U.S. Immigration and Customs Enforcement

ICE Health Service Corps (IHSC)
Enforcement and Removal Operations
U.S. Immigration and Customs Enforcement

Safety and Security Guide

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Foreword

This *Safety and Security Guide* supplements the following IHSC Directive:

- # 05-05 (ERO # 11780.1), Safety and Security

This guide explains concepts, assigns responsibilities, and details procedures for the implementation of an IHSC Safety and Security activities within IHSC-staffed medical clinics.

The intended audience is health staff supporting health care operations within IHSC-staffed medical clinics.

I. Overview

A. Purpose

IHSC is dedicated to promoting a safe and secure environment for health staff, detainees, and visitors. IHSC reduces safety hazards through effective training, administrative controls to reduce hazards and ensure security, safe work practices, and engineering controls such as fire detecting equipment. The purpose of this guide is to provide health staff with procedures and resources to implement the safety and security activities as required by the IHSC Safety and Security directive.

B. Responsibilities

Public Health, Safety, and Preparedness (PHSP) Unit

1. Provides national subject matter expertise on safety and security activities.
2. Provides technical guidance to IHSC staff on safety and security program activities.
3. Reviews this guide and the IHSC Directive 05-05, *Safety and Security,* and updates them as necessary.
4. Conducts periodic monitoring and assessment of implementation of safety and security activities.
5. Develops, reviews, and updates tools and resources to assist staff with implementation of safety and security activities.

Health Services Administrator (HSA) and Facility Health Care Program Manager (FHPM)

1. Oversees the medical clinic safety and security activities.
2. Oversees the medical clinic fire prevention and life safety activities.
3. Ensures daily, weekly, and monthly health and safety inspections in the medical clinic are conducted with deficiencies addressed and documented.
4. Ensures health staff receive initial and annual training on all safety and security policies, procedures, and guidelines.
5. Ensures coordination of the medical clinic safety and security activities with the facility's safety protocols.
6. Implements all safety and security monitoring activities to include fire and safety inspections, bio-medical equipment and hazardous tool management, special needs notifications, and mishap reporting.
7. Monitors and documents problems related to safety and security issues within the medical clinic and reports.

Health Staff

1. Complete all initial and annual safety and security training and maintain knowledge of the subject matter.
2. Observe safety and security requirements specified in training.
3. Comply with all federal and state laws governing fire protection.
4. Immediately report any unsafe conditions in the medical clinic to the HSA.
5. Immediately report security threats or violations, and workplace violence incidents.
6. Ensure that bio-medical equipment is operationally safe before each use.

C. Acronyms

ACA – American Correctional Association

ADA – Americans with Disabilities Act

ANSI – American National Standards Institute

CFR – Code of Federal Regulations

FD&C – Federal Food, Drug, and Cosmetic Act

FDA – U.S. Food and Drug Administration

JHA – Job hazard analysis

MDR – Medical device reporting

MSD – Musculoskeletal disorders

NCCHC – National Commission on Correctional Health Care

NIOSH – National Institute for Occupational Safety and Health, CDC

NFPA – National Fire Protection Association

OSHA – Occupational Safety and Health Administration

PBNDS – Performance-Based National Detention Standards

PPE – Personal protective equipment

SMDA – Safe Medical Devices Act

D. Definitions with Expanded Information

Administrative controls – Methods of controlling employee exposures through enforcement of policies and procedures, modification of work assignment, and training in specific work practices, and other administrative measures designed to reduce exposures.

Engineering controls – Controls that isolate or remove a hazard from the workplace (e.g., ventilation systems isolation, sharps disposal containers, self-sheathing needles).

Ergonomics – The science of designing the job to fit the worker, rather than physically forcing the worker's body to fit the job.

Injury or Illness – OSHA defines an injury or illness as an abnormal condition or disorder. Injuries include, but are not limited to, cuts, fractures, sprains or amputations. Illnesses include acute and chronic illnesses, including, but not limited to, skin diseases, respiratory disorders or poisoning.

Job hazard analysis (JHA) – A job hazard analysis is a technique that focuses on job tasks to identify hazards before they occur. It focuses on the relationship between the worker, the task, the tools, and the work environment. Ideally, after you identify uncontrolled hazards, you will take steps to eliminate or reduce them to an acceptable risk level.

Personal protective equipment (PPE) – Equipment that protects a person from hazardous exposures such as chemicals, dust, noise, radiation, and infectious diseases, and includes respirators, gloves, mask, goggles, gowns, face shields, ear plugs, hard hats, steel toe boots.

Special Needs Detainees – Detainees whose mental and/or physical condition requires different accommodations or arrangements than a general population detainee would receive to ensure that the detainee has meaningful access to the facility's programs or activities. Special needs detainees include but are not limited to those who have emotional disturbances, developmental disabilities, mental illness, physical impairments, chronical illness, disabilities, or are infirmed and have drug or alcohol addictions.

Workplace violence – Any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at work which can range from threats and verbal abuse to physical assaults and even homicide affecting or involving employees, clients, customers and visitors.

Worksite hazard analysis – Worksite hazard analysis involves a variety of worksite examinations to identify not only existing hazards, but also conditions and operations in which changes might create hazards. Effective management actively analyzes the all workplace conditions and the worksite, to anticipate and prevent harmful occurrences.

