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CARING FOR OUR CAREGIVERS: PROTECTING HEALTH CARE AND SOCIAL SERVICE WORKERS FROM WORKPLACE VIOLENCE

HEARING

BEFORE THE

SUBCOMMITTEE ON WORKFORCE PROTECTIONS

COMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

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CARING FOR OUR CAREGIVERS: PROTECTING HEALTH CARE AND SOCIAL SERVICE WORKERS FROM WORKPLACE VIOLENCE

Wednesday, February 27, 2019
House of Representatives
Committee on Education and Labor
Subcommittee on Workforce Protections
Washington, DC.

The subcommittee met, pursuant to notice, at 2:06 p.m., in room 2175, Rayburn House Office Building, Hon. Alma S. Adams [chairwoman of the subcommittee] presiding.

Present: Representatives Adams, Jayapal, Wild, McBath, Omar, Stevens, Byrne, Walker, Cline, and Wright.

Also present: Representatives Courtney, Khanna, Scott, and Foxx.

Staff present: Tylease Alli, Chief Clerk; Jordan Barab, Senior Labor Policy Advisor, Nekea Brown, Deputy Clerk; Hana Brunner, General Counsel Health and Labor; Itzel Hernandez, Labor Policy Fellow; Carrie Hughes, Director of Health and Human Services; Eli Hovland, Staff Assistant; Stephanie Lalle, Deputy Communications Director; Richard Miller, Director of Labor Policy; Max Moore, Office Aid; Veronique Pluviose, Staff Director; Banyon Vassar, Deputy Director of Information Technology; Katelyn Walker, Professional Staff; Cyrus Artz, Minority Parliamentarian, Marty Boughton, Minority Press Secretary; Courtney Butcher, Minority Coalitions and Member Services Coordinator; Akash Chougule, Minority Professional Staff Member; Rob Green, Minority Director of Workforce Policy; John Martin, Minority Workforce Policy Counsel; Hannah Matesic, Minority Legislative Operations Manager; Kelley McNabb, Minority Communications Director; Alexis Murray, Minority Professional Staff Member; Ben Ridder, Minority Legislative Assistant; Heather Wadyka, Minority Staff Assistant; and Lauren Williams, Minority Professional Staff Member.

Chairwoman ADAMS. The Subcommittee on Workforce Protections will come to order. I want to thank everyone for being here and thank our witnesses and all of the other folks who have come as well. I note that a quorum is present and want to thank the ranking member for being here as well.

I ask unanimous consent that Mr. Courtney of Connecticut and Mr. Khanna of California be permitted to participate in today's

hearing with the understanding that their questions will come only after all members of the Subcommittee on Workforce Protections on both sides of the aisle who are present have had opportunity to question the witnesses. Without objection? So ordered.

The committee is meeting today for this legislative hearing to hear testimony on Caring for the Caregivers Protecting Health Care and Social Service Workers from Workplace Violence. Pursuant to the committee rule 7(c), opening statements are limited to the chair and the ranking member and this allows us to hear from our witnesses sooner and it provides all members with adequate time to ask questions.

So I want to recognize myself now for the purpose of making an opening statement.

Today, we are here to discuss solutions for protecting our country's front line caregivers from violence in the workplace. The people who work in our Nation's hospitals, nursing homes and other health care institutions, as well as social workers and other health care providers offer critical assistance to those in need. They fulfill this role despite inadequate pay, odd and difficult hours, and as we will discuss, the frequent threat of violence at the hands of people they serve.

This hearing is an opportunity to assess the steps taken by the Occupational Safety and Health Administration to address workplace violence. It is also a forum to discuss relevant legislation, namely H.R. 1309, the Workplace Violence Prevention for Health Care and Social Service Workers Act, which would require OSHA to issue a strong violence prevention standard.

Workplace violence is a serious concern for 15 million health care workers in the United States. Although health care and facilities are viewed as a place to get well, the reality is that day-to-day work in these facilities exposes many employees to an unacceptably high risk of violent injury. Last year, the Bureau of Labor Statistics reported that health care and social service workers are—were nearly five times as likely to suffer a serious workplace violence injury than workers in other sectors.

Public employees are even worse off. In 2017, State government health care and social service workers were almost nine times more likely to be injured by an assault than private-sector health care workers. To make matters worse, public employees in 24 States, almost 9 million workers, are not even covered by OSHA and even though they do the exact same work as private sector employees and face the same hazards.

The injuries to caregivers are just not physical. And as we will hear today, even when the body recovers from workplace assaults, these professionals are often plagued with career ending post-traumatic stress disorders for the rest of their lives. These violent incidences are not just part of the job.

They are predictable, and they are preventable.

OSHA has not ignored this problem, but it currently lacks the tools to address it adequately. OSHA first issued guidance to protect health care and social service workers from workplace violence over 20 years ago.

The Obama Administration updated that guidance, prioritizing enforcement of safe working conditions for health care workers

threatened by workplace violence. And for the first time, the Obama Administration put workplace violence on the agency's regulatory agenda, starting the long rulemaking process. But where we are today isn't good enough. Far from it.

First, there is currently no OSHA standard that requires employers to implement violence prevention plans that would help reduce injuries to those workers. As a result, inspectors are forced to use the highly burdensome and time consuming General Duty Clause in the OSHA Act. And pending litigation may eliminate even that weak tool from OSHA's limited enforcement arsenal.

Second, the Trump Administration is unlikely to ever issue a workplace violence standard. One of President Trump's first actions was to issue the so called one in, two out Executive Order that requires agencies issuing a new regulation to rescind two regulations of equal cost. Shortly after taking office, the Trump Administration suspended work on the Workplace Violence Prevention Standard where it languished for a year.

Currently, OSHA plans to hold a panel with small businesses to discuss violence prevention at some point in the coming year. But the agency is many years away from issuing a proposed standard, much less a final one. Even if the Administration was committed to moving quickly, it simply takes far too long to issue an OSHA standard.

