coordinators are encouraged to track all complaints received and inspections conducted involving workplace violence in order to monitor any potential patterns.

CSHOs who are conducting inspections for a local, regional or national emphasis program and who identify incidents or workplace violence, through observations, employee interviews and/or injury and illness records, may expand the scope of the inspection to address these safety and health hazards.

A. Opening Conference.

1. CSHOs are to explain the reason for the inspection to the employer, including the incident that prompted the investigation.

   NOTE: CSHO may provide employers with a copy of OSHA's Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, Recommendations for Workplace Violence Prevention Programs in Late-Night Retail Establishments or other appropriate guidance.

2. CSHOs should request information on any hazard assessments performed and incident reviews at the facility concerning issues of workplace violence.

3. At the opening conference, CSHOs shall identify all employees who are in charge of security and/or responsible for the workplace violence prevention program (if any).

4. CSHOs shall initially determine whether the employer has a workplace violence prevention program.

   a. Conduct interviews and request relevant documents to determine whether the employer has considered or implemented a hierarchy of controls for worker protection against potential acts of workplace violence (e.g., engineering or administrative controls, work practices and personal protective equipment).

   b. The evaluation of an employer′s workplace violence prevention program should be based on any written safety programs and recordkeeping for injury and illness data. In addition, other information to be reviewed includes medical records related to incidents of workplace violence, police incident reports, actions taken to prevent future incidents and any other information deemed appropriate by the CSHO.

5. CSHOs should request all information regarding worker training programs and other methods used to inform workers of the potential for, and prevention of, workplace violence. Where appropriate, CSHOs should also request any discipline records related to violence or aggression shown at the workplace.

B. Walkaround and Records Review.

CSHOs should use professional judgment in determining which areas of the facility will be inspected. Documenting resident or patient handling

activities by videotaping or photography requires the resident's informed, written consent. Family members or guardians may give consent for those residents who are incapable of giving informed consent (See Appendix F). CSHOs should identify jobs or locations with the greatest potential for workplace violence, as well as any processes and procedures that put workers at risk, including: building layout, interior and exterior lighting, communication systems and absence of security systems.

CSHOs shall interview all employees on all work shifts (if available) who observed or experienced any acts of workplace violence. CSHOs should also interview first responders, police officers, managers and any others who observed the incident or its aftermath.

1. Access to employee medical records.

   In situations where the CSHO determines that medical records should be reviewed, an administrative subpoena should be obtained and served on the employer concurrently with the Medical Access Order (See CPL 02-02-072, Rules of Agency Practice and Procedure Concerning OSHA Access to Employee Medical Records (August 22, 2007)). CSHOs may also consider obtaining specific written consent from an employee pursuant to 29 CFR 1910.1020(e)(2)(ii)(B) and should ensure that the agency or agency employee receiving the information is listed on the consent form as the designated representative.

2. Injury/Illness Records.

   CSHOs should review the employer's injury and illness records from five years prior to identify any workers with recorded injuries associated with workplace violence and identify the frequency and severity of incidents to establish any existing trends. If there is evidence that a particular work-related incident that meets the recordkeeping criteria has not been recorded by the employer, a citation for violation of 29 CFR 1904.5 may be issued.

3. Other Records.

   Whenever possible, CSHOs should review the following types of records to determine if other incidents of workplace violence occurred and were undocumented in the OSHA log. As with the injury and illness records, CSHOs should identify the frequency and severity of the incidents.

   a. Workers' Compensation Records.

b. Insurance Records.

c. Police Reports.

d. Security Reports.

e. First-Aid Logs.

f. Accident or near-miss logs.

C. Citation and Notice Procedures.

Prior to issuing a citation or notice, Area Directors shall ensure the following: (1) a thorough evidentiary development/documentation of the case file, (2) early involvement in the investigation by the Regional Workplace Violence Program Coordinator, Regional Solicitor and the National Office Workplace Violence Program Coordinator, and (3) the approval for issuance from the Directorate of Enforcement Programs at least three weeks before the six month statutory deadline for issuing citations. Approval from the DEP is not required for cases that solely address recordkeeping violations.

The following requirements shall be cited as appropriate for employee exposure to workplace violence incidents. This list is not intended to be comprehensive.

Section 5(a)(1)	General Duty Clause; or
29 CFR 1960.8(a)	Executive Order 12196, Section 1-201(a) for Federal facilities (the General Duty Clause for Federal agencies).
29 CFR 1904	Recording and Reporting Occupational Injuries and Illnesses.
29 CFR 1910.151	Medical Services and First Aid.
29 CFR 1926.23	First Aid and Medical Attention
29 CFR 1926.35	Employee Emergency Action Plans

NOTE: Language used in the citations should focus on the hazard and in no way stigmatize groups of persons as being prone to violent behavior. Additional guidance on writing citations addressing workplace violence will be provided during CSHO training.

1. Section 5(a)(1) or 29 CFR 1960.8(a).

CSHOs must consult, at a minimum, the information on the OSHA

Safety and Health Topics page for Workplace Violence and the NIOSH Safety and Health Topics page to determine if a workplace violence hazard is recognized by the relevant industry. The following are the types of evidence or documentation necessary to establish each element of a general duty clause violation. Reference materials in Appendices B, C and E should be reviewed to support information presented in the citation or notice.

a. A serious workplace violence hazard exists and the employer failed to keep its workplace free of hazards to which employees were exposed. Documentation to meet this element should include:

- OSHA 300 (Injury/Illness) logs and 301 forms documenting injuries from workplace violence for the prior five years.
- Injury reports specific to instances of workplace violence, including any reports generated as part of the Joint Commission (formerly JCAHO—Joint Commission on Accreditation of Healthcare Organizations) accreditation/certification for healthcare settings.
- Past complaints or grievances noting the particular hazard.
- Meeting minutes where workplace violence issues were discussed.
- Workers' compensation records documenting injuries from workplace violence.
- Medical records regarding workplace violence incidents.
- Police and security records documenting incidents of workplace violence.
- Employee interviews, which include information on any previous incidents of violence.
- Actual or potential employee exposure to workplace violence.