II. Safety Management

A. Safety Management Plan

IHSC is committed to providing a safe and healthful workplace, and maintaining an environment free of hazards. To accomplish this, the HSA must ensure that a written, site-specific safety management plan is implemented which includes the following:

1. Program goals and objectives;
2. Leadership and staff involvement;
3. Description and assignment of responsibilities to staff;
4. Risk assessment or workplace analysis that identifies the workplace hazards;
5. Hazard prevention and control measures that include all engineering, procedural, and administrative controls, including the use of PPE utilized to eliminate or reduce existing hazards; and
6. Staff training.

B. Worksite Hazard Analysis

A worksite hazard analysis incorporates a variety of processes that examine the work environments to identify and eliminate existing or potential hazards. Identifying these hazards can be accomplished through a variety of methods:

1. Conducting surveys with staff;
2. Safety and health self-inspections or audits;
3. Conducting a JHA;
4. Encourage staff reporting of hazards;
5. Analysis of injury and illness trends;
6. Preventive maintenance; and
7. Formal inspections.

C. Weekly Fire and Safety Inspections

The HSA or FHPM must coordinate with the facility administrator or designee to ensure that qualified staff conducts a weekly fire and safety inspection, to include the medical clinic, as in accordance with the most current ICE detention or family residential standards, if applicable. This qualified staff member may be the facility safety officer or other staff member who by virtue of their education, credentials, and experience is qualified to conduct these inspections.

The Occupational Safety and Health Administration (OSHA) standard 29 CFR §1910.151(c) requires the provision of emergency eyewashes and/or safety showers in work areas where the eyes or body of any person may be exposed to injurious corrosive hazardous materials and chemicals. For the minimum performance and use requirements on eyewash equipment, OSHA follows the guidance established under the American National Standards Institute (ANSI Z358.1-2009). The requirements for testing are based on the manufacturer's instructions and ANSI protocols. ANSI standards state that plumbed flushing equipment "shall be activated weekly for a period long enough to verify operation and ensure that flushing fluid is available." The HSA or FHPM must ensure that testing of eyewash stations are completed weekly for three minutes to confirm safe and proper functioning and findings are documented with discrepancies addressed. The HSA or FHPM must also ensure health staff are trained on the proper operation of eyewash equipment during initial orientation and annual training; the training must be documented.

Weekly eyewash station testing is essential to help clear the supply lines of sediment and bacteria build-up that is caused from stagnant water. The required water temperature must be "tepid," as defined by ANSI a range of 60-100°F and recommended by medical professionals. Water temperature can be tested by filling a cup of sample water from the eyewash water stream and inserting a thermometer. Temperatures above 100°F can enhance chemical interaction and those below 60°F can cause hypothermic shock. Additional performance requirements include the following:

1. Units can deliver a minimum of 15 minutes of flushing.
2. Eye wash units are capable of being activated in 1 second or less.
3. Stay open ball valves are used to accommodate for hands-free rinsing.
4. Dust caps or dust covers are installed to protect the unit from contaminates.
5. The pathway are clear of obstructions.
6. Eyewash units are in a well-lit area and identified with a highly visible safety sign.

D. Exits

The general requirements for safe exits are mandated by OSHA standards under 29 CFR §1910.33-39. OSHA follows the exit route provisions of the National Fire Protection Association (NFPA) 101-2000, Life Safety Code. Therefore, if an employer can demonstrate compliance with NFPA codes, then OSHA deems the employer compliant with OSHA standards. The HSA and FHPM ensure that all exists in the medical clinic maintain the following safety requirements:

- Exit routes are free and unobstructed.
- Materials or equipment are not placed either permanently or temporarily within the exit route.
- Each exit is clearly visible and marked by a sign reading "Exit" in legible letters not less than 6 inches high and not less than ¾ of an inch in width, and adequately lighted so that one can see along the exit route.
- If the direction of travel to the exit or exit discharge is not immediately apparent, signs are posted along the exit access indicating the direction of travel to the nearest exit and exit discharge.
- Each exit route door is free of decorations or signs that obscure the visibility of the exit route door.

E. Electrical Hazards

Electrical standards and regulations are built on the combined guidance from OSHA under 29 CFR § 1910.303-305 and NFPA 70E. These standards cover a full range of electrical safety issues that include safety-related practices, maintenance, special equipment requirements, and installation. IHSC identifies the requirements that are necessary to provide a workplace and detention environment that is free of electrical hazards. The HSA ensures that health staff are trained in electrical safety hazards, including the following guidance related to the use of electrical equipment and power cords:

1. Power strips are not extension cords. Power strips are designed for use with low-powered loads, such as computers, peripherals, or audio and video components. They must not be used with high power loads such as refrigerators and microwave ovens.
2. Extension cords are not used as substitutions for the fixed wiring of a structure, or run through holes in walls, ceilings, or floors. Extension cords are not attached to building surfaces or concealed behind any building walls, ceilings, or floors.
3. Portable cords and plug connected equipment and extension cords are visually inspected before use for external defects or possible internal damage (such as a pinched or crushed outer jacket). If damage or defects are noted, the item is removed from service until repairs are rendered. Equipment not exposed to damage does not require visual inspection until they are relocated.
4. Electrical equipment machines are disconnected before cleaning or adjusting.
5. Avoid overloading outlets. Plug only one heat-producing appliance (e.g., coffee maker) into a receptacle outlet at a time. Major appliances are plugged directly into a wall receptacle outlet.

