Case 345. 71-year-old direct care worker at a group home died from complications of being struck on her face by a 12-year resident of the home.

A 71-year-old female direct care worker at a group home died from complications of being struck on her face by a 12-year resident of the home. The decedent and another employee entered the room after knocking on the door and announcing themselves. The resident became angry when she entered his room and he slapped her on the face. Her coworker heard the sound of the slap. The injured worker fell down onto the bed. She immediately got up and left the room. She recorded the incident but did not report the incident to management immediately. When she next reported to work, one of her teeth fell out and she was sent to local clinic which referred her to a dentist. The clinic indicated that she did not complain of a headache or pain. The clinic authorized her immediate return to work. The decedent was not scheduled to return to work for four days after her visit to the clinic. She went home after the clinic visit. Early the next morning, a family member found her unconscious and took her to the hospital where she died the following day. Her cause of death as stated on the death certificate was blunt traumatic head injury. The decedent had received entry level care giver training-providing residential services in community settings and had successfully completed all employer-required training.

MIOSHA General Industry Safety and Health Division issued the following **Safety and Health Recommendations** to the employer at the conclusion of its investigation:

An inspection/investigation of your worksite revealed the following conditions which may constitute a safety or health hazard to your employees:

WORKPLACE VIOLENCE

1. Create a stand-alone written Workplace Violence Prevention Program for Macomb Family Services that includes the following elements:

a. A workplace violence policy statement that includes responsibilities of all staff

b. Hazard/threat assessment including records review, inspection of the worksite and employee survey

c. Implementation of workplace controls and prevention strategies

d. Training and education of all staff

e. Incident reporting and investigation

f. Periodic review of the program

g. Specific procedures employees are to take for an incident of workplace violence in the residential homes, as well as the proper procedures to report those incidents.

2. Conduct training so that all employees are aware of what Macomb Family Service's workplace violence policy is and where that information can be found. In addition, train all employees to state clearly to consumers and employees that violence is not permitted or tolerated. Train all employees on recognizing when a consumer is exhibiting aggressive behavior and techniques for de-escalating that behavior.

3. Ensure all consumers who receive a psychiatric consultation are screened for a potential history of violence before being admitted to the home. In addition, consider using hand-held metal detecting wants to detect weapons that may be concealed by the consumer.

4. 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.

5. 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.

6. Provide staff members with security escorts to parking area in evening or late hours. Ensure that parking areas are highly visible, well lit AND safely accessible to the building.

ERGONOMIC HAZARDS

1. Establish an ergonomic committee comprised of management and employees that devotes time to ergonomic issues including conducting assessments of job tasks that are showing early signs of or are actually causing ergonomic related injuries and illnesses

2. The employer's injury and illness reports for calendar years 2006-2013 described ergonomic related injuries. The use of lifts should be utilized as often as possible.

3. Contact an outside ergonomic expert to assist with the identification, evaluation, and control of ergonomic hazards.

4. Continue to evaluate all ergonomic injuries by on-site Direct Care Workers. An effective medical management program should include establishment of one occupational physician or group that is familiar with your operations to refer all employees to who have suspected workplace ergonomic related injuries or illnesses for appropriate diagnosis and treatment. Allow physicians and nurses' regular time to tour employee work stations to identify ergonomic risk factors which may lead to work related musculoskeletal disorders (MSDs).

5. Continue to provide training on ergonomic hazards for employees and management on resident transfers, proper lifting techniques, proper working postures, and office ergonomic issues. Also continue to provide training to staff on the following:

a. How to recognize the primary ergonomic risk factors of awkward posture (body position), force (how much you lift/push/pull), and repetition (how often you perform the task).

b. How to recognize the early symptoms of ergonomic related injuries and/or illnesses

c. Proper procedures for reporting and recording ergonomic related injuries or illnesses

d. Proper working postures (i.e., neutral body position) and proper use of equipment provided (i.e., lift assists).

6. Provide more in depth ergonomic training to members of the ergonomic committee.

7. Continue to pursue equipment purchases (i.e., lift assists). Workstations redesigns, modified work practices, and other tools that are identified by the health and safety committee, ergonomic committee and/or outside ergonomic expert as ways to reduce or eliminate ergonomic hazards.

a. Manual lifting of residents should be minimized in all cases and eliminated when feasible.

b. Ensure that lift assists are maintained in good operating condition by performing regularly scheduled preventive maintenance and removing lift assists from use when not operating properly.

c. Continue to utilize the Federal OSHA "Guidelines for Nursing Homes (OSHA 3182-3R 2009) to control ergonomic related risk factors related to resident handling/patient transfers for Certified Nurses Aids (CNAs) and Resident Assistants (RAs).

d. Evaluate the effectiveness of ergonomics efforts and follow up on unresolved problems. Evaluation helps sustain the effort to reduce injuries and illnesses, track whether or not ergonomic solutions are working, identify new problems, and show areas where further improvement is needed. Evaluation and follow up are central to continuous improvement and long-term success.