- Documentation that the workplace violence hazard was *reasonably foreseeable* by the employer.

NOTE: Cite the specific hazard employees are exposed to, not the events that led to the incident or the lack of a particular abatement method.

b. Industry and Employer Recognition.

Where present, CSHOs should document the existence of industry and/or employer recognition of the hazard.

(1) Industry Recognition

- Documentation from the business groups and associations (including the Joint Commission for healthcare facilities) affiliated with the employer identifying the problem of workplace violence.

- Journal articles and research showing the existence of workplace violence in the given industry.

- NIOSH and OSHA publications.

- National consensus standards.

- State and local laws that address workplace violence in specific industries, such as healthcare facilities or late-night retail.

(2) Employer Recognition

- Documentation of any employees informing the employer of the hazard or related inspections of the employer.

- Employer awareness of any prior incidents, injuries or close calls related to workplace violence.

- Any precautions/protective measures taken by the employer to prevent or minimize workplace violence.

- Documentation of how the employer currently addresses workplace violence including a security plan, training plan, presence of a preventative plan and other safety documents.
- Interviews of management, including the person responsible for certifying the OSHA 300 logs.
- Employee interviews.
- Union complaints.
- Employer awareness of local and state laws, i.e., state or municipal licensing or accrediting regulations. (See Appendix A for a partial list.)

c. The hazard caused or was likely to cause death or serious physical harm.

- Documentation that the workplace violence *hazard* caused or was likely to cause serious physical harm. Examples include employee interviews, injury and illness logs and police reports.
- Evidence of actual instances where employees were threatened with physical harm or seriously injured or killed as a result of workplace violence.

d. There are feasible abatement methods available to address the hazard.

CSHOs should document any feasible abatement methods and an explanation of how they would materially reduce the hazard. (Appendix B includes information on types of feasible abatement methods. See Appendix C for information on studies and abatement methods for healthcare and retail settings.) In certain cases, an expert knowledgeable in the industry may need to be retained to show that the proposed abatement measures are feasible and recognized within that industry. Area Directors should consult with the Regional Solicitors in such situations.

NOTE: See Appendix E for an example of a memorandum to the Assistant Secretary that contains sample case file documentation and Alleged Violations Description citation language to support a general duty clause violation.

2. Observation of Hazards.

If potential workplace violence hazards noted by a CSHO during an inspection are not covered by a particular standard and do not rise to the level of a 5(a)(1) general duty clause violation, a hazard alert letter recommending the implementation of protective measures that address identified hazards shall be considered. (See Appendix D for a sample hazard alert letter.)

D. Closing Conference—Abatement Methods.

In workplaces where a potential for violence against employees has been identified, the employer should be encouraged to develop and implement a workplace violence prevention program. CSHOs should discuss with the employer potential controls for these types of hazards. However, it is the employer's responsibility to employ the most effective feasible controls available to protect its employees from acts of workplace violence.

The selection of abatement methods should be based on specific hazards identified in a workplace analysis of the facility/place of employment, temporary duty locations and workers' travel routes while on duty. (For examples of industry-specific abatement methods, see Appendix B.)

E. Training.

Area Directors and Regional Training Coordinators shall ensure that Compliance Officers performing workplace violence inspections are familiar with the most recent guidelines on the subject and are adequately trained on workplace violence prevention, recognition of high-risk situations, and ways to defuse hostile situations. Training should also include instruction on potential workplace risk factors, types of workplace violence, and abatement measures available to address the hazard. CSHOs are also encouraged to review training materials developed by the NIOSH, FBI, and USDA (See Appendix A). This training is intended to assist CSHOs to understand specific workplace violence incidents, to identify hazard exposure and to assist the employer in abating the hazard.

F. IMIS Coding.

The OSHA-170 and "Immlang" questionnaire shall be completed for any inspection of workplace violence resulting in a fatality or catastrophe.

OSHA-1 Block 42

Type = N   ID = 16   Value = Violence

OSHA-7 Item 46

When an OSHA-7 is completed and the complaint alleges employee exposure to workplace violence, CSHOs should enter the code "N-16-Violence" in optional information.

The "N-16-Violence" code applies to the following forms: OSHA-1, OSHA-7, OSHA-36, OSHA-90, and OSHA-55.

XIV. Consultation.

Whenever a consultation visit is made in response to this instruction, use N-16-Violence in item 18 on Form-20 and in item 22 on Form-30.

Appendix A - Additional Resources

Many Federal, state and local agencies; private industry employers; universities and schools have workplace violence prevention programs or policies that include hazard analysis and controls and may include disciplinary procedures for work rule violations.

OSHA
Recommendations for Workplace Violence Prevention Programs in Late-Night Retail Establishments. OSHA 3153-12R, 2009.

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. OSHA 3148-01R, 2004.

OSHA Safety and Health Topics Workplace Violence. [https://www.osha.gov/SLTC/workplaceviolence/index.html]

Preventing Violence against Taxi and For-Hire Drivers. OSHA Fact Sheet, 2010.