F. Clinic Inspections and Monthly Health and Safety Assessment

The health and safety assessment addresses IHSC compliance requirements as well as federal, state and local laws related to infection prevention and control measures, emergency preparedness, fire prevention and life safety, hazard communication requirements, biohazardous waste management, and radiation control and

monitoring. The HSA and FHPM must ensure that each monthly Health and Safety Assessment is conducted for the medical clinic and findings are documented on the PHSP Unit SharePoint site. Documentation of each month's Health and Safety Assessment is due by the 15th of the following month. If the FHPM, or a designee other than the HSA completes the assessment, the respective individual must provide a copy to the HSA with details about negative observations or deficiencies documented on the comments sheet. The HSA must address all discrepancies and document corrective actions in the comments section.

The HSA and FHPM must ensure that daily (each day the clinic is operational), weekly, quarterly, and annual health and safety medical clinic inspections are conducted and documented, and checklists are completed and retained on file. Checklists to guide clinic inspections are available in the PHSP Activities Toolkit on the PHSP Unit SharePoint site.

G. Hazard Prevention and Control

Once hazards that can cause injury or illness are identified in the workplace environment, implementing engineering controls, safe work practices, administrative controls, PPE, and safety and health training should prevent or control them. These actions include, but are not limited to, the following:

1. Engineering controls, which include removing the hazard or substitute something.
2. Safe work practices, which include policies and procedures that correct or control the hazard.
3. Administrative controls, which include administrative measures aimed at reducing staff exposure to hazards.
4. PPE, which includes equipment that protects a person from hazardous exposures, such as chemicals, dust, noise, radiation, and infectious diseases, and includes respirators, gloves, mask, goggles, gowns, face shields, ear plugs, hard hats, and steel toe boots.
5. Safety and health training, to ensure that all staff understand the hazards of their job, when and where PPE is required, and how to prevent harm to themselves and others.

The HSA and FHPM must ensure all health staff are effectively trained on health and safety issues and processes: during initial orientation and annual training; or whenever processes, procedures, or materials change.

H. Utility Management Plan

The HSA must implement a utility management program for the medical clinic in collaboration with the facility administrator or designee. The utility management program ensures operational reliability of utility systems that support patient care and reliable and sufficient emergency power to provide uninterrupted electricity to alarm systems, egress illumination, and exit sign illumination. Utility systems include emergency power, electrical and water shut off, heating, ventilation, air conditioning, and plumbing. The HSA must communicate any discrepancies immediately to the facility maintenance supervisor and document findings on the Monthly Health and Safety Assessment checklist.

III. Fire Prevention and Life Safety

A. Fire Prevention Plan

IHSC staff must promote fire prevention and life safety through training, drills, and inspections. The HSA and FHPM oversee fire prevention and life safety activities in the medical clinic and coordinate with facility staff responsible for safety to ensure that all health staff have reviewed the facility fire prevention, control, and evacuation plan upon initial assignment and annually. This plan must be written and must be specific to each site. The plan must provide information on fire hazards in work areas and guidance for health staff to take in the event of a fire or the evacuation of the medical clinic. A hard copy of this plan must be kept in the medical clinic and available to health staff.

B. Fire and Evacuation Drills

The HSA and FHPM ensure fire drills are conducted in the medical clinic once per shift and per quarter, by health staff so that staff on each shift participates in an annual drill. Additionally, the FHPM should attend at least one of the quarterly drills to monitor staff involvement and provide an after-action report to highlight strengths or weakness. If the fire and evacuation drills conducted by the facility do not meet the requirement of "once per shift per quarter" for IHSC staff, IHSC qualified personnel may conduct the drill and/or a table top exercise to meet the drill requirement.

1. Health staff ensure all occupants evacuate during fire drills conducted in the medical clinic, except where security or patient health is jeopardized, or when logistically not feasible.
2. Fire evacuation signs with displayed floor plans and evacuation routes are posted in the medical clinic with directional arrows and "You are here" markers in English, Spanish, and the next most prominent language at the facility in the event of a fire.
3. Health staff must simulate drills in areas where detainees are not evacuated.
4. the health staff and/or FHPM document, in written form, and evaluate fire drills.

C. Fire Safety Procedures

If a fire is discovered and detainees or health staff are in immediate danger, the immediate priority is to evacuate all detainees and health staff from the hazard. During the event of a fire, health staff are responsible for ensuring they implement the evacuation plan and adhere to evacuation routes. Health staff must take immediate actions to ensure that safety to life takes precedence, to include:

1. **R**escue. Health staff ensure detainees and staff move from the immediate danger to the designated evacuation area(s).
2. **A**larm. Activate the fire alarm.
3. **C**ontain. Close all doors.
4. **E**vacuate. Evacuate the building at the nearest fire exit, when ordered, in a calm orderly manner.
    a. The clinical director (CD), HSA, FHPM, nurse manager, or lead clinician on-site makes the decision to evacuate the medical clinic.

b. All health staff must assemble at a pre-determined outside area to allow the HSA or designee to account for all staff.
c. the facility administrator or designee should determine the assembly point for detainees.