The Government Accountability Office estimated conservatively that it takes OSHA over 7 years to issue a standard. The reality is much longer. It took OSHA 20 years to issue its silica and beryllium standard. Front-line caregivers can't wait that long for a solution.

To ensure that health care and social service workers have the protection they deserve, Congressman Courtney from Connecticut, who will be with us today, has introduced the Workplace Violence Prevention for Health Care and Social Service Workers Act. This bill would compel OSHA to issue a standard requiring employers within the health care and social service sectors to develop and implement a workplace violence prevention plan.

That plan would identify risks, specify best work practices and environmental controls, and require training, reporting, and incident investigations. OSHA's standard would require employers to maintain a violence incident log and prepare an annual summary of such incidents.

I would also extend protection—it would also extend protections to public employees in the 24 States not covered by OSHA protections by requiring State health care institutions and social service agencies that receive Medicare funds to comply with the standard.

Finally, instead of forcing health care and social service workers to wait years or decades for effective OSHA protections, this legislation would require OSHA to issue an interim final standard 1 year after enactment and a final standard within 42 months of enactment. These are not radical, impractical, infeasible or unaffordable requirements.

While the Federal Government's efforts have stalled, some states, such as California, have already adopted violence prevention standards that protect health care workers without putting an undue burden on employers.

The measures as H.R. 1309 would require OSHA to include in a standard are almost exactly the same as what OSHA has been recommending in its guidance documents. They are also nearly identical to the Joint Commission recommendations for health care institutions across the country. The difference is that these measures would for the first time be enforceable. Health care and social service workers do important, live-saving work and the least that we can do is to ensure that they can come home safe at the end of their workday. We need to ask ourselves what is the price of inaction?

Today we will hear that price. And we will hear what we can do to prevent it. I want to thank all of our witnesses for being with us today and I look forward to your testimony.

I now recognize the distinguished ranking member for the purpose of making an opening statement.

[The statement of Chairwoman Adams follows:]

Prepared Statement of Hon. Alma S. Adams, Chairwoman, Subcommittee on Workforce Protections

Today, we are here to discuss solutions for protecting our country's front-line caregivers from violence in the workplace.

The people who work in our Nation's hospitals, nursing homes and other health care institutions as well as social workers and other health care providers offer critical assistance to those in need.

They fulfill this role despite inadequate pay, odd and difficult hours, and as we'll discuss the frequent threat of violence at the hands of the people they serve.

This hearing is an opportunity to assess the steps taken by the Occupational Safety and Health Administration to address workplace violence.

It is also a forum to discuss relevant legislation, namely: H.R. 1309, the "Workplace Violence Prevention for Health Care and Social Service Workers Act," which would require OSHA to issue a strong violence prevention standard.

Workplace violence is a serious concern for 15 million health care workers in the United States.1

Although health care facilities are viewed as a place to get well, the reality is that day-to-day work in these facilities exposes many employees to an unacceptably high risk of violent injury.

Last year, the Bureau of Labor Statistics reported that health care and social service workers were nearly five times as likely to suffer a serious workplace violence injury than workers in other sectors.

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In 2017, State government health care and social service workers were almost nine times more likely to be injured by an assault than private-sector health care workers.

To make matters worse, public employees in 24 States almost 9 million workers are not even covered by OSHA, even though they do the exact same work as private sector employees and face the same hazards.

The injuries to caregivers are not just physical.

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These violent incidents are not just part of the job. They are predictable, and they are preventable.

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OSHA first issued guidance to protect health care and social service workers from workplace violence over 20 years ago.

The Obama Administration updated that guidance, prioritizing enforcement of safe working conditions for health care workers threatened by workplace violence.

And for the first time, the Obama Administration put workplace violence on the agency's regulatory agenda, starting the long rulemaking process.

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As a result, inspectors are forced to use the highly burdensome and time-consuming General Duty Clause in the OSHA Act.

And pending litigation may eliminate even that weak tool from OSHA's limited enforcement arsenal. Second, the Trump Administration is unlikely to ever issue a workplace violence standard.

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Shortly after taking office, the Trump Administration suspended work on the Workplace Violence prevention standard while it languished for a year.

Currently, OSHA plans to hold a panel with small businesses to discuss violence prevention at some point in the coming year, but the agency is many years away from issuing a proposed standard—much less a final one.

Even if the administration was committed to moving quickly, it simply takes far too long to issue an OSHA standard.

The Government Accountability Office estimated, conservatively, that it takes OSHA over 7 years to issue a standard. The reality is much longer.

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OSHA's standard would require employers to maintain a Violence Incident Log and prepare an annual summary of such incidents.

It would also extend protections to public employees in the 24 States not covered by OSHA protections by requiring State health care institutions and social service agencies that receive Medicare funds to comply with the standard.

Finally, instead of forcing health care and social service workers to wait years or decades for effective OSHA protections, this legislation would require OSHA to issue an interim final standard 1 year after enactment, and a final standard within 42 months of enactment.

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They are also nearly identical to the Joint Commission recommendations for health care institutions across the country.

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The least we can do is ensure that they can come home safe at the end of their workday. We need to ask ourselves: What is the price of inaction?

Today we will hear that price.

And we will hear what we can do to prevent it.

I want to thank all of our witnesses for being with us today and I look forward to your testimony. I now yield to the Ranking Member, Mr. Byrne for his opening statement.

Mr. BYRNE. Thank you, Madame Chairwoman and let me say I want to congratulate you on receiving the gavel on this subcommittee. I had it last Congress and I know it is in good hands this Congress. This is not the first time that Ms. Adams and I have worked together on things. She founded the Bipartisan Historically Black College and University Caucus and was gracious enough to ask me to be her co-chair on that. So here we are again.

Chairwoman ADAMS. That is right.

Mr. BYRNE. It's good. I thank the gentlewoman for yielding. Allow me to begin this afternoon by saying that protecting the safety of health care and social service workers is not a partisan issue. It doesn't take having a liberal or conservative bent to appreciate the hard work and empathy that hospital workers and community caregivers demonstrate every single day on the job. Their dedication to carrying for the most vulnerable members of our communities is extraordinary and these workers deserve our gratitude, our respect, and our commitment to ensuring that they are safe on the job.