Additional resources are listed on OSHA's Workplace Violence Topic Page under Possible Solutions and Additional Information.

National Institute for Occupational Safety and Health (NIOSH)
NIOSH has a workplace violence web page that lists publications pertaining to workplace violence and other resources. These references include additional controls/abatement methods for workplace violence hazards.

NIOSH Safety and Health Topic: Occupational Violence. [http://www.cdc.gov/niosh/topics/violence].

Center for Disease Control and Prevention, National Institute for Occupational Health. (2002). "Occupational Hazards in Hospitals." DHHS (NIOSH) Pub. No. 2002-101. [http://www.cdc.gov/niosh/docs/2002-101/#5]

Federal Bureau of Investigation
The FBI has several documents addressing workplace violence and recommendations for reducing the risk. For more information visit the FBI web site at: [http://www.fbi.gov]

FBI [2010]. Law Enforcement Bulletin: Workplace and Campus Safety. [http://www.fbi.gov/stats-services/publications/law-enforcement-bulletin/february-2010/title-1].

FBI [No Date]. Workplace Violence, Issues in Response. [http://www.fbi.gov/stats-services/publications/workplace-violence].

States Laws and Programs to Address Workplace Violence

Several states have laws that address workplace violence. Maine's Department of Labor created a 2007 Labor Report, which provided a summary of existing state laws (*Report of the Task Force on Workplace Violence and Safety to the Joint Standing Committee on Labor*). CSHOs should always check state laws and guidance prior to conducting an inspection to ensure that they are aware of the most current regulations and guidance.

In addition, some states have created websites that address workplace violence. Below is a sampling of such websites.

California

The state of California has Guidelines for Security and Safety of Health Care and Community Service Workers, which provides information and guidance to employers and employees in healthcare and community service settings about workplace security issues It also has Guidelines for Workplace Security.

Delaware

The State of Delaware has a Workplace Violence Policy document that employers can use as a guideline for a written workplace violence program. This document is available at: [http://www.delawarepersonnel.com/policies/docs/workplace_violence.pdf].

Iowa

Iowa OSHA created a PowerPoint presentation describing workplace violence risk factors and steps employers and employees can take to help reduce the occurrence of workplace violence. The Iowa Department of Administrative Services has a section of its MS Manual entitled "Violence-Free Workplace Guidelines," which applies to executive branch employees.

Minnesota

According to the Minnesota Department of Labor & Industry's Workplace Violence Prevention website, the department "works with employers and employees to increase their understanding of workplace violence in a way that emphasizes prevention and voluntary compliance."

New Mexico

The New Mexico Environmental Improvement Board, which issues occupational safety and health standards, issued a regulation (11.5.6) that requires convenience stores open between the hours of 11:00 p.m. and 5:00 a.m. either to have two workers on duty, or one clerk and a security guard, or to install bulletproof glass or other safety features to limit access to store personnel. See http://www.nmcpr.state.nm.us/nmac/parts/title11/11.005.0006.htm for more information.

New York
According to the New York State Department of Labor Workplace Violence Prevention Information website, the "New York State Public Employer Workplace Violence Prevention Law" was enacted to ensure that public workplaces are evaluated and that effective response and prevention strategies are implemented to prevent and minimize workplace violence.

Oregon
Oregon OSHA has published a "concise guide to preventing aggression" in the workplace entitled, "Can It Happen Here?" to assist employers in evaluating risks and implementing a policy against workplace violence.

Washington
According to Washington's Department of Labor and Industries, several existing provisions of the Washington Administrative Code may apply to the hazards of violence in the workplace. See http://lni.wa.gov/Safety/Rules/Policies/PDFs/WRD505.pdf for more information.

Wyoming
Wyoming created a sample Workplace Violence and Prevention Program for employers to use when drafting their company's own program.

Other Resources.

Canadian Center for Occupational Safety and Health (CCOHS) topic page: *Violence in the Workplace* is available at [http://www.ccohs.ca/oshanswers/psychosocial/violence.html].

Florida State University: [http://www.vpfa.fsu.edu/Employee-Assitance-Program/Workplace-Violence].

Michigan State University Criminal Justice Resources: *Workplace Violence* is available at: http://staff.lib.msu.edu/harris23/crimjust/workplac.htm. This website lists online publications and articles, books and other sources of information pertaining to workplace violence.

Appendix B – Potential Abatement Methods

The employer may use any one or combination of the following abatement methods to materially reduce or eliminate the hazard of workplace violence. Other references should also be reviewed to determine the most effective methods applicable to the workplace.

General recommendations for all industries and administrative workplaces:

- Conduct a workplace violence hazard analysis (this includes analyzing vehicles used to transport clients).
- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.
- Provide employees with training on workplace violence.

- Implement Engineering Controls, such as:
    - 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 recording on a 24-hour basis for high-risk areas.
    - Place curved mirrors at hallway intersections or concealed areas.
    - 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.

- Implement Administrative Controls—to change work practices and management policies in order to reduce exposure to hazards. Such controls include:
    - Establish liaisons 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 (in addition, address concerns where the perpetrator is the manager). 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.