The person ordering the evacuation ensures all detainees and staff are evacuated before leaving the fire area, and notifies the HSA, or designee. The HSA or designee must notify the assistant field office director (AFOD) or designee of any fire incident in the medical clinic and the evacuation as soon as possible.

D. Fire Protection Equipment

Fire protection equipment must be located in specific locations throughout all facilities.

1. Fire Extinguisher Use

a. To minimize the potential for loss of life and property to fire, the HSA ensures portable fire extinguishers are readily accessible in all areas of the medical clinic. OSHA standard 29 CFR § 1910.157 provides guidance on the use of portable fire extinguishers. This standard describes two portable fire extinguishers functions: (1) control or extinguish small or incipient stage fires (i.e., a fire in the initial or beginning stage), and (2) protect evacuation routes that a fire may directly or indirectly block with smoke or burning or smoldering materials. Attempting to extinguish even a small fire carries some risk. Fires can increase in size and intensity in seconds and block the users exit path and create a hazardous atmosphere.
b. The HSA and FHPM ensure health staff receive initial and annual training on the use of fire extinguishers. This training includes how to access the extinguisher, operate the unit, effectively apply the extinguishing agent, and conduct a fire risk assessment before attempting to extinguish a fire. Training should simulate how to use the equipment without operating the fire extinguishers.
c. Prior to fighting any fire with a portable fire extinguisher, health staff must perform a risk assessment that evaluates the fire size, the firefighters' evacuation path, and the atmosphere in the vicinity of the fire (see Portable Fire Extinguisher Risk Assessment Tool).

2. Fire Extinguisher Inspections

The HSA and FHPM ensure qualified staff conduct fire extinguisher inspections on all fire extinguishers located in the medical clinic. Fire extinguishers must meet the following requirements:

a. Located conspicuously with proper size and classification for fire hazard for that location.
b. Visually inspected monthly to ensure extinguishers: 1) display pressure gauge readings or indicators in the operable range or position; 2) are properly mounted on the wall, clearly identified, and accessible with no obvious physical damage; and 3) have inspection tags attached that are signed and dated at least monthly.
c. Re-certified and preventive maintenance performed annually by a qualified individual.

3. Manual Fire Alarm Pull Stations

The HSA ensures all health staff are familiar with the location and operation of all manual fire alarm pull stations located in the medical clinic. These pull stations must remain accessible and unobstructed.

4. Automatic Sprinkler Systems

The HSA must coordinate and verify that a certified fire suppression inspection company, in accordance with NFPA life safety code, inspected the automatic sprinkler system in the medical clinic. Staff should not store materials within 18 inches from the sprinkler head to prevent interference with the discharge pattern of water in the event of a fire.

E. Fire Safety Practices

IHSC promotes a fire conscious workforce who follows fire safe practices to prevent fire hazards from occurring. The HSA must ensure all health staff are knowledgeable of the facility fire prevention and life safety plan, evacuation routes, assembly points, and follow fire prevention safe practices. These practices include but are not limited to:

1. Implementing a smoke-free work environment in all IHSC-staffed medical clinics.
2. Practicing good housekeeping and preventing the accumulation of trash in the medical clinic.
3. Prohibiting the use of portable space heaters in medical clinics.
4. Ensuring that all exits and fire protection equipment are free and unobstructed.

During renovations or new construction, the HSA must ensure enforcement of fire prevention and life safety measures in accordance with NFPA 101: Life Safety Codes.

IV. Security Protocols and Controls

A. Security Controls

To maintain a safe and secure work environment, the HSA ensures that health staff receive initial and annual training on security control protocols for their facility. Security control measures include but are not limited to secure control center entry procedures, security ID badge use and wear, contraband restrictions, key and lock control access and proper handling, radio control and proper use, and visitor entry and escort procedures.

B. Bomb Threats or Suspicious Packages

Any IHSC staff member who receives a bomb threat via telephone, or discovers a bomb or suspicious package or object must immediately notify his or her supervisor, HSA, or other designee, as specified in the facility Emergency Response Plan. If the threat is received by phone, staff should take note of the following:

1. Time and date of the call
2. Exact words of the caller

3. Age and sex of the caller (if this can be determined)
4. Speech patterns or accent
5. Background noises
6. Length of call and number call was received from (try to keep the caller on the phone as long as possible and do not hang up)
7. Ask the following script of questions from and about the caller:
    a. Where is the bomb right now?
    b. When is the bomb going to explode?
    c. What kind of bomb is it?
    d. What does it look like?
    e. Where are you?
    f. What is your name?
    g. Did you place the bomb? Why?
    h. What will cause it to explode?
    i. script questions must be posted next to all staff telephones

If an IHSC staff member suspects they have received a mail bomb:

1. IHSC staff must not handle the letter, envelope, or package.
2. IHSC staff must notify the immediate supervisor, HSA, or designee for further instructions and clear the immediate areas of all personnel.

If a suspicious object is discovered, IHSC staff should assume it is a bomb and:

1. Not touch the object.
2. Notify the immediate supervisor, HSA, or designee for further instructions and clear the immediate area of all personnel.

Refer to the *IHSC Directive 05-03, All-Hazards Emergency Preparedness and Response,* and the *05-03-G-01, All-Hazards Emergency Preparedness and Response Guide,* for additional guidance on bomb searches, evacuation procedures, and reporting incidents located in the IHSC policy library.