For this reason, I want to thank Mr. Courtney for coming forward with this bill to give us an opportunity to have a robust discussion about it. And I do appreciate that, Mr. Courtney, you are a great Member of Congress and a good friend.

The nature of work in these industries requires health care and social service workers to interact directly with individuals who are experiencing tremendous stress, trauma, and grief, which can cause a situation to devolve and put workers safety at risk. Under the General Duty Clause of the Occupational Safety and Health Act of 1970, employers are already required to take definitive steps to protect employees and provide a safe work environment.

But an acknowledgment of the particular risks facing health care and social service workers OSHA has taken concrete steps in the rulemaking process to better understand the circumstances that exist for these workers and to determine how to provide these industries with a solution. And I share the frustration about it not happening fast enough.

We need a solution that protects workers and provides employers with the necessary flexibility to ensure that their employees are safe on the job. Therefore, I want to go on record strongly supporting protections for workers in this industry in regard to workplace violence. I also commend OSHA for its rulemaking activities in this area and urge the agency to move forward expeditiously in this regard.

In December 2016, almost literally as they were walking out the door, the Obama Administration's OSHA initiated rulemaking process by issuing a public request for information on workplace violence in these sectors. The following month, in January 10, 2017, the agency held a meeting with stakeholders to discuss the specific challenges facing these workers.

Once the Trump administration assumed leadership, OSHA doubled down on these rulemaking efforts by scheduling a small business panel on the rulemaking for early 2019. Meanwhile, the Trump administration's OSHA continues to provide employers with the best practices for ensuring a safe work environment and continues to issue citations to employees who fail—employers who fail to prevent workplace violence under the General Duty Clause for the OSHA Act.

These are positive and deliberate steps and by undertaking this rulemaking process, OSHA is striving to create a thoroughly researched approach that addresses the risk of workplace violence and the hospital and home health care settings fully and effectively.

I am concerned however, that the legislation under discussion, H.R. 1309, might undermine this ongoing rulemaking process. Instead of allowing for a collaborative and evidence-based process, I am concerned we are intentionally or unintentionally ramming through a regulation with limited input from affected stakeholders.

The proposed bill was introduced only a week ago and frankly I think needs further discussion and work. That is OK, that is what we do in these committees.

H.R. 1309, in an effort to speed up the rulemaking process, takes some short cuts and doesn't allow OSHA the time or the ability to adequately conduct additional studies or analyze public comments. Instead, the bill seeks to impose a mandate and I am concerned that not enough research has been done on the critical topic. Protecting workers from instances of workplace violence is a policy priority that Republicans and Democrats see eye to eye on.

I would prefer that this committee holds oversight hearings to allow Committee members to hear directly from individuals and experts so that we can formulate the best course of action to keep our caregivers safe. When things go wrong, our caregivers rise to the occasion. They deserve a thoroughly vetted and researched solution that protects them in the line of duty.

It is the responsibility of members of this committee to approach complex and important matters under our jurisdiction like the issue before us today with are and dedication to ensure that we do right by these valued members of our communities. And I yield back.

[The statement of Mr. Byrne follows:]

Prepared Statement of Hon. Bradley Byrne, Ranking Member, Subcommittee on Subcommittee on Workforce Protections

Thank you for yielding.

Allow me to begin this afternoon by saying that protecting the safety of health care and social service workers is not a partisan issue. It doesn't take having a liberal or conservative bent to appreciate the hard work and empathy that hospital workers and community caregivers demonstrate every single day on the job. Their dedication to caring for the most vulnerable members of our communities is extraordinary, and these workers deserve our gratitude, our respect, and our commitment to ensuring that they are safe on the job.

The nature of work in these industries requires health care and social services workers to interact directly with individuals who are experiencing tremendous stress, trauma, and grief, which can cause situations to devolve and put workers' safety at risk.

Under the general duty clause of the Occupational Safety and Health Act of 1970 (the OSH Act), employers are already required to take definitive steps to protect employees and provide a safe work environment. But in acknowledgement of the particular risks facing health care and social service workers, the Occupational Safety and Health Administration (OSHA) has taken concrete steps in the rulemaking process to better understand the circumstances that exist for these workers, and to determine how to provide these industries with a solution. We need a solution that protects workers and provides employers with the necessary flexibility to ensure that their employees are safe on the job.

Therefore, I want to go on the record strongly supporting protections for workers in this industry in regards to workplace violence. I also commend OSHA for its rulemaking activities in this area and urge the agency to move forward expeditiously in this regard.

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When things go wrong, our caregivers rise to the occasion. They deserve a thoroughly vetted and researched solution that protects them in the line of duty. It's the responsibility of members of this committee to approach complex and important matters under our jurisdiction, like the issue before us today, with care and dedication to ensure that we do right by these valued members of our communities.

Chairwoman ADAMS. Thank you, Mr. Byrne. Thank you, Mr. Byrne. Before we begin, I ask unanimous consent to insert into the record a statement from the American Federation of State County and Municipal Employees and a statement from the Emergency Nurses Association. Without objection, all of the members who wish to insert written statements into the record may do so by submitting them to the committee clerk electronically in Microsoft Word format by 5 p.m. on February 13, 2019.

I would like to now introduce our witnesses. Our first witness, Ms. Patricia Moon-Updike from Cudahy? Cudahy, Wisconsin. Ms. Moon-Updike is a registered nurse and a member of the Wisconsin Federation of Nurses and Health Professionals, an affiliate of the American Federation of Nurses.

Our next witness, Dr. Angelo McClain is the Chief Executive Officer of the National Association of Social workers. Dr. McClain has been a licensed and practicing social worker for the past 30 plus years, served for 6 years as Commissioner for the Massachusetts Department of Children and Families and prior to that, Dr. McClain was Vice President and Executive Director of Value Options New Jersey and was Vice President of Network Management and Regional Operations for the Massachusetts Behavioral Health Partnerships.