- Develop a written, comprehensive workplace violence prevention program, which should include:
  - A policy statement regarding potential violence in the workplace and assignment of oversight and prevention responsibilities.
  - A workplace violence hazard assessment and security analysis, including a list of the risk factors identified in the assessment and how the employer will address the specific hazards identified.
  - Development of workplace violence controls, including implementation of engineering and administrative controls and methods used to prevent potential workplace violence incidents.
  - A recordkeeping system designed to report any violent incidents. Additionally, the employer shall address each specific hazard identified in the workplace evaluation. The reports must be in writing and maintained for review after each incident and at least annually to analyze incident trends.
  - Development of a workplace violence training program that includes a written outline or lesson plan.
  - Annual review of the workplace violence prevention program, which should be updated as necessary. Such review and updates shall set forth any mitigating steps taken in response to any workplace violence incidents.
  - Development of procedures and responsibilities to be taken in the event of a violent incident in the workplace.
  - Development of a response team responsible for immediate care of victims, re-establishment of work areas and processes and providing debriefing sessions with victims and coworkers. Employee assistance programs, human resource professionals and local mental health and emergency service personnel should be contacted for input in developing these strategies.

Retail Industry. (See OSHA publication 3153)

Minimizing Risk through Engineering Controls and Workplace Adaptations

- Limit window signs to low or high locations and keep shelving low so that workers can see incoming customers and so that police can observe what is occurring from the outside of the store.
- Ensure that the customer service and cash register areas are visible from outside of the establishment.
- Place curved mirrors at hallway intersections or concealed areas.
- Maintain adequate lighting inside and outside the establishment.
- Install video surveillance equipment and closed-circuit TV to increase the likelihood of identification of perpetrators.
- Use door detectors so that workers are alerted when someone enters the store.
- Have height markers on exit doors to help witnesses provide more accurate descriptions of assailants.
- Install and regularly maintain alarm systems and other security devices, panic buttons, handheld 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.
- Install fences and other structures to direct the flow of customer traffic into and around the store.
- Control access to the store with door entry (buzzer) systems.
- Install physical barriers between customers and workers, such as bullet-resistant enclosures with pass-through windows.
- Use drop safes to limit the availability of cash to cashiers and post signs stating that cashiers have limited access to cash.
- Use a panic button and responsive staff or other system that can be used to call for back-up assistance, when needed in an emergency.
- Use an x-ray or other security screening to detect and prevent weapons from being brought into the facility.

Minimizing Risk through Administrative and Work Practice Controls

- Integrate violence prevention activities into daily procedures, such as checking lighting, locks and security cameras to help maintain a secure worksite.
- Require workers to use the drop safes and keep a minimal amount of cash in each register.
- Develop and implement procedures for the correct use of physical barriers, such as enclosures and pass-through windows.
- Establish a policy of when doors should be locked. Require workers to keep doors locked before and after official business hours.

- Require workers to lock unlocked doors when not in use.
- Require that deliveries be made during normal daytime operations.
- Develop and implement emergency procedures for workers to use in case of a robbery or security breach, such as calling the police or triggering an alarm.
- Train all staff to recognize and defuse verbal abuse that can escalate to physically combative behavior.
- Train all staff and practice drills for physically restraining combative patients or clients, including the use of physical restraints and medication, when appropriate.

Healthcare and Social Services Facilities. (See OSHA publication 3148)

Engineering Controls and Workplace Adaptations to Minimize Risk

- 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 without grids for patients who "act out" and establish separate rooms for criminal patients.
- Provide comfortable waiting rooms (client or patient) 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.
- Install partitions in transport vehicles to protect drivers from aggressive patients or clients.

Administrative and Work Practice Controls to Minimize Risk

- State clearly to patients, clients and employees that violence is not permitted or tolerated.
- Ensure that adequate and properly trained staff is 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 is 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. Review any workplace violence incidents from the previous shift during change-in-shift meetings.
- 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, physicians and other clinicians 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 healthcare 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 healthcare 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.

Taxi Drivers. (See OSHA fact sheet, Preventing Violence against Taxi and For-Hire Drivers)

- Use automatic vehicle location or global positioning systems (GPS) to locate drivers in distress.
- Use caller ID to help trace the location of fares.
- Provide first-aid kits for use in emergencies.
- Install in-car surveillance cameras to aid in apprehending perpetrators.
- Install partitions or shields to protect drivers from would-be perpetrators. These must be used properly to work effectively.
- Coordinate with police—taxi owners and police need to track high-crime locations and perpetrator profiles.
- Use radios to communicate in case of emergency (e.g., "open mike switch").
- Provide safety training to teach protective measures to drivers, dispatchers and company owners.
- Use silent alarms to alert others in the event of danger (e.g., "bandit lights").
- Install cashless fare systems (i.e., debit/credit cards) to discourage robbers.

Appendix C - Studies of Workplace Violence Abatement Methods

General / Combined Studies.

Bibliography of studies looking at the effectiveness of workplace violence prevention in different settings.

1. Injury Prevention Research Center. 2001. *Workplace Violence: A Report to the Nation.* The University of Iowa.

2. Loomis, D., Marshall, S. W., Wolf, S. H., Runyan, C. W., Butts, J. D. 2002. *Effectiveness of Safety Measures Recommended for Prevention of Workplace Homicide.* JAMA 287(8): 1011-1017.

3. National Institute for Occupational Safety and Health (NIOSH). 1996. *NIOSH Current Intelligence Bulletin #57: Violence in the Workplace: Risk Factors and Prevention Strategies*. NIOSH Publication No. 96-10 (July 1996).

4. Wassell, J.T. 2009. Workplace violence intervention effectiveness: A systematic literature review. Safety Science, 47: 1049-1055.

Healthcare and Social Services.

Bibliography of studies looking at the effectiveness of workplace violence controls in the healthcare setting:

1. Arnetz, J. E., Arnetz, B. B. 2000. Implementation and evaluation of a practical intervention programme for dealing with violence towards health care workers. Journal of Advanced Nursing, 31(3): 668 – 680.

