AFT Nurses and
Health Professionals

Checklist for the Hospital Preparedness Plan for All Hazards

This checklist is a tool for local leaders and health and safety activists who engage with management on joint safety and health committees. It can help you to compare the facility's health and safety policies and procedures to best practices and OSHA standards. The checklist is a living document—it can be revised and reused as needed to reflect changes in best practices and standards as well as facility-specific needs. The union can use the result of the checklist assessment to develop priority issues.

Your feedback is needed to improve this checklist. Please let us know what is useful and where the checklist is not reflective of current practices at this point in the pandemic.

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I. General Requirements for Labor-Management Health and Safety Committees

Representation Issues	**Completed**	**In Progress**	**Not Started**
Equal representation between union and management representatives on the committee.			
The union has chosen their own representatives.			
Frontline workers on the committee represent different units and different shifts as much as is feasible.			
Union representatives have release time to participate in meetings.			
Union representatives' positions are backfilled so that their meeting attendance does not aversely impact staffing in their units.			
The management chair is in senior management or has the decision-making ability to effect changes recommended by the committee.			
Management consistently sends managers or staff with the relevant expertise to address concerns.			
Chairing and Scheduling			
Meetings are co-chaired by the union and management or there is rotating chairing.			
Meetings are scheduled for the year or have a regular meeting schedule.			
There is a plan in place for rescheduling meetings if they are cancelled.			
Meetings are held frequently enough to meet health and safety needs.			
Agendas and Minutes			
Agendas and reports are sent in advance.			
The union can add new items to the agenda.			
There is space in the agenda for last minute concerns.			
The union keeps notes in addition to the official minutes.			
The official minutes from the previous meeting are sent in advance so that you have time to review them before the meeting.			
The union challenges management over inaccuracies in the official minutes.			
Reports are organized to provide meaningful information—they are not just data dumps			
Responsibility for action items is assigned, with deadlines for completion.			
The union keeps a chart or spreadsheet tracking progress that includes when issues are brought to the committee and if or when they are addressed.			
The Local Executive Board (LEB) or a dedicated Safety Rep reviews the spreadsheet regularly.			
Union Strategy and Strength			
The union meets in advance of the joint committee to prepare and plan.			
The union makes information requests regularly for OSHA 300 logs, COVID-19 logs, OSHA 301 forms/incident reports, or other needed documentation.			
The union conducts root cause analysis on incidents/issues and/or insists on root cause analysis during the joint committee meeting.			
The union makes a strategic plan for safety and health that considers strengths, weaknesses, opportunities, and barriers or threats.			
The union communicates health and safety efforts regularly to members.			
The union has an escalation plan for health and safety tactics.			
Training			
The employer provides all committee members with initial and routine training on: -All current facility health and safety policies and programs, including the roles of all personnel responsible for safety in the facility and its department. -State and federal health and safety standards and regulations (OSHA, CMS, Joint Commission,			

etc.) -Hazard assessment, data analysis, including OSHA log analysis, and incident investigation. -New technology and implications for personnel safety.			

II. Respiratory Infectious Diseases (including COVID-19, influenza, and other emerging or highly infectious diseases)

Union access to written plans, policies, and procedures	**Completed**	**In Progress**	**Not Started**
The union has a copy of the current written respiratory protection plan. The employer must provide this under the OSHA Respiratory Protection Standard.			
The union has a copy of the current COVID-19 plan, including related policies and procedures. (Under the now withdrawn OSHA COVID-19 emergency temporary standard for healthcare the union had the right to current and past copies.)			
Recordkeeping and reporting, workplace presumption			
The employer records all cases of employees infected with COVID-19 infection on the *COVID-19 log* as required by OSHA, *regardless of whether employees were infected at work*. (This part of the ETS is still in effect, 29 CFR 1910.502(q)(2)(ii), (q)(3)(ii)-(iv), and (r)) The employer must redact the names on the log if provided to the union.			
The employer records all *work-related cases* of COVID-19, flu, and highly infectious disease among staff and contractors on the *OSHA 300 log*. Names should not be redacted for COVID-19 cases.			
The union regularly requests the COVID-19 log, the OSHA 300 log and OSHA 301 forms.			
The union asks members infected with COVID-19 to request their individual log entry on the COVID-19 log to confirm whether the employer is meeting recordkeeping requirements.			
The employer reports work-related hospitalizations from COVID-19, flu, or other highly infectious diseases to OSHA within 24 hours as required by the OSHA recordkeeping standard.			
The employer reports work-related fatalities from COVID-19, flu, or other highly infectious diseases to OSHA within eight hours.			
The employer recognizes that cases of employee infection with COVID-19, influenza, and highly infectious diseases are work-related for healthcare workers responding to an outbreak.			
Employee health provides information to infected workers on how to apply to workers compensation.			
Patient screening, testing, monitoring, and reporting infectious disease/COVID-19 cases, visitor policies			
The hospital has a process to screen all potentially infected patients before entry, for both admissions and ambulatory/outpatient procedures.			
The hospital has a process to screen and triage patients upon arrival.			
Masking or source control for patients and visitors is enforced.			
The hospital has a process to isolate suspect case patients immediately upon arrival, including use of a separate waiting area, or requiring patients to wait in a parked car.			
Staff have been trained to rapidly identify and isolate suspect case patients in an airborne infection isolation room (AIIR) or an enclosed room if an AIIR is not available.			
The hospital has an agreement that emergency medical services personnel notify hospital staff (in advance) if the patient is potentially infectious. OR All patients arriving via emergency transport are presumed to be infectious and personnel are provided respirators, gowns, gloves, and eye protection.			
Staff receiving patients from within the facility are notified of the patient's infection status.			