Following Dr. McClain, we will hear from Mr. Manesh Rath. Mr. Rath is a partner at Keller and Heckman. He is a trial and appellate attorney specializing in occupational safety and health and other issues.

Our last witness, Dr. Jane Lipscomb, is a nurse and epidemiologist, who spent her career as a Professor of Nursing and Medicine at the University of Maryland researching and addressing the epi-

demic of occupational health and safety hazards facing our Nation's health care and social service work force. She has also served as an expert witness in numerous OSHA enhancement enforcement cases.

To the witnesses, we have a few instructions for you. We appreciate all of you for being here today. We do look forward to your testimony but let me remind you that we have read your written statements and they will appear in full in the hearing record. Pursuant to committee rule 7(d), and the committee practice, each of you is asked to limit your oral presentation to a 5 minute summary of your written statement. And let me remind you as well that pursuant to Title 18 of the U.S. code, section 1001, it is illegal to knowingly and willfully falsify any statement, representation, written or in writing A document or material fact presented to Congress or otherwise concealed to cover up A material fact.

And so before you begin you testimony, please remember to press the button on the microphone in front of you so it will turn on and the members can hear you. And as you begin to speak, the light in front of you will turn green. After 4 minutes, the light will turn yellow to signal that you have 1 minute remaining. And when the light turns red, your 5 minutes have expired and we would ask that you would please wrap it up at that time.

We will let the entire panel make their presentations before we move to member questions. When answering a question, please remember to once again turn your microphones on. We are going to first recognize Ms. Patricia Moon-Updike. Ms. Moon-Updike.

STATEMENT OF PATRICIA MOON-UPDIKE, WISCONSIN FEDERATION OF NURSES AND HEALTH PROFESSIONALS

Ms. MOON-UPDIKE. Thank you, Chairwoman Adams, Ranking Member Byrne and members of the subcommittee for this opportunity to testify today. My name is Patricia Moon-Updike and I am a registered nurse and member of the Wisconsin Federation of Nurses and Health Professionals which is affiliated with the health care division of the American Federation of Teachers. I also want to thank Representative Courtney for developing the legislation. This hearing gives voice to those who cannot speak for fear of retaliation. During my career I worked in an ICU, in obstetrics, in the correctional health services and as a psychiatric nurse. I got to be what I wanted to be when I grew up.

During—then, on June 24, 2015, it all changed. I was working in the Behavioral Health Division of Milwaukee County in the Child and Adolescent Treatment Unit. I was so excited to be working with these kids. It was close to the end of my shift, and I was sitting with a new nurse orienting on the unit. There was a boy, quite large for his age, who was getting very aggressive in the hallway. This young man, who was very well known to the staff and management, had a history of breaking windows and damaging doors in—on that the unit.

He was not assigned to be my patient that day, but the new nurse that I was orienting felt that he needed to intervene so I also went to help. The youth was screaming and thrashing. Along with his assigned nurse, we worked to deescalate the situation and we needed to get him into the seclusion room. Someone gave the code

for security and we believed that four security guards would be coming to help but only two of those security guards arrived.

The patient was bucking and screaming but we got him into the seclusion room and set him on the mattress on the floor and someone yelled clear. Everyone stepped back away from him and then he then spun around on his back and kicked his leg high in the air striking me in the neck, hitting me with such force in my throat that my head snapped backward and I heard a bang and a pop and all the air rushed out of me.

I grabbed my throat. Someone pulled me out of the room and I remember sitting in a chair not being able to breathe, holding on to my trachea for dear life and I knew that if I let it go, it would collapse and I would die right in that hallway. I was praying to stay conscious.

I was taken to the trauma hospital, which fortunately was right across the street. I was so scared out of my mind and I feared that I would not be able to say goodbye to my children.

I woke up after surgery with a large collar around my neck and I was fortunate. I was in pain. I was bruised and I was in shock but my trachea was intact and I was breathing on my own.

Two days later the nightmares started. I couldn't sleep. I figured it would pass. However, this was a different kind of feeling than I had ever experienced before. As time passed, I became more scared of people and children being unpredictable. Excuse me, sorry.

Since this injury in 2015, I have been diagnosed with moderate to severe PTSD, moderate anxiety, insomnia, depressive disorder and social phobia related to this incident. I suffer from terrible memory problems. I cannot wear a seat belt properly, it comes too close to my neck and I have to wear it around my waist. I have not been to a mall, a concert or a sporting event since this assault due to my fear of crowds.

I loved being a nurse. I do not know what to call myself now. There is a deep loss when you used to make a difference in the lives of people, in your true calling and passion and now in that place is extreme sadness and fear.

The assault that happened to me was not random or a freak event, but a predictable scenario that could have been prevented had there been a plan in place and more trained staff to assist. The individual who assaulted me should have been on a one to one assignment given his previous behavior on that unit. There should have been four security officers and there should have been a plan in place to provide more security if there had been multiple incidents going on simultaneously.

My colleagues spoke to management and pressed for improvements but our voices were not heard. I know that the requirements in this legislation can help prevent violence. Under this bill, the facility that I worked in would be required by OSHA to develop violence protection program. This is crucial because currently there is no oversight in that facility by OSHA or by any State agency.

We can't accept violence as part of the job. Prevention is possible. When systems are put into place to reduce the risk of violence when nurses and health care workers are safer, so are our patients. We need the equipment, personnel and training to do our job safe-

ly. Our parents, our patients and our health care system cannot afford to lose more good nurses and health care workers to prevent preventable violence.

Since the assault I have challenged myself to do things to beat this. I try to still be the person I used to be. I promised my union that when I was ready, I wanted to help other health care worker providers and I hope telling my story will help prevent assaults like this on other health care providers. With your help it will.

I thank you and I respectfully urge you to support this legislation.