V. Workplace Violence

Workplace violence as defined by OSHA is "violence or the threat of violence against workers." It can range from a threat or verbal abuse to a physical assault or homicide. This form of violence can be communicated as an oral or written statement, gesture, or expression in a direct or indirect threating manner. Workplace violence can result in physical or psychological harm or damage to personnel as well as government property; it is the leading cause of job-related deaths. IHSC is committed to preventing recognized violence hazards in the workplace and encourages employees to report all incidents and threats of violence in their work areas.

A. Types of Workplace Violence

There are four types of workplace violence that are identified under OSHA Directive CPL 02-01-058, Enforcement Procedures and Scheduling for Occupational Exposure to Workplace Violence. These include the following:

1. Type 1: Criminal intent (violent acts by people who enter the workplace)
2. Type 2: Customer/client/patients (violence directed at workers by patients)
3. Type 3: Co-worker (violence against co-workers, supervisors, or managers)
4. Type 4: Personal (violence by someone who does not work there, but who is known to, or has a personal relationship with, an employee)

If attempts to reduce or eliminate serious, recognized workplace violence hazards are not addressed, OSHA citations can be made under the General Duty Clause of the Occupational Safety and Health Act.

OSHA identifies correctional and detention facilities and healthcare settings as high risk industries for workplace violence. The HSA must ensure health staff receive workplace violence safety education. The goal of this training to prepare staff to recognize unacceptable conduct, know what to do if they witness or are subjected to workplace violence, and know how to protect themselves.

B. Responsibilities

Workplace violence awareness is everyone's responsibility. All IHSC personnel must adhere to work practices designed to ensure a safe and secure workplace environment, and early de-escalation. IHSC staff must also refrain from verbal threats or physical actions that create a security hazard for others. Additional guidance is available in OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.

IHSC aims to reduce the risk of violence in the workplace through asking perpetrators to leave the medical clinic, requesting security assistance to remove perpetrators from the medical clinic, initiating disciplinary action, reporting incidents to the Joint Intake Center (JIC), DHS Office of Inspector General (OIG), or Office of Professional Responsibility (OPR), which may result in referral for disciplinary action or criminal prosecution. IHSC staff must promptly notify the contract officer representatives (CORs) of any workplace violence incidents involving contract staff.

A. Worksite Hazard Analysis

Effective management of workplace violence begins with identifying existing or potential hazards in the workplace environment. A worksite analysis involves a mutual step-by-step assessment to find existing or potential hazards that may lead to incidents of workplace violence. A team that includes the HSA, AHSA, FHPM, other supervisors and health staff should conduct the assessment. The assessment can include a review of previous incidents, employee surveys, a review of specific job tasks and protocols, and a workplace security analysis to identify hazards, conditions, operations, and situations that could lead to potential violence.

B. Worksite Hazard Prevention and Control Measures

Once completed, the HSA must implement appropriate steps to prevent or control any existing or potential hazards identified in the worksite analysis. OSHA suggests the following prevention and control measures: (1) identifying and evaluating control options for workplace hazards; (2) selecting effective and feasible controls to eliminate or reduce hazards; (3) implementing these controls in the workplace; (4) following up to confirm that these controls are used and maintained properly; and (5) evaluating the effectiveness of controls and improve, expand, or update them as needed.

Some control options include substituting a hazard with a safer work practice, implementing administrative controls, or introducing engineering controls to remove or create a barrier between the worker and the hazard. Examples of suggested administrative, work practice, and engineering controls for preventing workplace violence are identified in OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. The HSA must follow up on these control measures to confirm whether they are used and maintained properly and to evaluate their effectiveness in the elimination of workplace violence or the need for improvement or expansion.

C. Reporting Incidents

IHSC federal staff must report all workplace violence incidents involving an employee as aggressor to the HSA immediately. The HSA must then notify through the supervisory chain of command in a timely manner. Workplace violence incidents involving employees as aggressors must be reported to the JIC, OPR, or OIG in accordance with ICE memo for reporting misconduct. IHSC contract staff must report incidents to his or her supervisor, government technical monitor, and/or other designated person pursuant to the policies and procedures set forth by their employer for reporting workplace violence. Workplace violence that results in an injury must be recorded and/or reported in accordance with IHSC Directive 05-02, *Occupational Health,* and 05-02-G-04, *Occupational Health Guide: Workforce Health* located in the IHSC policy library.

VI. Ergonomics

OSHA refers to ergonomics as "the study of work" and further defines it as "the science of designing the job to fit the worker, rather than physically forcing the worker's body to fit the job." Many contributing factors in the health care work environment can cause injuries and soft tissue disorders over time, such as working long hours on one's feet, performing repetitive tasks with one's hands, sitting and keyboarding at computer workstations, and heavy lifting during patient care and transfers. Adapting tasks within the work environment and educating staff on prevention techniques can help reduce these painful and disabling injuries and the associated musculoskeletal disorders (MSD).