	Completed	In Progress	Not Started
The employer has developed a process to notify facility infection control, local or state health department of positive cases and has a method to track admissions and discharges of positive cases.			
The hospital has criteria and a protocol for when visitors will be limited or restricted.			
Screening, testing, monitoring and reporting staff infections			
The employer has implemented a daily symptom screening process for staff, contractors, and volunteers.			
The employer has implemented a system for staff, contractors, and volunteers to report symptoms, close contact exposure, or positive test results.			
A written protocol has been developed and implemented for semi-weekly or weekly screening/surveillance testing for staff, contractors, and volunteers.			
A written protocol has been developed and implemented for semi-weekly testing in areas with *staff outbreaks*.			
Notification of exposure and medical removal			
The employer notifies staff of COVID-19 close contact exposure within 24 hours of the exposure being known to the employer, except in designated COVID-19 care areas where staff know they are in close contact with suspected or confirmed cases, regardless of their vaccination status.			
Staff infected with COVID-19 are removed from the workplace for a minimum of 10 days or 7 days with a negative test as recommended by the CDC. Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC			
The employer will not recall infected, symptomatic staff to work.			
Infected employees will not face retaliation for refusing to return to work while symptomatic.			
Employee health services will provide information to COVID-19 infected workers on applying for workers' compensation for COVID-19 infection.			
Staffing/Administrative controls			
A cohort of staff who will only care for suspected and confirmed COVID-19 patients has been identified to reduce infection spread within the facility.			
Staff in COVID-19-positive patient care areas who are at higher risk of severe disease have been reassigned to other areas.			
The employer will use strategies such as staff cross training, staff financial incentives, and use of agency staff before resorting to contingency and crisis staffing standards.			
The employer will reduce/discontinue elective care before resorting to contingency and crisis staffing standards.			
The employer will notify the union of plans to implement contingency or crisis staffing standards or care.			

Respiratory Protection Program 1910.134 - Respiratory Protection. | Occupational Safety and Health Administration (osha.gov)	Completed	In Progress	Not Started
The LEB understands the requirements of the Respiratory Protection Standard.			
Medical Evaluation, Fit Testing, and Training Requirements			
The employer provides OSHA compliant mandatory *medical evaluation* for all staff who need to wear a respirator in compliance with the OSHA respiratory protection standard. (Appendix C)			
As much as feasible, the employer offers a wide variety of respirators for workers to choose from at the workplace.			
The employer conducts *annual fit testing* for all staff who need to wear a respirator in compliance with the standard.			
The employer conducts *fit testing for any novel* respirators (new to the worker) in compliance with the standard.			
Fit testing includes a choice of respirators so the worker can choose the one with the most comfortable fit.			
Fit testing results are documented. Workers have access to documentation about their fit testing results.			
The employer provides OSHA compliant training to workers as required by the standard.			
Respirator Access and Supply			
The employer provides respirators for staff who are in close contact or potentially in close contact to patients and visitors with suspected or confirmed COVID-19.			
The employer provides respirators for staff and contractors who are in close contact or potentially in close contact to patients and visitors with suspected or confirmed influenza or may be infected with a novel, highly infectious virus.			
The employer provides respirators for staff and contractors who want to wear them or does not prevent them from wearing their own respirators.			
The employer maintains an inventory and tracks the supply of personal protective equipment (face masks, N95 respirators and equivalents, elastomeric respirators, PAPRs (powered air-purifying respirators), face shields, goggles, gowns, gloves and fit-testing supplies).			
The employer shares the PPE inventory with the union.			
The facility will invest in a supply of reusable respirators (elastomeric respirators, PAPRs, or CAPRs) and training and the supplies needed to disinfect them.			
PAPRs or CAPRs will be available to any worker assigned a respirator who cannot be successfully fit tested to use a disposable respirator.			
The employer has estimated the number of respirators and other PPE needed for a minimum eight-week infectious disease outbreak or surge. See the NIOSH PPE burn rate calculator: Personal Protective Equipment (PPE) Bur Rate Calculator | CDC This estimate should be based on a conventional provision of respirators and other PPE and not on a contingency or crisis provision: Optimizing Personal Protective Equipment (PPE) Supplies (cdc.gov)			
The facility has a stockpile of the PPE needed for a minimum eight-week surge, including disposable respirators and reusable respirators and disinfecting supplies. The employer maintains the stockpile.			
The facility will implement a protocol for regularly assessing the condition of N95s and other respirators in the stockpile. The employer will dispose of expired respirators from the facility stockpile.			