[The statement of Ms. Moon-Updike follows:]

Statement of
Patricia Moon-Updike, RN
Wisconsin Federation of Nurses and Health Professionals
Hearing on "Caring for the Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence."
U.S. House of Representatives
Committee on Education and Labor
Subcommittee on Workforce Protections
Feb. 27, 2019

Thank you, Chairwoman Adams, Ranking Member Byrne and members of the subcommittee for the opportunity to testify today. My name is Patt Moon-Updike, and I am a registered nurse and member of the Wisconsin Federation of Nurses and Health Professionals, which is affiliated with the healthcare division of the American Federation of Teachers.

I also want to thank Rep. Courtney for developing legislation to prevent workplace violence against healthcare and social service workers. This hearing gives a voice to those who cannot speak for fear of retribution, and the legislation provides a path to make our working environments safer.

I have wanted to be a nurse since I was 9 years old. I was able to realize my dream when I graduated from nursing school in 2007, following years raising foster children and my own four children. During my career as a nurse, I worked in an intensive care unit, in a mother and baby unit, in correctional health services and as a psychiatric nurse. I got to be what I wanted to be when I grew up!

Then, on June 24, 2015, it all changed. I was working at the Behavioral Health Division of Milwaukee County in the Child and Adolescent Treatment Unit. I had also previously worked at this facility in the Women's Treatment Unit. I was only three days into my position with the Child and Adolescent Unit, and I was so excited to be working with and hopefully making a difference in the lives of these kids.

It was close to the end of shift, and I was catching up on my charting for the day and orienting a new nurse on the unit. There was a teen boy, quite large for his age, who was getting very aggressive in the hallway. This young man, who was very well known to the staff and management, had a history of breaking large windows and damaging doors in the unit. He was

not assigned to be my patient that day, but my nurse orientee felt that he needed to intervene, and headed down the hallway. The patient's nurse was not yet visible to me, and I did not want our orientee alone in this situation, so I too went to help.

The youth was screaming, posturing and thrashing. Along with his assigned nurse, we worked to de-escalate the situation and get him into the seclusion room. Someone gave the code for security. We nurses believed that four security guards would be coming to help. But only two security guards arrived. This meant that each guard would take one of his limbs, his nurse would take a limb and his head and the orientee would take a limb. I guarded his back as we put him to the floor and walked down the hallway because he was bucking us and screaming. We did get him into the seclusion room and set him on a mattress that was on the floor. Someone yelled "clear" and everyone stepped away from the patient. He then spun around on his back and kicked his leg high into the air striking me in the neck, hitting with such force to my throat that my head snapped backward; I heard this "bang" and "pop," and all the air just rushed out of me.

I grabbed my throat and spun around. I heard someone screaming "Patt's been hit," and then someone grabbed me from behind, led me out of the room and put me in a chair in the hallway. All I remember is sitting in a chair, not being able to breathe, holding on to my trachea for dear life; I just knew if I let go, it would collapse and I would die right there in that hallway. I was praying to stay conscious and focusing on the blood pressure cuff and the oxygen saturation monitor to keep my mind active.

I was taken to a trauma hospital, which luckily was located just across the street. I was scared out of my mind, and reality was fast setting in that I might not even be able to say goodbye to my children. They were afraid for me every day when I went to work, and here I was on a gurney having my scrubs cut off, nurses yelling that they couldn't find a vein to put a line in. I could understand absolutely everything that was going on around me because *I was one of them*!

I was intubated through my nose, while awake, with blood dripping down my face. I was headed to surgery, so they could find out if he had crushed my trachea. I still hadn't removed my hand from my throat; they couldn't even pry it off. I was that terrified. They had to take my hand away from my throat during surgery.

I woke up in ICU with a huge collar around my neck, and I had been taken off intubation. I was very lucky. My trachea was intact. My head did look like Rocky after a fight, but I was breathing on my own. My whole body just hurt, and I was still in shock.

I was released from the hospital two days later. After I went home, the nightmares started. I couldn't sleep. I figured this was normal and it would pass. I was a nurse, I wore a cape. I could

get past this. However, I soon found out that this was a different kind of "feeling" than I had ever experienced before. I have had obstacles in my life, but I would get back up, brush myself off and get movin' on. This time it was different. As the days passed, I became more "scared" of people, of people being unpredictable, people in crowds being unpredictable, children being unpredictable.

I did seek professional help. Since June 2015, I have been diagnosed with moderate to severe post-traumatic stress disorder, moderate anxiety, insomnia, depressive disorder and social phobia related to this incident. I fought with Milwaukee County Workers Compensation attorneys until August 2018—eventually winning my claim after two court hearings and many months under surveillance, some of it harassing.

I suffer from terrible memory problems. I cannot wear a seat belt properly because it comes too close to my neck; I must wear both belts around my waist. I have not been to a mall, concert or sporting event since the assault because of my fear of crowds.

I always told my kids that if you went to work at something you loved, you never went to work. I LOVED being a nurse. I have a huge problem still calling myself a nurse. I do not know what to call myself now. There is a deep loss when you used to make a difference in the lives of people, in your true calling and with passion. Now, that space is filled with extreme sadness and fear—through no fault of your own.

When I last worked as a registered nurse, I made $62,000 a year. Now, on Social Security Disability after deductions for Medicare, I bring home $12,720 a year. I lost my career. The assault that happened to me was not a random or freak event, but a predictable scenario that could have been prevented had there been a clear plan in place and better-trained staff there to assist. The individual who assaulted me should have had a one-to-one assignment to a nurse, given his previous behavior. There should have been four security officers provided as well as a plan in place to provide appropriate security if multiple incidents are occurring at the same time. All staff should have received significant training on subduing an individual. My colleagues and I spoke to management and pressed for improvements, but our voices were not heard. Assault should not be part of the job for healthcare workers.

I know that the requirements in this legislation can help prevent violence by requiring healthcare facilities to conduct better risk assessments and to develop locally relevant policies, training, systems and whistleblower protections for nurses who speak up. Under this bill, the facility I worked in would be required by the Occupational Safety and Health Administration to develop a violence prevention program. This is crucial because there currently is no oversight by OSHA or any state agency.