2. Blando, J. D., McGreevy, K., O'Hagan, E., Worthington, K., Valiante, D., Nocera, M., Casteel, C., Pee-Asa, C. 2008. Violence: Recognition, Management and Prevention: Emergency Department Security Programs. Community Crimes and Employee Assaults. The Journal of Emergency Medicine. Article in Press.

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11. Goodridge, D., Johnston, P., Thomson, M. 1997. Impact of a nursing assistant training program on job performance, attitudes, and relationships with residents. Educ Gerontol, 23: 37–51.

12. Hunter, M. E., Love, C. C. 1996. Total quality management and the reduction of inpatient violence and costs in a forensic psychiatric hospital. Psychiatric Services, 47(7).

13. Infantino, J.A., Musingo, S.Y. 1985. Assaults and injuries among staff with and without training in aggression control techniques. Hosp Community Psychiatry; 36: 1312– 1314.

14. Lipscomb, J., McPhaul, K., Rosen, J., Brown, J. G., Choi, M. Soeken, K., Vignola, V., Wagoner, D., Foley, J., Porter, P. 2006. *Violence prevention in the mental health setting: The New York state experience.* The Canadian Journal of Nursing Research, 38(4): 96-117.

15. Martin, K. H. 1995. *Improving staff safety through an aggression management program.* Archives of Psychiatric Nursing, IX(4): 211 – 215.

16. McPhaul, K., Lipscomb, J., (September 30, 2004). *Workplace Violence in Health Care: Recognized but not Regulated*. Online Journal of Issues in Nursing. Vol. 9, No. 3, Manuscript 6. Available: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/No3Sept04/ViolenceinHealthCare.aspx

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Minnesota nurses' study. Occupational and Environmental Medicine, 62(10): 675–681.

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19. Walters, H., Kay, R. 2004. *Developing a compassionate control strategy*. Australian Nursing Journal, 76: 1 – 3.

Retail.

Bibliography of studies looking at the effectiveness of workplace violence controls in the retail setting:

1. Casteel, C.H., Peek-Asa, C. 2000. Effectiveness of Crime Prevention Through Environmental Design (CPTED) in Reducing Robberies. American Journal of Preventive Medicine, 18(4S): 99-115.

2. Casteel, C., Peek-Asa, C., Greenland, S., Chu, L. D., Kraus, J. F. 2008. *A study of the effectiveness of a workplace violence intervention for small retail and service establishments*. Journal of Occupational and Environmental Medicine, 50(12): 1365 – 1370.

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<u>Appendix D - Sample 5(a)(1) Hazard Alert Letters</u>

Note: The letters below are sample hazard alert letters, which may be customized to the specific incident and/or industry that have been inspected.

LATE NIGHT RETAIL

[Date]

Best One Gas Station
100 Orange Lane
Middle, IA 33333

Attention: Thomas Brown, General Manager

Dear Mr. Brown:

An inspection of your workplace at ***[street address, city and state]***, on ***[date]***, revealed that employees were exposed to hazards associated with workplace violence. The Occupational Safety and Health Administration (OSHA) regards workplace violence as a serious safety and health hazard. The purpose of this letter is to bring your attention to this hazard and to encourage you to address it within your establishment.

Our inspection found that you have not developed or implemented measures to protect workers from assaults or other forms of physical violence in your workplace. On several occasions, ***[list examples, e.g., the police have responded to your establishment regarding several robberies where two employees were shot and there have been other assaults involving firearms]***.

Since no OSHA standard specifically addresses workplace violence, we do not consider it appropriate at this time to invoke the General Duty Clause, Section 5(a)(1) of the Occupational Safety and Health Act of 1970. No citation will be issued for the presence of this workplace ***[hazard or risk]***. In the interest of workplace safety and health, however, I recommend that you voluntarily take the necessary steps ***[appropriate abatement action, e.g., as outlined in Recommendations for Workplace Violence Prevention Programs in Late-Night Retail Establishments (OSHA pub. # 3153-12R, 2009)]***. These recommendations may help to eliminate or materially reduce your employees' exposure to the risk factors listed above.

Feasible methods to protect employees from the hazard of physical assault may include, but are not limited to, the following: ***[List appropriate abatement actions]***.

(1) Develop a coordinated plan covering work practices and training to prevent/mitigate employee exposure to assault(s).

(2) Develop work schedules that would ensure that employees are not working alone.
(3) Provide reliable means of communication to employees who may need to summon assistance.
(4) Where work must be conducted on the night shift, coordinate with local law enforcement to have officers on site clear work stations of all patrons when changing shifts.

For additional guidance, please refer to ***[OSHA or industry-specific publications, e.g., Recommendations for Workplace Violence Prevention Programs in Late-Night Retail Establishments (OSHA pub. # 3153-12R, 2009)]***.

Under OSHA's current inspection procedures, we may return to your work site in approximately ***[recommended time period, e.g., one year]*** to further examine the conditions noted above.

Attached is a list of available resources that may be of assistance to you in preventing work-related injuries due to workplace violence.

If you have any questions, please feel free to contact the ***[Area Office]*** at ***[phone number]***.

Sincerely,

[Name]
Area Director

Attachments ***[(#)]***
OSHA's Internet web page on Workplace Violence.
OSHA Publication #3153 - Recommendations for Workplace Violence Prevention Programs in Late-Night Retail Establishments.
Free consultation, including on-site visits, from OSHA's 24(d) on-site consultation program.