	Completed	In Progress	Not Started
In the event of contingency or crisis levels of care as established the CDC, the employer does not require extended N95 use beyond five donnings as recommended by NIOSH/CDC. Strategies for Optimizing the Supply of N95 Respirators: COVID-19 | CDC			
The facility has established multiple channels for purchasing PPE and other supplies from multiple suppliers.			
Facility has a contingency plan for PPE shortages, including working with the health department to obtain supplies.			
Substandard or Counterfeit Respirators			
The employer verifies that N95s are certified by NIOSH and are not counterfeit. Approved N95 Respirators 3M Suppliers List | NPPTL | NIOSH | CDC Counterfeit Respirators / Misrepresentation of NIOSH-Approval | NPPTL | NIOSH | CDC			
There is a clear reporting procedure for employees to use if respirators or other PPE is substandard or may be counterfeit. Management documents and tracks these reports.			
Workers are not required to use respirators they feel are substandard or counterfeit.			
The employer removes questionable N95s or other respirators from circulation until they can be investigated and found to be authentic.			
The union will have access to the reports on substandard or counterfeit respirators.			
OSHA Personal Protective Equipment Standard Personal Protective Equipment - Overview | Occupational Safety and Health Administration (osha.gov) 1910.132			
The LEB understands the requirements of the Personal Protective Equipment Standard.			
Management has performed a hazard assessment for each job title to determine which PPE is necessary for worker protection.			
The PPE identified as necessary in hazard assessments is made available at all times to the employees in each job title.			
The union and labor-management health and safety committee review the hazard assessments at least annually and revise them as necessary.			
Vaccines			
Training on the vaccines for COVID-19 and influenza, including benefits, risks, and side effects, is provided to staff prior to vaccine administration.			
Training is provided in oral and written language accessible to staff. Training includes opportunities for staff to ask questions and receive answers from knowledgeable trainers.			
A declination form has been implemented for the flu vaccine. Staff who decline the flu vaccine must sign the declination form after training.			
The employer must provide a process to allow employees to apply for medical or religious exemptions for the COVID-19 vaccine.			
Staff and contractors may take days off to recover from the side effects of the vaccines without reprisal. They do not have to use their own sick days or annual leave.			

Training	**Completed**	**In Progress**	**Not Started**
In addition to training on PPE and vaccination, the employer provides staff with language and reading level-appropriate training on hazards associated with COVID-19, flu, or a highly infectious emerging disease, including: -modes of transmission -signs and symptoms -infection control practices -staying home when sick -actions to take for unprotected exposures -reporting methods to track COVID-19 exposure, illness, and return to work procedures.			
The employer has a process to provide updated and ongoing job-specific training as needed for staff floating to new areas.			
Ventilation and Surge Plans			
The facility ventilation system has been assessed, and increased ventilation exchanges and filter efficiency improvements are implemented as per ASHRAE standards. The facility uses MERV 13 or better filters in HVAC systems wherever feasible.			
The Director of Operations makes regular reports to the Health and Safety Committee on efforts to maintain the HVAC system, including assessments and the maintenance schedule.			
The Director of Operations makes regular reports on efforts to maintain the AIIRs and the committee members review the reports regularly.			
The facility has a plan and the capacity to implement temporary AIIRs and/or ventilated headboards.			
Surge capacity plans include temporary barriers to control movement and reduce infection spread into non-COVID-19 patient care areas.			
Surge capacity plans include strategies to use in emergency departments to mitigate surge and accommodate additional patients. Strategies such as alternate triage sites, use of telemedicine and call centers may be considered to reduce surge on the facility.			
Surge capacity plans include strategies to help increase hospital bed capacity, including transfers to other facilities.			