A. Musculoskeletal Disorders (MSDs)

MSDs are injuries, soft tissue (muscles, tendons, ligaments, joints, and cartilage) and nervous system disorders that generally develop gradually over weeks, months, and years causing disabling pain, numbness, tingling stiff joints, difficulty moving, muscle loss, and sometimes paralysis. MSDs are referred to by several

names such as cumulative trauma disorders, repeated trauma, repetitive stress injuries, and occupational overexertion syndrome and can include medical conditions such as carpal tunnel syndrome, tendinitis, sciatica, herniated discs, and low back pain. Work-related MSDs result from prolonged exposure to ergonomic risk factors causing damage to the body. OSHA lists health care workers, such as registered nurses, in the top ten occupations for acquiring MSDs. Some work-related risk factors that are likely to cause MSDs include the following:

1. Exerting excessive force;
2. Excessive repetition of movements;
3. Awkward postures or unsupported positions;
4. Static postures, or positions that staff must hold for long periods of time;
5. Motion, such as increased speed or acceleration when bending or twisting;
6. Compression, from grasping sharp edges like tool handles;
7. Inadequate recovery time due to overtime, lack of breaks, and failure to vary tasks;
8. Excessive vibration and whole body vibration; and
9. Working in cold temperatures.

B. OSHA Guidance under the General Duty Clause

Although OSHA does not have specific enforcement standards only guidelines governing ergonomics, citations can be given under the General Duty Clause of the Occupational Safety and Health Act, which requires employers to keep the workplace free from recognized serious hazards, including ergonomic hazards. In addition, state occupational safety and health programs have the option to enforce more restrictive standards that OSHA does not address. The HSA must be aware of their state occupational safety and health requirements and ensure that work-related injuries resulting from ergonomic risk factors are addressed.

C. Job Hazard Analysis (JHA)

Recognizing potential ergonomic problems and preventing staff from developing MSDs can be simple and inexpensive by identifying job tasks that pose ergonomic risk factors. Conduct a JHA to identify these risk factors. After identifying tasks that contribute to risk factors, HSAs should implement procedural changes, controls, or equipment to correct and control these hazards and ultimately prevent or reduce MSDs. A list of these control mechanisms includes the following:

1. Engineering controls such as redesigning the work station or adding ergonomically designed equipment;
2. Work practices such as changing work practices, using proper lifting techniques and keeping work areas clean;
3. Administrative controls such as worker rotation and more task variety; and
4. PPE.

D. Safe Work Practices

To bring awareness into the work environment and minimize occupational injuries, improve worker comfort, productivity, and job satisfaction, all IHSC staff must be familiar with ways to control ergonomics-related risk factors to allow them to actively participate and for their own protection. The HSA must ensure that health staff receive information regarding job-specific hazards, safe work practices, and ergonomics to include simple adjustments that they can do in their work environment. Some examples include the following:

1. Advise staff to be aware of their posture.
    a. Use supportive shoes and cushioned mats if required to stand for long periods.
    b. Keep frequently used trays and supplies within close reach to avoid having to reach for them.
2. Advise staff to keep their arms and hands relaxed and to be aware of tensions that may occur as they perform different tasks.
    a. Maintain neutral wrist and arm postures when working.
    b. Sit close to their work areas and avoid forceful twisting and turning motions.
3. Advise staff to avoid static positions.
    a. Encourage staff to vary activities and change their position while sitting, and shift their weight when standing to work.
    b. Alternate how they hold objects like forceps.
4. Advise staff to avoid ergonomic-related risk factors when using computers.
    a. Place monitor so their viewing distance is between 18 and 30 inches.
    b. Place monitor so to top of the screen is approximately at eye level.

VII. Bio-Medical Equipment

A. Program and Responsibilities

IHSC staff must maintain all medical equipment to ensure an acceptable level of safety and quality. The IHSC bio-medical equipment management program incorporates the operational assessment and oversight of all equipment used in IHSC-staffed medical clinics for the diagnosis, treatment, monitoring, and care of patients to ensure the equipment is accessible, safe, and accurate. The HSA must implement and oversee a bio-medical equipment management program which includes a written bio-medical equipment management plan; bio-medical equipment inventory; inspections; annual preventive maintenance; equipment failure notification; MDR; documentation and recordkeeping; and training.

B. Daily Inspections and Annual Preventative Maintenance

Bio-medical equipment operational safety is essential in providing safe and effective patient care. Health staff must ensure that bio-medical equipment is operationally safe before each use. The HSA must ensure that bio-medical equipment is inspected in accordance with manufacturer's recommendations and documented.

1. IHSC staff should conduct daily checks on refrigerators and freezers that store medications to ensure the temperatures are within acceptable limits per the manufacturer's recommendations, CDC guidance on vaccine storage and handling, and laboratory requirements under Title 42, Code of Federal Regulations,

Part 493 and CMS Clinical Laboratory Improvement Amendments (CLIA). These daily checks ensure the following:

a. Refrigerated medications are stored in designated refrigerators maintained at a temperature within the manufacturer's recommendations for each medication. For vaccines, CDC recommends storage temperatures be kept between 36 degrees Fahrenheit (F) and 46 degrees (F).
b. For maintaining frozen vaccines, freezer temperatures are kept between -58 degrees (F) and +5 degrees (F).
c. Refrigerated vaccines are stored in dual-zone units only and should not be stored in dormitory-style refrigeration units.
d. Refrigerated biological specimens, test reagents, and controls are stored in designated refrigerators maintained at a temperature within the manufacturer's instructions provided with the test. CDC recommended practices on CLIA testing indicate that typically, a refrigerator stores patient samples between 35 and 46 degrees (F) and a freezer between -13 degrees (F) and 5 degrees (F).
e. Health staff must maintain written documentation of daily refrigerator and freezer temperature readings.
f. Health staff who identify temperature discrepancies notify the HSA or designee and pharmacy staff.