This glaring gap is not just a problem in Wisconsin. OSHA does not cover state and local public employees in 23 other states. Even if the administration approved a rule on this issue, my former friends and colleagues, along with thousands of nurses across the county, would not be safe while helping patients. This bill will remedy this gap for workplace violence overall and provides specific protections for someone like me—a public employee working in a hospital. Healthcare workers are not alone in needing an entity in place to investigate workplace safety issues. I ask that you also support the Protecting America's Workers Act, introduced earlier this month, which would extend OSHA oversight to public employers in all of the states for all hazards.

Without this bill and the OSHA investigative powers it brings, healthcare and social service workers have no voice, no way to advocate for a safer workplace. They have no protection against retaliation if they do complain. Everyone assumes that violence is part of the job.

But that is not true. Prevention is possible when systems are put into place to reduce the risk of violence. When nurses and healthcare workers are safer, so are our patients. Nurses, healthcare workers and social workers need the equipment, security personnel and training to do our jobs safely. Our patients and their families, our healthcare system, those we care for cannot afford to lose more good nurses and healthcare workers to preventable violence.

Since the assault, I have challenged myself to do things to beat this—to try to still be the person I used to be. I promised my union that when I was ready, I wanted to help other healthcare providers. I hope telling my story will help prevent assaults like this on other healthcare workers.

Thank you, and I respectfully urge you to support the Workplace Violence Prevention for Health Care and Social Service Workers Act.

Chairwoman ADAMS. Thank you very much, Ms. Moon-Updike. Dr. McClain, you are recognized for 5 minutes.

STATEMENT OF ANGELO MCCLAIN, CHIEF EXECUTIVE OFFICER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Dr. MCCLAIN. Thank you, Chairwoman Adams and Ranking Member Byrne and subcommittee members for the opportunity to speak to you today and share some of my experiences as a social worker over the last 30 years.

I want to start by telling a story of my first day on the job as a social worker. First day, first hour. I was a—it was 8 a.m. in Amarillo, Texas and a coworker came and said go with me, we have got a case. We drove into the black community and we knocked on the door and the mother said we do not allow white people in our home. So the worker turned to me and said I guess this one is yours. And so I went in to the home.

The door shut immediately behind me. And low and behold there was the largest butcher knife I have ever seen in my face—in my life in my face. And the mother said to me if you get us in trouble I will hunt you down and I will kill you in a dark alley. And I looked in—deep into her eyes and I knew she was serious.

And due to my training, I said to her, ma'am, you know, please put down the knife. I am here to make sure your children are safe. Luckily her husband came out of the back of that point and said honey, I think he is here to try to help us.

Fast forward a few years later, I found myself in one of the largest housing projects in Boston. And I went to visit, I had this one client I saw every Thursday at 11 a.m. so she knew I was coming. And when I got there she was sitting outside on the stoop which is never a good thing. And I said to her why are you out here?

And she said well, you are going to be taking my children today. I said why are you saying that? She says you've been real clear. If A, B, C, and D aren't in place my children had to go in foster care. Then she starts yelling he is here to take my kids, he is here to take my kids. And a crowd of about 30 to 50 people gathered around and encircled me and several of those folks had weapons, one individual in particular had a gun and he wanted to make sure that I knew he had a gun.

And I thought how did I get myself into this situation and how do I get myself out of it. So I told them I am here on official business and I want you to disperse. I am going to count to three and if you don't disperse, you're going to be in a heap of trouble. I used the word heap intentionally thinking that might throw them off. And I counted to three. Luckily they dispersed and I was able to conduct my business and help that mother and eventually she became one of my better clients.

I kind of share these stories to let you know that the—to try to put a face on this and thank you, Patricia, for your comments. These tragedies that happen to social workers and health care providers, they are far too common. If you take a—and I'll share just a half a dozen or so situations I'm aware of.

In Congressman Courtney's district in Connecticut in 1998, a social worker was murdered by a client as she was entering her agen-

cy. In 2008 there were two fatalities of a social worker, Brenda Yeager in New York as she was making a home visit. She was beaten and suffocated. In Massachusetts in 2008 Diruhi Mattian was murdered while she was doing a home visit. In 2009, retired Commander Charles Springle, a Navy social worker was shot and killed along with four other colleagues by a service member who was seeking counseling services.

In 2011, Stephanie Moulton from Massachusetts was killed by a client with mental illness as she was working in a group home. In 2015, Laura Sobel from Vermont who was working for the Department of Children and Families there, she was murdered while she as exiting the building in her parking lot.

And just last year, Pamela Knight who worked for the Illinois Department of Children and Families was murdered in the line of trying to protect children. And I could go on and on with these stories.

Believe it or not, social work is among the 10 most dangerous professions that we have. Social workers and health care professionals are twice as likely as others to face violence at work.

In a study in 2003, we learned that 58 percent of social workers out of about 1,000 respondents reported that they had experienced violence in the workplace. And 15 percent of them had been physically assaulted within the past year. Based on the studies I have looked at, there is about 30 percent of social workers who have had a physical—have been physically assaulted at some point in their career. 48 percent of social workers in a study reported that they had no knowledge of an agency safety policy. Violence, workplace violence against social workers is real and it happens frequently.

In 2013, the Bureau of Labor and Statistics reported over 1,000 social workers were injured on the job. And we know the numbers that we are aware of. One study shows that it was 85 percent under counting in those situations.

There is hope. Some of my work in Massachusetts and some of the work that Governor Patrick did there, we were able to put some measures in place. We passed a Social Workers Safety Act in 2013 which required all agencies to have a violence prevention plan. Fast forward 6 years later, those things are in place. And Governor Patrick in 2009 signed into legislation a Massachusetts Employee Safety and Health Advisory Committee—

Chairwoman ADAMS. Dr. McClain, can you wrap up please?

Dr. MCCLAIN. Yes, I can. Because of OSHA standards didn't apply to State employees. I think it is essential that the OSHA standards that we get legislation that would put those standards in place. Thank you.