III. Needlestick Safety and OSHA Bloodborne Pathogens Standard

Bloodborne Pathogens - Standards | Occupational Safety and Health Administration (osha.gov) 1910.1030	Completed	In Progress	Not Started
The LEB understands the requirements of the Bloodborne Pathogens (BBP) Standard.			
The union has a copy of the Exposure Control Plan. The employer must have a written plan as required by the standard.			
All staff with potential exposure to blood and other infectious materials are offered the hepatitis B vaccines at no cost, as required by the BBP standard.			
All staff offered the vaccine receive training in accessible language in advance of vaccination.			
Staff who refuse the vaccine must sign a declination form.			
The employer maintains a sharps log of sharps injuries which at minimum documents the type and brand of device involved and a description of and the location of the incident.			
The health and safety committee reviews the sharps log at least annually in order to understand trends and recurrent problems with devices or training and to update BBP policy in response.			
The health and safety committee, a subcommittee, or a group of non-managerial employees helps to identify, evaluate, and select effective safer devices and other engineering controls.			
This committee identifies, evaluates, and implements safer work practices.			
The employer follows the recommendations of the committee by purchasing safer devices.			
The employer works to eliminate or reduce sharps hazards through use of needleless IV systems, jet injectors, skin glue, and/or blunt suture devices.			
Sharps-related engineering controls are examined and maintained or replaced on a regular schedule, as required by the BBP standard.			
The facility has enough FDA-approved sharps containers or other sharps containers.			
Sharps containers are located where they are accessible to staff and as close as feasible to the immediate area where they are used as required by the BBP standard.			
Sharps containers are kept upright at all times when in use.			
Sharps containers are replaced when three-fourths full or full to the full line.			
Staff with potential exposure to sharps injuries are receive training upon hire and annually thereafter.			
Staff are trained in the following: -To not remove needles from syringes by hand. -To avoid recapping unless there is no feasible alternative or it is required by a medical procedure. -If a needle must be recapped, it is done with a mechanical device or with a one-handed “scoop” technique (using the needle itself to pick up the cap and the cap is pushed against a hard surface. Staff are trained not to use both hands to recap. -To only dispose of sharps in approved containers.			
The employer has a “No blame, no shame” non-retaliatory exposure reporting policy to encourage staff to report all needlestick incidents.			

IV. Chemical Exposure

OSHA Hazard Communication Standard Hazard Communication - Overview | Occupational Safety and Health Administration (osha.gov) 1910.1200 - Hazard Communication. | Occupational Safety and Health Administration (osha.gov)	**Completed**	**In Progress**	**Not Started**
The employer labels all chemicals used in the workplace, including hazardous drugs and cleaning supplies. The employer ensures that labels conform to the Globally Harmonized System for Hazard Communication			
The employer provides comprehensive training for workers on all chemicals to which they may be exposed. (OSHA and Joint Commission requirement). -Training is provided in a language and at an educational level understood by the worker.			
Workers are trained not to combine products or transfer them into other containers other than as directed by the manufacturer.			
The employer keeps safety data sheets for all chemicals used in the workplace in a place accessible to workers, 24 hours a day, 7 days a week.			
The employer trains workers on how to interpret and access the safety data sheets. (OSHA and Joint Commission requirement)			
For each chemical substance used in the facility, the employer stays within the OSHA permissible exposure limit (PEL) over a time-weighted average (TWA) and under the short-term exposure limit (STEL). -The employer is aware of the exposure minimum that is immediately dangerous to life and health (IDLH).			
The employer keeps up to date on recommended exposure limits (RELS) (may be lower than OSHA PELS and applies to more substances) using the following resources: -online *NIOSH Pocket Guide to Chemical Hazards* -*NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings* -Safety data sheets for each chemical used in the facility (OSHA hazard communication standard) -Sources recommended by OSHA, including the *CAL/OSHA Permissible Exposure Limits of Chemical Contaminants*			
The employer has analyzed processes for handling, storage, transport, use, and disposal of hazardous chemicals and made changes to reduce staff contact. (Joint Commission Requirement)			
Eyewash Stations and Drench Showers 1910.151 - Medical services and first aid. | Occupational Safety and Health Administration (osha.gov)			
Eyewash stations and drench showers are located no more than a ten-seconds distance from areas where workers can be exposed to injurious, corrosive materials. They are not obstructed. -The Joint Commission requires hospitals to meet OSHA 1910.151 and 1048(i)(2)(i)(3) and American National Standards Institute (ANSI) Standard Z358.1, including Appendix B.			
Eyewash and drench stations are accessible, marked, tagged, and maintained at all times for immediate emergency use.			
Staff are trained on when and how to use eyewash stations and drench showers.			