HEALTHCARE AND SOCIAL SERVICES

[Date]

General Hospital
200 Main Street.
Springfield, OR 88888

Attention: Jane Smith, President

Dear Ms. Smith:

An inspection of your workplace at ***[street address, city, and state]***, on ***[date]***, revealed that employees were exposed to hazardous conditions associated with workplace violence. The Occupational Safety and Health Administration (OSHA) regards workplace violence as a serious safety and health hazard. The purpose of this letter is to bring your attention to this hazard and to encourage you to address it in your hospital.

Our inspection found that you have not developed or implemented measures to protect workers from assaults at your workplace. ***Two employees over the past two years report being assaulted by a client, but neither of these incidents had been reported to the employer.***

We do not consider it appropriate at this time to invoke the General Duty Clause, Section 5(a)(1) of the Occupational Safety and Health Act of 1970. No citation(s) will be issued at this time for the presence of this workplace violence ***[hazard or risk]***. In the interest of workplace safety and health, however, I recommend that you voluntarily take the necessary steps to eliminate or materially reduce your employees' exposure to the risk factors stated above.

Feasible methods to protect employees from workplace violence may be obtained from ***[list appropriate reference(s), e.g., OSHA publication, Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers (Pub # 3148-11R, 2004)]***. Listed below are some of those methods: ***[List appropriate abatement action(s)]***.

(1) Establish a comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents.
(2) Develop work schedules that would ensure that employees are not working alone.
(3) Provide reliable means of communication to employees who may need to summon assistance. One possible means of communication is the use of two-way radios.
(4) The team coordinator should periodically inspect the workplace and evaluate employees' tasks to identify hazards, conditions, operations and situations that could lead to violence.

(5) Identify potential places of safety and shelter at each work location.
(6) Conduct mandatory training for employees to learn, at a minimum, the following items: (a) How to recognize the earliest stages of a possible assault; (b) How to avoid or mitigate potential violent encounters (including some words that non-English speakers may use to help de-escalate an assault; (c) How to seek refuge/assistance if violence appears imminent; and (d) How to use restraint and/or release techniques.
(7) Place curved mirrors at hallway intersections or concealed areas.

Under OSHA's current inspection procedures, we may return to your work site in approximately ***[recommended time period, e.g., one year]*** to further examine the conditions noted above.

Attached is a list of available resources that may be of assistance to you in preventing work-related injuries due to workplace violence.

If you have any questions, please feel free to call the [Area Office] at [phone number].

Sincerely,

[Name]
Area Director

Attachments ***[(#)]***
OSHA's Internet web page on Workplace Violence.
Free consultation, including on-site visits, from OSHA's 24(d) on-site consultation program.
Free publications on Workplace violence - Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers (Pub. # 3148-11R, 2004).

Appendix E – Notification Memo Template for the National Office

MEMORANDUM FOR:	DAVID MICHAELS, PhD, MPH Assistant Secretary
THROUGH:	RICHARD E. FAIRFAX Deputy Assistant Secretary
FROM:	THOMAS GALASSIS, Director Directorate of Enforcement Programs
SUBJECT:	Notification of Workplace Violence 5(a)(1) Activity **Gala Hospital** **Harper, Texas** **Inspection #999999983** **Total Penalty: $3,500**

ISSUE:
This memorandum is to notify you of Region IV's intention to issue a citation with a penalty of $3,500 to Gala Hospital. The six-month statute of limitations for issuing these citations expires on September 3, 2010. The Ames Area Office will issue the citations upon National Office approval.

COMPANY BACKGROUND

Gala Hospital is a 455-bed regional medical center that employs approximately 3,000 employees, 50 of whom work in the psychiatric ward located on the 4th and 5th floors of the South wing. The nurses at this location are represented by the ABC Nurses' Union, Unit 23, Local 675.

OSHA INSPECTION HISTORY:

Beginning in 1993, OSHA had inspected Gala Hospital eight times, resulting in the issuance of 14 serious violations and 16 other-than-serious violations. An inspection in 1999 was based on a complaint regarding a violent incident, which had taken place on the psychiatric unit of the hospital between a nurse and a patient. OSHA issued a letter of significant findings (a 5(a)(1) letter), which provided recommendations for the enhancement of policies that the hospital had designated as its workplace violence program. Information provided by OSHA covered the following areas: worksite analysis, engineering controls, administrative controls, work practice controls, recordkeeping, training and education, and evaluation of the program.

REASON FOR INSPECTION:

On January 3, 2010 OSHA's Area Office received a formal complaint from the President of the Gala's Nurses' Union. The complaint alleged that five nurses were assaulted while working at the Gala Hospital's In-patient Psychiatric Unit located on the 4/5 South floor of the hospital. Additionally, the complaint alleged that the employer had failed to put effective work practices in place and had not made any security changes to reduce worker exposure to the hazards associated with workplace violence. Utilizing OSHA's non-formal complaint process, the employer was contacted regarding the allegations. The employer responded to the allegations in a January 28, 2010 letter. The complainant received a copy of the response from the employer and on February 15, 2010, the Area Office received a letter from the complainant disputing the employer's response to the complaint. This resulted in the initiation of a March 3, 2010 inspection.

INSPECTION SUMMARY:

The current inspection was opened on March 3, 2010 and conducted by Assistant Area Director (AAD) Madeline May. AAD May returned to the facility on March 20th, 27th and April 3rd to complete the inspection. The sixth-month date following this inspection is September 3, 2010.