The HSA ensures preventive maintenance performance checks with an authorized or certified service contractor are completed and documented. Medical equipment preventive maintenance is a schedule of planned maintenance actions including equipment inspection, lubrication, and calibration, aimed at the prevention of breakdowns and failures before they occur.

Federal requirements and accrediting body recommendations determine the frequency of preventive maintenance schedules. The HSA or designee must adhere to the manufacturer's recommendations on preventive maintenance intervals for all biomedical equipment checks in accordance with recommendations from the Joint Commission Standard EC.02.04.01; and Centers for Medicare & Medicaid Services (CMS) Memorandum Summary: Hospital Equipment Maintenance Requirements.

C. Equipment Inventory

The HSA ensures an electronic bio-medical equipment inventory list is created and updated as new equipment is acquired or becomes unserviceable or obsolete, and that inventory audits are conducted as required.

The HSA must implement and manage a medical device reporting program to include documenting medical device incidents, providing training and education on the reporting program to medical staff, and submitting mandatory and voluntary reports to the FDA and/or the medical device manufacturer in accordance with Federal regulations (see Medical Device Reporting).

D. Equipment Failure Notification

Health staff must immediately notify the HSA of any bio-medical equipment failures (except for needing battery replacement). Health staff should label the equipment as "out of service" and ensure it is not used for patient

care or treatment. Health may not use the equipment again until required maintenance by an authorized or certified service contractor is completed and documented.

E. Medical Device Reporting (MDR)

The Medical Device Reporting regulation 21 CFR 803 provides a surveillance mechanism for the Federal FDA and manufacturers to identify and monitor significant adverse events involving medical devices. The authority for the MDR regulation is the Food Drug & Cosmetic (FFD&C) Act, section 519 (a) as amended by the Safe Medical Devices Act (SMDA) of 1990 and codified as 21 USC § 360i. These regulations include the mandatory reporting requirements to the FDA for medical device manufacturers, importers, and user facilities related to certain device-related adverse events and product problems.

F. Mandatory Reporting and Recordkeeping

IHSC observes the MDR reporting requirements for all suspected medical device related deaths to both the Food and Drug Administration (FDA) and the manufacturer, if known. The HSA must report patient deaths to the FDA and the manufacturer within ten (10) working days of becoming aware that a device caused or contributed to the incident.

The HSA or designee reports serious injuries or illnesses to the manufacturer, or to the FDA if the manufacturer is unknown. The HSA submits these mandatory reports using the MedWatch Form FDA 3500A within ten (10) working days of becoming aware that the device caused or contributed to the incident.

The HSA or designee musts submit semi-annual summaries of reports to the FDA twice each year: (1) January 31, covering reports for the previous July 1 to December 31; and (2) July 31,covering reports for the previous January 1 to June 30. A semi-annual report submission is not necessary if there were no individual reports to FDA or manufacturers during the reporting period.

G. Voluntary Medical Device Reporting

The FDA Medical Device Reporting Program also includes a voluntary reporting system for any incident where the use of a medication (drug or biologic) at any dose is suspected to have resulted in an adverse outcome in a patient. This includes any product problem regarding the quality, performance or safety of any medical product. The HSA or designee submits the report on a MedWatch Voluntary Reporting Form FDA 3500. All adverse medication events must also be reported in accordance with IHSC Directive 11-06, *Time Frame for Submitting Medical Incident Reports*.

H. MDR Program Management Responsibilities

The HSA must implement and manage the medical device reporting program. This includes: documenting and tracking data regarding medical device incidents and trends; providing training and education on the reporting program for health staff; understanding of the FDA reporting forms; and submitting voluntary and other reports to FDA and/or the medical device manufacturer in accordance with Federal laws and regulations.

VIII. Hazardous Tool Management

A. Tool Control Program and Responsibilities

All health staff must maintain awareness of tool control to ensure the safety and protection of detainees, staff, and visitors from harm within IHSC facilities. Tool control management refers to the accountability, control, and maintenance of all medical and dental instruments, equipment, and supplies with the potential to pose a risk to facility security or personal safety. Supplies can include needles, syringes with attached needles, lancets, and other sharps. Tools are items that can be used as a weapon, capable of doing serious bodily harm, or being used in an escape or escape attempt.

The HSA must implement and manage a tool control program within the medical and dental clinics in accordance with ICE 2011 PBNDS, American Correctional Association (ACA), and National Commission on Correctional Health Care (NCCHC) standards. The HSA maintains an inventory of all restricted tools, continually controls and accounts for all tools, and keeps the tools in locked storage when not in use.

The clinical hazardous tool program components include:

2. A written tool control program;
3. A restricted hazardous tool inventory;
4. Procedures for accountability, storage, and issuing tools to staff;
5. Procedures for surveying and destroying excess, broken or worn-out tools;
6. Procedures in the event of lost tools; and training requirements.

B. Accountability, Storage, and Issuing Tools

The HSA prepares a computer-generated inventory list of all restricted and hazardous tools used in the medical and dental clinics; maintains a hard copy of restricted tools inventory at each respective medical and dental clinical work area; and submits a second copy of the inventory list to the facility's manager for security.