Hierarchy of Controls	**Completed**	**In Progress**	**Not Started**
The employer uses the NIOSH hierarchy of controls to reduce workers' exposure to chemicals including: -Elimination/substitution (Choosing less hazardous cleaners, for example when feasible) -Engineering controls (Use of technology or barriers, or other physical changes, for example ventilated cabinets for hazardous drug handling.) -Administrative and work practice controls (Changing the way work is done to reduce exposure, such as rotating staff.) -Personal Protective Equipment (This is at the bottom of the hierarchy because it is the least effective and is more likely to fail.)			
Workers exposed to waste anesthetic gases, surgical smoke, corrosive chemicals, or hazardous drugs are trained on all policies and procedures used to reduce exposure, including: -Engineering controls that provide localized ventilation. -Administrative or work practice controls to limit workers' exposure. -Appropriate selection, donning, doffing, and disposal of PPE.			
The employer rotates job assignments or adjusts work schedules to reduce exposure to chemicals, including for pregnant workers.			
The employer provides extensive and ongoing training on PPE selection, donning, usage, doffing.			
Staff know when to double glove and know the break-through time for specific glove materials.			
Staff are encouraged to report if they have a chemical exposure.			
Staff are encouraged to report if they develop sensitivities which may be a result of chemical exposures, including headaches, rashes, or adult-onset asthma.			
The hospital Emergency Operations Plan explains policies and procedures in response to a hazardous chemical spill or gas leak. (Joint Commission requirement)			
The employer conducts exercises for staff on how to respond to a hazardous chemical spill or gas leak. (Joint Commission requirement)			
The employer has implemented a spill prevention, control, and countermeasure (SPCC) plan as required by the EPA (40 CFR part 112).			
The employer follows the guidance in the *NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings.*			

V. Workplace Violence and New Jersey law, “Violence Prevention in Health Care Facilities” NJ Regulation: N.J.A.C.8:43E-11

Committee Requirements	**Completed**	**In Progress**	**Not Started**
At least 50% of the committee members must provide direct patient care. The remaining members must have experience relevant to violence prevention.			
The union must be consulted regarding selection of healthcare worker committee members.			
A management representative from the facility who is responsible for overseeing all aspects of the program must participate in the committee.			
The committee must:			
-Meet at least quarterly.			
-Complete an annual risk assessment to analyze risk factors and identify patterns of workplace violence (WPV). (The annual risk assessment should be part of a continuous process to evaluate and improve the WPV prevention program.)			
-Analyze trends in violent incidents through collection and review of the data. (This data analysis informs the committee’s recommendations and is part of the evaluation and improvement of the WPV prevention plan.)			
-Review the design and layout of the facility.			
-Develop a written prevention plan and submit it to management outlining policies, procedures, and responsibilities. Recommendations must be based on the risk assessment.			
-Identify information in the plan that might pose a threat to security if made public and redact that information if provided publicly.			
-Review de-identified data from incident investigation reports. The committee must have access to the data prior to de-identification in keeping with procedures established by the committee.			
-Develop strategies to encourage reporting of violent incidents.			
-Develop incident reporting procedures.			
-Develop procedures to investigate incidents and complete investigation reports.			
-Develop, review, evaluate and revise training content and methods annually.			
-Identify a training coordinator or team.			
Minimum Requirements for the Workplace Violence Prevention Plan			
The plan must be updated at least annually, with the date listed. It must describe:			
-The annual risk assessment. It must be comprehensive and address layout, access, the area crime rate, lighting, and alarms.			
-Methods to reduce risks, including facility modifications, changes to equipment, job design, staffing, security, and revision of training content.			
-The recordkeeping process.			
-Incident response: Reporting, investigation, evaluation, and follow-up methods, including medical and psychological care.			
-How employees will access the post-incident response system.			
The plan must include procedures to document and communicate about patient violence incidents and risk, between all shifts and all job titles impacted by risk of patients’ violence.			
The plan must be made available: -within two business days to a healthcare worker or collective bargaining agent. -immediately to the Office of Certificate of Need and Healthcare Facility Licensure/Department of Health and Senior Services.			
If at least 10% of a facility’s workforce speaks a language other than English exclusively, the employer must provide a written translation of the plan.			