The basis of the inspection is a complaint that alleges that employees at the facility are exposed to the hazard of physical assaults by patients in the psychiatric ward and in other areas of the hospital, such as the Emergency Room and Outpatient Drug Treatment Clinic. The initial complaint listed five instances in 2009 when nurses were attacked while working in the 4/5 South Psychiatric Unit. During the course of this inspection, a nurse working on 8th West was shot two times by a young patient who had brought a gun into the hospital. Employee interviews conducted during the inspection revealed that the hospital was clearly aware that its employees were exposed to hazards associated with workplace violence. While Gala Hospital has some components of a workplace violence prevention program in place, it has failed to provide a cohesive and comprehensive prevention program to address these hazards. In addition to the incidents listed in the complaint, AAD May uncovered additional incidents of workplace violence that had occurred within the last three years.

On or about October 23, 2007, a patient waiting in the Emergency Room attempted to punch a nurse in the face, after first throwing a chair. The nurse who was almost hit had not been told about the chair incident.

On or about July 3, 2008, a technician called in sick to the Psychiatric Ward, 4/5 South and her duties were distributed to the remaining staff. During the day one patient complained that he was in pain and wanted to leave the ward. When a nurse tried to give the patient his medication, he knocked her unconscious, causing her to fall and break her leg. When interviewed, the nurse noted that the patient had broken a phone two days earlier but that it had not been noted in his chart.

On or about February 2, 2009, a security guard was trying to assist a patient at the Outpatient Drug Clinic when the patient attacked the guard. When the guard fell, the patient continued his attack.

On or about March 15, 2010, a nurse was shot two times by a young patient on 8 South within the general medical facility. The patient had been admitted on March 14, 2010 for severe stomach pains and was also showing signs of paranoia. A psychiatrist, who was called to evaluate her, stated that she was showing good behavioral control but prescribed some medications. Prior to the shooting, the patient did not show any outward signs of violence. On March 15th, a nurse went into the room to check on the patient. When the nurse left, the patient followed the nurse into the hall and pointed a gun at the nurse and other staff members. The Assistant Nurse Manager observed what was happening and attempted to grab the gun. A struggle ensued and the Assistant Nurse Manager sustained gunshot wounds to her hand and left jaw. A security guard was then shot in the leg when he arrived at the scene and scuffled with the patient. The Assistant Nurse Manager spent four days in the hospital and had surgery on her jaw.

On or about March 28, 2010, a nurse on the psychiatric ward was kicked by a patient while security was trying to hold the patient down. The unit requested two security guards but only one showed up, stating that the other guards were busy.

During interviews with staff, one of the main concerns raised by all employees was the two-floor layout of the psychiatric ward and the danger they thought it posed for transporting patients on the stairs. Patients who could not travel up and down stairs had to be taken out of the locked unit into the public areas of the hospital to be transported on the elevators, where nurses were alone with the patients. Concern was also raised because there was no full-time security presence on the ward. If there was an incident, staff called security, but response time varied anywhere between five and fifteen minutes and sometimes took as long as thirty minutes. If there were a full-time security presence, staff felt the response time would be seconds.

Patients were not screened or searched unless they showed outward signs of aggression. Employee interviews indicated that patients and visitors are not informed about the hospital's policy concerning workplace violence. During the employee interviews, almost no one could state exactly where the workplace violence prevention program was located or what information it contained. The majority of the employees stated that there was no guidance on how to deal with workplace violence and they were instructed to use their own judgment. Some employees stated that when they reported an incident to their supervisor, they were told to just deal with it and focus on making the client happy. In the psychiatric ward, several employees stated that when they reported an incident to their supervisor, the supervisor would say that the employee had done something wrong and caused the incident. Some employees indicated that they were concerned about possible retaliation.

The employer has taken several measures to reduce employee exposure to violent activities (see employer recognition in the 5(a)(1) justification below). However, the staff believed these measures were not effective and that additional efforts were needed to reduce injuries in the workplace.

GENERAL DUTY CLAUSE JUSTIFICATION:

Citation 1, Item 1: Section 5(a)(1) - The employer did not furnish employment and a place of

employment that were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees were exposed to the hazard of being assaulted by violent patients causing fatal or serious physical injuries while working in the psychiatric ward, emergency department's behavioral care unit and the general medical floors.

(a) The employer failed to keep the workplace free of a hazard to which employees were exposed:

Employees are exposed to violent behavior by patients that results in verbal threats and assaults to staff. Within the past five years, there have been approximately 20 cases that have resulted in 212 restricted duty days and 399 days away from work, as well as 106 non-recordable cases as a result of gunshot wounds; serious fractures; contusions; bites; head injuries; being punched in the face and being hit and kicked by violent patients in the psychiatric ward, emergency department and the general medical floors. Out of the 20 cases of restricted duty or days away from work, five of these cases occurred on the psychiatric ward. Some of the contraband patients have been successful in bringing into the hospital include: a gun, box cutters, knives, razor blades, lighters and drug paraphernalia.

Employees are exposed to violent patient behavior during the transportation of patients up and down the set of stairs in between the psychiatric floors of 4 and 5 South. When a staff member is transporting a patient, one nurse may sometimes be left alone on the floor with the remaining patients. There is no full-time security presence on the ward, and the response times when they have been called for can run between 5-30 minutes.

Fourteen employees were interviewed in the course of the inspection. Most could not explain the details of the hospital's workplace violence prevention program, nor could most describe the location of such a program. Management employees could give more information than non-management employees regarding the workplace violence prevention program at the facility.

Violence in the workplace entries reflected on the OSHA 300 logs for 2005 included 6 entries; in 2006, there were 4 entries; in 2007, there were 2 entries; in 2008, there were 3 entries, and in 2009, there were 5 entries. These entries included multiple strains, sprains, contusions, fractures, gunshot wounds and bites. In 2010, there were 12 incidents involving agitated patients, with 2 recordable entries.