The HSA or designee reviews tool inventories, revises the inventory as restricted tools are added or removed, and keeps all restricted tools in locked storage when not in use. The HSA establishes procedures for issuing restricted hazardous tools and sharps to health staff. In addition, the HSA conducts required monthly audits on medical restricted tool inventories with the facility tool control officer. To maintain inventory control and prevent compromising product sterility, health staff always keep sterile packs under lock and key. Health staff must not open sterile packs for inventory audits or any other non-medical reason, except when tampering or theft is suspected. In the event of an incident, health staff must notify the HSA within 24 hours.

C. Excess, Broken, or Lost Tools

The HSA ensures health staff survey and dispose of broken or worn-out tools used in the medical clinic. Health staff should dispose broken or worn-out tools in an appropriate and secure manner, in collaboration with the facility's tool control officer or security officer.

When a medical or dental restricted hazardous tool item is missing or lost (e.g., scissors, needles, syringes with attached needles, lancets, dental instruments, etc.), health staff must immediately notify the HSA. The HSA verbally notifies the facility's manager for security or shift supervisor immediately, and provide written notification to the facility administrator. In addition, the HSA or designee contacts all health staff to notify them of the missing tool. When a lost tool is recovered, the responsible health staff member must notify the HSA, complete a lost or missing tool report, and forward it to the facility's manager for supplies and shift supervisor.

IX. Special Needs Accommodation

Elderly detainees, detainees with disabilities, or health staff with conditions that put them at risk for injury require accommodations. Consideration for accommodation of the elderly and those with disabilities who have special needs is an important part of the design and daily operation within an IHSC clinical environment.

A. Detainee Special Needs

The HSA must provide guidance and coordinate with other facility departments regarding necessary modifications, accommodations, or assistance needed for detainees. For IHSC policy and procedural guidance for determining and providing care to ICE detainees determined to have special needs, *see* IHSC Directive 03-11, *Special Needs Patients* located in the IHSC policy library.

B. Staff Special Needs

The HSA provides guidance and coordinate with other facility departments regarding the necessary modifications, accommodations, or assistance needed by health staff with special needs. For federal staff, the HSA should consult ICE Procedures to Facilitate the Provision of Reasonable Accommodation, available through the Diversity Management Division, Disability Employment Program. The HSA should direct contract staff to their employer for reasonable accommodation requests. Refer also to the Rehabilitation Act of 1973 for additional guidance.

X. Mishap Reporting

A. Staff Injury Reporting

Staff injuries are work-related if an event or exposure in the work environment caused or contributed to the condition, or significantly aggravated a pre-existing condition. OSHA mandates employers report and record work-related staff injuries or illnesses if it meets one or more of the recording criteria defined in 29 CFR §1904. The HSA or designee must record and report those work-related staff injuries or exposures meeting criteria according to OSHA requirements. For guidance on the management of occupational injuries and illnesses, see IHSC Directive 05-02, *Occupational Health,* and 05-02-G-04, *IHSC Occupational Health Guide: Workforce Health* in the IHSC policy library.

B. Clinical incidents and detainee injury reporting

The HSA reports all clinical incidents and detainee injuries in accordance with IHSC Directive 11-06, *Risk Management.*

XI. Program Monitoring

PHSP Unit staff periodically collect information from the HSA or designee to monitor the implementation of the safety and security activities and assess compliance with these activities.

XII. Training and Education

The HSA or designee ensures orientation and annual training includes safety and security. The HSA or designee implements and documents this training in accordance with IHSC Directive 01-04, *Medical Education and Development* located in the IHSC policy library. Topic-specific training requirements mandated by federal laws or accreditation standards are listed below.

C. Training requirements for fire and life safety

1. Fire prevention;
2. Fire control to include smoke and fire containment procedures;
3. Immediate actions in the event of a fire to include evacuation procedures;
4. Location of fire alarms and extinguishers; and
5. Fire extinguisher use, types, and hands-on training.

D. Training requirements for medical equipment use

1. Operators of medical equipment are effectively trained and documented as competent on the equipment they operate prior to equipment use.
2. Operators of medical equipment are trained on equipment in accordance with the manufacturer's guidelines.

E. Training requirements for hazardous tool management

1. Procedures for tool accountability, storage, and issuing tools;
2. Procedures on mandatory shift tool/sharps counts; and
3. Procedures for broken/worn-out tools, or in the event of lost or missing tools.

XIII. References and Resources

(1) FDA Medical Device Reporting (MDR) Requirements

(2) NFPA 101: Life Safety Codes

(3) National Institutes of Health - Emergency Shower and Eyewash Station Equipment

(4) OSHA Electrical Regulations

(5) OSHA | Ergonomics

(6) OSHA | Workplace Violence

(7) OSHA | Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers

(8) CDC - NIOSH | Violence in the Workplace (96-100)

(9) OSHA Injury and Illness Recordkeeping and Reporting Requirements

(10) OSHA Regulation on Exit Routes, Emergency Action and Fire Prevention Plans

(11) OSHA | Portable Fire Extinguishers

(12) ICE | Procedures to Facilitate the Provision of Reasonable Accommodation, available through the Diversity Management Division - Disability Employment Program

(13) Rehabilitation Act of 1973

(14) ICE memo for reporting misconduct, 7 May 2018