Annual Risk Assessment	**Completed**	**In Progress**	**Not Started**
The facility must conduct a job task analysis in collaboration with and for each healthcare worker. The committee uses job task analyses to identify risk and mitigations.			
Risk factors to be assessed include: -Working with unstable or volatile persons (under drug or alcohol influence, or acute psychiatric distress), -Working with person with a history of violence/criminal background, -Prevalence of weapons on-site among patients, family, and visitors, -Presence of gang members, -Overcrowding, long waits for service, -Working in isolation with patients, -Lack of staff training, -The impact of staffing, including security personnel, -The facility's physical layout and access restrictions, including egress paths -The crime rate in the surrounding area, -Non-working alarm systems, -Communications devices, surveillance cameras and mirrors, and -Poor visibility/lighting in facility and parking areas.			
A walk-through/site inspection covering all worksite areas must occur at least annually and as needed. The walk-through must be conducted by at least two members of the committee; at least one must be a direct care staff member.			
Methods/mitigations to reduce identified risks include: -Lighting (indoors and in parking lots), -Installation and maintenance as needed of alarm systems, closed circuit TV, metal detectors, cell phones, personal alarms, codes, drop phones, panic alarms, audio surveillance systems, -Assigning and training personnel to respond to each alarm, -Training and posting security personnel where needed, -Controlled access, as needed, to staff offices and employee work areas.			
Training must:			
Be conducted upon hire and annually thereafter.			
Be at least two hours long and held during paid work time.			
Include (but is not limited to) at least two of the following: Handouts, presentations, discussion, role-playing, and DVD or computer-based training activities.			
Be conducted in easily understood terminology.			
Be provided in a language other than English if 10% of the facility's workers speak a language other than English exclusively. Handouts shall be provided in that language.			
Include the requirements of the state regulations.			
Provide a review of the facility's relevant policies.			
Teach de-escalation techniques.			
Teach appropriate responses to workplace violence, including the use of restraining techniques.			
Include reporting requirements and procedures.			
Teach the locations and operation of safety devices.			
Include resources for coping with violence.			
Include a summary and analysis of the facility's risk factors identified in the risk assessment and mitigation methods implemented.			
Address multicultural diversity to increase staff sensitivity.			
Teach Active Shooter response protocols, including US Homeland Security RUN, HIDE, FIGHT.			

Incident Response, Investigation, and Reporting	Completed	In Progress	Not Started
Response protocols must be in writing, be easily understood by all employees, and take confidentiality issues into account.			
A healthcare worker present during the incident or who is first on the scene afterwards will follow the protocol.			
Law enforcement officials will be summoned if necessary to assist victims, assess and secure the area, ensure safety of everyone involved, protect evidence, and reduce distractions.			
Management will encourage and support employees who wish to press legal charges against patients or individuals who assault them at work			
The facility will provide a written incident report for each violent act and provide a de-identified copy to the designated management representative and the committee according to the established procedure.			
The investigation will: -Focus on fact-finding, prevention, and corrective action rather than assessing blame or fault-finding. In addition to the information required in the incident report, the investigation will document actions taken by the facility in response to the incident.			
The incident report will include: -The date, time, and location. -The identity, job title, and job task of the victim. The name will not be included on the incident report if the case meets the confidentiality requirements of the OSHA recordkeeping rule and would not be entered on the OSHA 300 log or NJOSH 300 log. -The identity of the perpetrator, if known. -A description of the act, including whether a weapon was used. -A description of physical injuries. -The number of staff in the vicinity and their actions in response. -Recommendations of police advisors, employees, or consultants.			
The committee will decide if and when de-identified data will be aggregated.			
After review of the incident reports, the facility in collaboration with the committee will encourage appropriate follow-up, consider protocol changes, and add elements to training.			
Incident Response, and Data Analysis Beyond What the NJ Law Requires			
The union can insist that staffing levels just prior to the incident must be included in the analysis and describe how improved staffing could have prevented it. This is different from just listing the number of staff present and how they responded to the incident.			
The union should insist that the committee takes time to conduct root cause analysis on incidents as part of the investigation. The incident report and any corresponding witness accounts should be included in the root cause analysis. The committee can devote time during the regular meeting or assign a subcommittee to meet regularly to conduct root cause analyses of incidents.			
The union should insist that data reports on WPV incidents provide meaningful information and are not just a data dump. For example, reports can show whether incidents are increasing or decreasing over time.			
The facility should have a no weapons policy.’ No Weapons’ signs should be posted at all entrances to facility.			