[The statement of Dr. McClain follows:]

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Written Testimony of
Angelo McClain, PhD, LICSW, Chief Executive Officer
National Association of Social Workers

U.S. House of Representatives
Committee on Education and Labor
Subcommittee on Workforce Protections
"Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence"

February 27, 2019

Thank you, Chairwoman Adams and Ranking Member Byrne, and Members of the Subcommittee, for the opportunity to testify regarding the workplace violence challenges faced by social workers, health, and social service workers and the need for prevention and protection. I am also pleased to support and address the importance of the "Workplace Violence Prevention for Health Care and Social Service Workers Act" (H.R. 1309). I am Dr. Angelo McClain, Chief Executive Officer of the National Association of Social Workers (NASW). Our organization, which was founded in 1955, is the largest association of professional social workers in the nation with over 115,000 members and 55 chapters. Part of NASW's mission is to promote, develop, and protect the practice of social work and social workers. There are over 600,000 social workers in the United States, and they are the nation's largest provider of mental health services.

The National Association of Social Workers is proud to support the Workplace Violence Prevention for Health Care and Social Service Workers Act. This bill is a crucial step in reducing the staggering number of preventable physical and psychological assaults on social workers and other health and social services professionals. Developing a standard that anticipates the risks associated with the practice of social work is critical to preventing violence in those settings.

As the committee seeks to comprehensively address this important safety issue, NASW also urges you to consider the soon-to-be reintroduced "Social Worker Safety Act of 2019". This legislation would establish a Social Worker Safety Grant Program within the Department of Health and Human Services to aid state efforts to improve workplace safety measures for social workers. This bill provides states with critical resources designed to alleviate workplace violence threats by allowing grant money to be used to

purchase safety equipment, make facility improvements, facilitate safety training programs, provide support services for social workers who have been victims of violence, or track incident data to mitigate future offenses against social workers, among other important uses. This bill was first introduced in 2007 as the "Teri Zenner Social Work Safety Act" and was named after a social worker in Kansas who was tragically stabbed to death by a 17-year old client in 2004. NASW also urges you to consider another soon-to-be reintroduced bill, the "Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act". This legislation would establish a Social Work Reinvestment Commission to provide independent counsel to Congress and the Secretary of Health and Human Services on policy issues related to recruitment, retention, research and reinvestment in the profession of social work, and for other purposes. A key focus of the Commission's efforts would be to improve social worker safety, and the bill also authorizes grants to assist entities in carrying out a workplace improvement program.

I urge Congress to take up and pass the "Social Worker Safety Act", the "Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act" and H.R. 1309, as these complementary measures will lead to safer workplaces for those performing important services that put them in high-risk and potentially dangerous situations. Trauma and violence must no longer be accepted as part of the workplace for health care and social service workers.

On a daily basis, social workers in a variety of settings are in harm's way. Our profession works in home care agencies, hospitals, child guidance centers, family services agencies, schools, mental health clinics and case management agencies, to name just a few settings. These are jobs that often require work beyond the agency walls where the risk of threats and violence are more prevalent. However, even within agencies we have had reports of incidents of violence against social workers. For this and other reasons, social work is among the top 10 most dangerous professions. Social workers and health professionals are twice as likely to face job-related violence as compared to other occupations. Between 2011-2013, there were 23,000 workplace assaults, and nearly 75% of these were in healthcare and social service settings (OSHA, 2016). In 2013, 1,100 social workers were injured as a result of workplace violence, according to the Bureau of Labor Statistics (BLS). Unfortunately, these staggering statistics do not capture the substantial number of unreported assaults, which, according to one survey, are as high as 85% of all assaults (AFGE, 2016). In a 2003 survey of 1,600 social workers, 58% of the 1,129 respondents said that they had experienced at least one violent incident in their career (Newhill, 2003). In 2004, NASW partnered with the Center for Health Workforce Studies, University of Albany, to conduct a national safety study of 10,000 licensed social workers. 44% of the respondents reported facing personal safety issues in their primary employment setting and 30% felt that their employers did not adequately address safety issues. Many social workers are employed by public agencies and are placed at increased risk due to the settings in which they work and the nature of the services they perform (NASW, 2004). Additionally, preventing workplace violence is a key success factor in reducing clinician and staff burnout and increasing retention.

I would like to highlight the unique and significant risk child welfare workers face. Violence against these workers is prevalent for several reasons. Child welfare clients are not receiving services voluntarily, and their families often have other volatile issues, such as domestic violence and substance abuse. Further, child welfare workers often make home visits in struggling neighborhoods. Child welfare workers spend a large percentage of their time in communities and, as a result, may experience a higher risk of harm. Additionally, these child welfare workers tend to prioritize physical and emotional safety of the child leaving child welfare workers more vulnerable to becoming targets of violence themselves. Finally, many state governments currently are suffering from budget cuts; therefore, adequate funds to properly train

and protect public workers are not prioritized. The Social Worker Safety Act aims to provide states with these much-needed resources.

Increased rates of violence in society, deinstitutionalization, and greater enforcement around child custody have heighted the inherent risk to social worker safety. These professionals enter dangerous situations regularly, and, unlike police or probation officers, they often enter these situations without any form of self-protection. In their day-to-day work, they encounter volatile situations that can quickly escalate to physical violence. Their clients include individuals who have violent histories, may be psychiatrically unstable, or experiencing extreme emotional stress. Because of the nature of social work, these professionals are also often involved in high-conflict situations, such as child custody disputes, removal of children from parents, and work with probationers and court-involved individuals. Social workers serve vulnerable populations and those with serious, chronic physical and mental conditions. As a critical workforce serving underserved populations that have often been disconnected from health and mental health care, social workers are at times subject to unpredictable situations and environments.