(b) The hazard was recognized:

Industry Recognition:

(1) Joint Commission requirements, Sentinel Event Alert, (Issue 45, June 3, 2010), "Preventing Violence in the Health Care Setting"

(2) HR Magazine (March 1995, Vol. 40, page 51) "Preventing violence against health-care workers"

(3) NIOSH Publication No. 2002-101, Violence: Occupational Hazards in Hospitals

(4) The Online Journal of Issues in Nursing (September 30, 2004)

(5) Hospitals and Health Networks (September, 2006, Vol. 80, page 56) "Stopping ED violence before it happens"

(6) The Health Care Manager (Oct.-Dec. 2008, Vol. 27, page 357) "Hidden workplace violence: What your nurses may not be telling you"

(7) Security Management (November 2009, Vol. 53, page 22) "Protecting Caregivers"

Employer Recognition:

(1) On October 20, 1993, the OSHA Area Office received a formal complaint regarding a violent incident that occurred in the psychiatric unit of the hospital. The complaint had Sandra Gold, president and CEO of Gala Hospital, listed as the management official. An inspection was conducted and a hazard alert letter was sent to the hospital concerning workplace violence.

(2) Following this complaint and the recommendations included in the hazard alert letter, all employees of the psychiatric ward carry a pendent-type wireless personal emergency assistance alarm; all employees in the psychiatric ward and most nurses in the hospital carry a cordless phone in case of an emergency.

(3) In the hospital's Security Management Plan, there are chapters that address workplace violence: Violent Patients (2333-5.15); Assault of Hospital Employees or Medical Staff (2333-5.16); Armed Intruders (2333-5.26); Suggestions for Managing Code Blue Situations (security emergencies and disturbances).

(4) Sandra Gold, the president and CEO of Gala Hospital, had signed all of the OSHA 300A summaries, which captured the 20 cases that had resulted in restricted and/or lost work days due to incidents of workplace violence.

(5) The Vice President of Quality and Patient Safety admitted in an interview that workplace violence was a hazard in the hospital.

(6) On January 3, 2010, the OSHA Area Office received a complaint alleging that five nurses were assaulted while working in the hospital's in-patient psychiatric unit located on 4/5 South floors of the hospital. The complaint also alleged that the employer had failed to put effective work practices in place and had not made any security changes to reduce worker exposure to the hazards associated with workplace violence. The employer responded to the allegations in a letter dated January 28, 2010.

(c) The hazard was causing or was likely to cause death or serious physical harm:

There have been approximately 20 cases, in the past five years, of restricted duty and/or days away from work, as well as 106 non-recordable cases because of injuries such as gunshot wounds, serious fractures, contusions, bites, head injuries, punches to the face and hits and kicks by violent patients in the psychiatric ward, emergency department and the general medical floors. These injuries resulted in 212 restricted work days and 399 days away from work.

(d) There was a feasible and useful method to correct the hazard:

Among other methods, feasible and acceptable means to abate the hazard of workplace violence in Gala Hospital include:

(1) Ensure that all patients who receive a psychiatric consultation are screened for a potential history of violence before being admitted to the hospital. In addition, consider using hand-held metal detecting wands to detect weapons that may be concealed by the patient.

(2) Ensure that security staff members are readily and immediately available to render assistance in the event of an incident of workplace violence and that security has had specialized training to deal with aggressive behavior.

(3) Make the psychiatric ward a one-floor unit so that employees are not alone with patients on the floor. In lieu of creating a one-floor unit, administrative controls should be put in place to prevent employees from being alone with patients. In particular, employees should not be transporting potentially violent patients alone in stairwells or in elevators. Security should be present and available immediately in the event of an incident of violence.

(4) Use a system to flag a patient's chart anytime there is a history or act of violence and train staff to understand the flagging system. Put procedures in place that would allow communication of any incident of workplace violence to the staff that might come in contact with that patient so that employees who might not have access to a patient's chart would be aware of a previous act of aggression or violence.

(5) Conduct more extensive training so that all employees are aware of what the hospital's workplace violence policy is and where that information can be found. In addition, train all employees to state clearly to patients, clients and employees that violence is not permitted or tolerated. Train all employees on recognizing when a patient is exhibiting aggressive behavior and techniques for de-escalating that behavior.

(6) Create a stand-alone written Workplace Violence Prevention Program for the entire hospital that includes the following elements:

- A workplace violence policy statement that includes responsibilities of all staff
- Hazard/threat assessment including records review, inspection of the worksite and employee survey
- Implementation of workplace controls and prevention strategies
- Training and education of all staff
- Incident reporting and investigation
- Periodic review of the program
- Specific procedures employees are to take for an incident of workplace violence in the hospital, as well as the proper procedures to report those incidents.

Appendix F – Informed Consent Form Example

Release and Consent

I hereby consent and release to the U.S. Department of Labor, Occupational Safety and Health Administration (OSHA), the right to use my picture and sound being videotaped or photographed during an OSHA inspection of ____________________________ (name of facility) commenced on ______________ (date). I understand that this videotape or photograph will be used solely to document employee safety and health conditions at the facility, and may be used as evidence in legal proceedings related to those conditions.

____ ______________________

Signature of Resident Date

In the event that there has been a medical or legal determination that a resident cannot give informed consent to be videotaped or photographed, the following shall be used:

On behalf of ____________________________ (name of resident), I hereby grant to the U.S. Department of Labor, Occupational Safety and Health Administration, the right stated above.

____ _______________________

Signature of person authorized to give informed consent on resident's behalf Date

Signature of Witness | Date