Recordkeeping	Completed	In Progress	Not Started
Records must be kept for at least 5 years and include any record of violent acts in the workplace, including: -NJOSH 300 and OSHA 300 logs -staff termination records -union grievances and complaints -workers compensation records -insurance records -medical records -police reports -301 Incident logs/incident reports -minutes of safety meetings -training records -employee questionnaires			
The employer must provide these records and any de-identified and/or aggregated data immediately upon request to NJDHSS			
The employer must provide employees and/or authorized representatives with access to the employee's identifiable records and to de-identified or aggregated data within two business days.			
Post-Incident Response System			
Prompt and appropriate medical care is provided following an assault.			
A post-incident response team provides support to the victim and witnesses.			
Individual crisis counseling, group crisis counseling, or other interventions are provided to victims and staff witnesses.			
Medical confidentiality and protection from discrimination are included in post-incident response protocols.			
Prohibition of Retaliatory Action			
The employer does not discharge, suspend, demote, or cause other adverse employment action to anyone for reporting workplace violence or engaging in efforts to address it.			

VI. Safe Patient Handling

Committee Requirements	Completed	In Progress	Not Started
At least 50% of the members are healthcare workers representing the different disciplines.			
The union must be consulted regarding non-management appointees to the committee.			
Supervisors, healthcare workers and other staff who have experience, expertise, and responsibility for safe patient handling (SPH) participate in the committee.			
The committee selects the chairperson.			
The committee must:			
-Meet at least quarterly.			
-Develop, implement, evaluate and revise the SPH program.			
-Evaluate and select SPH equipment.			
-Develop a mechanism to allow employee input into the program.			
-Establish a written SPH policy.			
-Establish uniform protocols and procedures for patient assessment, including assigning responsibility for conducting patient assessments, how to evaluate patients' capacity, and frequency of patient assessments.			
-Ensure that patient assessments are communicated to all responsible staff.			
-Ensure that selection and use of equipment is based on the patient's assessment.			
-Needs assessments for departments or units are conducted.			
-Analyze data to identify units and shifts with ongoing injuries and track the impact of injuries on employee turnover.			
Employer Duties			
The employer must: -Designate a manager responsible for overseeing the SPH program.			
-Maintain a detailed written description of the program.			
-Provide a copy upon request to the Office of Certification of Need and Health Care Facility Licensure in the Department of Health and Senior Services.			
-Provide a copy within two business days to an employee or the union.			
Translate the written program into another language if at least 10% of the employees speak that language exclusively.			
SPH Policy Requirements			
A needs assessment is required for each patient.			
Assisted patient handling is always used except when a patient is capable of moving themselves or in a medical emergency if a patient's life is threatened and SPH equipment is not immediately available.			
Patients have the right to refuse assisted lifting equipment.			
All elements of the policy must be consistent with patient and worker safety and well-being and meet the requirements of the law.			
It must be signed by the CEO, be summarized and posted where staff, patients, residents, and visitors can see it.			

Patient Assessment Requirements	Completed	In Progress	Not Started
The committee must:			
-Identify methods to determine patients' strength, physical and cognitive ability, preference, and circumstances that may impact transferring and repositioning tasks.			
-Determine when to perform patient assessments. At minimum, patients must be assessed at admission and whenever changes occur that impact the patient's dependency level.			
-Ensure that patient assessments are communicated to everyone responsible for lifting, transferring, or repositioning a patient.			
-Ensure that the selection and use of equipment is based on the patient's assessment.			
Needs Assessment for Unit or Department			
Needs assessments must be conducted every three years, or sooner if needed, to determine the type and quantity of equipment required and, if necessary, prioritize the need for equipment among departments.			
The needs assessment focuses on: -Typical patient type and care needs in the unit. -Categories of staff and types of patients getting injured. -When and where injuries are occurring. -Number and leading types of musculoskeletal injuries and disorders among healthcare workers. -Tasks that cause injury or are difficult/painful to perform. -Specific equipment associated with employee or patient injuries. -Available equipment and problems with its use. -Potential problems with new equipment. -Access, storage, and maintenance of equipment. -Facility costs from unassisted and assisted patient handling injuries. This includes at minimum medical and workers compensation costs. -Indirect impact of injuries on staff turnover and replacement.			
Resources to be used (at minimum) to conduct needs assessments: -OSHA 300 logs or NJOSH 300 logs -OSHA 301 form/Incident reports -Reports of workers compensation claims/insurance reports -Fatality reports (employees and patients) -Employee interviews and surveys -Reviews and observational reports of workplace conditions			
SPH Plan Implementation			
The committee will draft an implementation plan addressing at minimum: -How to phase in the SPH program. -Employees must complete training before using equipment. The plan must address how this will be communicated and enforced. -The availability of an adequate number of devices in each unit as determined by the committee.			
Financial Plan			
The committee will recommend a financial plan for the program. Minimum requirements are: -Recommended annual budget. -Recommendation for a three-year financial plan, which takes the facility's financial constraints into consideration.			

Equipment Selection, Usage, and Maintenance	**Completed**	**In Progress**	**Not Started**
The committee will:			
-Recommend equipment selection.			
-Promote and monitor the use of the equipment.			
-Ensure that healthcare workers who will handle the equipment have opportunities to try and evaluate equipment from vendors prior to purchase.			
-Worker evaluations of equipment are factored into purchasing decisions.			
-Establish an evaluation process to determine whether selected equipment is appropriate for the task, comfortable for the patient, and safe and stable for the patient and worker.			
-Develop a plan to ensure users have prompt access to equipment.			
-Develop and implement procedures to ensure equipment is cleaned, maintained, and stored safely and in compliance with manufacturers' recommendations.			
-Ensure damaged equipment is not allowed to stay in circulation Train workers about how to identify and turn in equipment that is damaged or hazardous			
-Develop and implement a plan to ensure equipment batteries are charged as needed.			
-Develop and implement a plan to ensure patient slings are accessible, clean, and appropriate to the equipment.			
Training			
The facility, under the direction of the committee will:			
-Ensure that training will be based on research and proven approaches.			
-Ensure training is conducted prior to equipment use and annually thereafter.			
-Provide training for at least two hours during paid work time.			
-Provide appropriate interim training for staff beginning work between annual training sessions.			
-Provide refresher training as needed.			
-Review the training content and methods at least annually and make necessary revisions.			
Training is:			
-Mandatory for supervisors, all users, members of the committee, and all departments and staff that are engaged in patient handling.			
-Provided in a manner and language employees can understand.			
-Provided in another language if at least 10% of the facility's healthcare workers speak that language exclusively.			
Training includes: -An explanation of SPH policies and practices. -Causes and prevention of musculoskeletal injuries and disorders. -How to recognize early indications of MSD injuries and disorders before serious injury develops. - Identification, assessment, and control of patient handling risks, including use of patient assessments. -Demonstration of SPH equipment. -Trainee participation in operating unit-specific equipment. -Trainees demonstrate that they are proficient with unit-specific equipment for patients with a wide range of physical limitations. -Injury reporting procedures. -Explanation, demonstration, and practice of researched and proven manual patient handling methods for patients who refuse equipment. There should be a policy, and training in place that establishes the minimal amount of workers required for each type of manual lifting tass so that employees performing manual lifting are protected from musculoskeletal injury.			

The committee appoints one or more people to develop educational materials for patients and families.	**Completed**	**In Progress**	**Not Started**
Educational materials are included in admissions packets and in discussion with patients and family members following the patient assessment.			
Reporting, Injury Investigation, Analysis and Recordkeeping			
The facility under the direction of the committee will:			
-Encourage employees to report injuries and near misses in a non-punitive environment.			
-Designate a person(s) to: ---Develop a protocol for conducting injury investigations. ---Prepare investigation reports. ---Educate staff when an injury or near miss occurs.			
-Appoint an appropriate department to receive and analyze the reports and generate de-identified, aggregated data reports.			
-At minimum, reports need to take the following into account: ---Needs assessments ---Safe and proper use of equipment ---Injuries associated with patient refusals to use equipment ---The overall efficacy of the program.			
-Establish a system for monthly reports based on incident reports.			
-Maintain records of MSD injuries.			
The department tasked with these duties will inform the committee of any violations of the requirements.			
Incident Response, and Data Analysis Beyond What the NJ Law Requires			
The union should insist that the committee conducts root cause analysis on incidents, or assigns a subcommittee meet regularly to conduct root cause analysis.			
The union should evaluate if the monthly reports and other data and reports generated by the employer provides meaningful information or if the reports are just a data dump that meet the letter of the SPH law, but not the spirit of it. The union should be prepared to ask for information that compares injuries over time.			
Evaluation and Recommendations			
The committee will evaluate de-identified, aggregated data to identify units and shifts with ongoing injuries and track the impact of injuries on turnover.			
The committee will have access to reports and data prior to de-identification as determined necessary by the committee. (Committee members will need to respect workers' confidentiality.)			
The committee will provide evaluation results and recommendations for improvement to the facility's governing body at least annually.			
Prohibition Against Retaliation			
The employer cannot retaliate against a healthcare worker because the worker refuses to perform a patient handling task due to a reasonable concern about worker or patient safety, or the lack of appropriate and available equipment. -Retaliatory action is defined as discharge, suspension, or demotion or other adverse employment action. -A worker must notify their supervisor of the refusal and the reason promptly.			