I want to illustrate some of the tragedies social workers have experienced due to workplace violence. In Congressman Courtney's home district in Connecticut, a social worker was murdered by a client in 1998 as she was entering her agency. This social worker posthumously received the Connecticut NASW chapter Social Worker of the Year Award. In 2008, there were two fatalities. New York social worker Brenda Yeager was beaten and suffocated while visiting a client family home and Diruhi Mattian was killed in Massachusetts during a home visit with a client. In 2009, Retired Commander Charles Keith Springle, a Navy social worker, was shot and killed, along with four other troops, by another service member seeking counseling services at Camp Liberty in Baghdad. In 2011, Stephanie Moulton, a social worker in Massachusetts, was killed by a client with mental illness at a group home. In 2012, Stephanie Ross, a caseworker in Tampa, was stabbed to death by a client. In 2015, Lara Sobel, a social worker in Vermont, was killed in her workplace parking lot by a client who had recently lost custody of a child. In 2018, Pamela Knight died while working to protect children in her capacity as an investigator for the Illinois Department of Children and Family Services. In addition to these tragic fatalities, there are a staggering number of assaults that are often under reported. Every day social workers across the nation provide a wide range of services in increasingly complex environments. Workplace violence against social workers is an occupational risk hazard that is preventable and needs to be addressed systemically at all levels of society.

As a licensed and practicing social worker over the past 30 plus years, and as former Commissioner of the Massachusetts Department of Children and Families from 2007 to 2013, I have been directly and indirectly involved in numerous workplace violence situations, including numerous assaults, both physical and verbal, on social workers and other health professionals. I have never been physically assaulted, but I have been threatened with physical harm on a number of occasions with guns, knives and other weapons. I also have experienced verbal assaults. During the first hour of my first day on the job as a social worker, I went on a home visit to see a family regarding a potential abuse situation. Upon entering the home, the mother closed the front door and within a nanosecond got a butcher knife and held it up to my face. She threatened "If you get us in trouble, I will hunt you down in a dark alley and kill you". Due to a combination of my size, street smarts, social work training, and ability to defuse situations, I was able to move this confrontation to a constructive interaction and avoid any physical harm. Just a few years later, I went on a home visit with another family. The mother was sitting on the front stoop and we began discussing the possible removal of her children. Within minutes, I found myself surrounded by a crowd of neighbors, one of whom was carrying a gun. I told the group to

disperse, and they did, but this could have had a tragic ending. I share these experiences to put a human face on the urgent need for action, and to underscore how very many of us in the social work profession encounter actual or threatened violence in the workplace.

The Massachusetts health and human services community has been repeatedly stunned by the deaths of their own (Stephanie Moulton in 2011 and Diruhi Mattian in 2008), as well as other harms to social workers in the state. In 2005, a 10-year veteran of the Massachusetts Department of Social Services retired due to a traumatizing experience of being stalked by a teenage client. Describing her decision to leave her job, she said "I doubt myself now. I always went into every home with an open mind. I don't know if I trust myself to be fair after this. My babies have to come first. I can't put them at risk." She was tormented at the thought of leaving the profession she once loved. "Most of these kids have been abandoned by adults," she says. "I never thought I would end my career walking away from them, too."

In 2009, Massachusetts Governor Patrick issued Executive Order 511 to address health and safety protections for commonwealth employees because public workers are not covered by federal Occupational Health and Safety Administration (OSHA) standards and rules. That order established the Massachusetts Employee Safety and Health Advisory Committee, which was tasked with examining the safety of state workers and making recommendations to reduce workplace injuries and illnesses. In 2014, the Committee issued a report based on a 2010-2012 study showing that violent assaults, among others, caused the most injuries to state workers in Massachusetts. Approximately 3,000 Massachusetts state workers experienced job-related injuries serious enough to require time off from work, and four workers lost their lives during that time period. Notably, the most at-risk state employees were health and human services workers, corrections officers, and transportation workers.

While I was Commissioner in 2013, Governor Patrick signed the Social Work Safety in the Workforce bill, which requires all direct services providers receiving funding from the state's Executive Office of Health and Human Services to provide workplace violence prevention and crisis response plans. This legislation, and the resulting regulations, which took effect in 2015, have been critically important in improving the safety of social workers and reducing staff burnout and improving employee retention in Massachusetts.

Recognizing the urgent need to address safety and risk factors associated with social work practice, NASW has long supported the development of policies and procedures designed to eliminate violence in the various workplace settings in which social workers practice. NASW also supports the conduct of research to document the extent of the problem and develop effective systemic solutions. In addition to NASW's dedicated advocacy in support of the Social Worker Safety Act, the organization in 2012 developed "Guidelines for Social Worker Safety in the Workplace" which are a crucial resource to communities, private and public agencies, and local, state, and federal policymakers committed to creating a safer work environment for social workers and related professionals. A copy of these guidelines is attached. These standards are based on the safety policy that was developed in Massachusetts during my tenure as Commissioner and address both primary trauma (e.g. physical and/or verbal assault) and secondary trauma (e.g., post-traumatic stress disorder, etc.). NASW safety guidelines include many of the tactics outlined in H.R. 1309, such as the use of safety technology (e.g. mobile panic buttons, security cameras), "buddy" systems for off-site client visits, comprehensive risk assessments of both clients and work settings, incident reporting and logging practices, and annual training.

NASW has a variety of other resources available to employers and others aimed at recognizing the risks social workers face, identifying high-hazard work environments, and protecting social workers from these risks. This includes a publication, *Security Risk*, which outlines strategies and tactics around safety. Notably, Integra Health, which was involved in the case regarding the murder of Stephanie Ross in Florida, relied upon NASW's guidelines and resources in designing training for its service coordinators as part of its post-incident corrective actions.

Although policies such as those in Massachusetts and NASW's guidelines around safety have been mission-critical in protecting social workers, a strong OSHA standard is essential. It is essential that Congress, through H.R. 1309, impose a workplace violence prevention standard that is mandatory for covered workplaces and affects many public employees, a significant number of whom are social workers. NASW strongly supports all the recommendations for the OSHA guidelines. They are feasible and effective for protecting social service workers. NASW strongly supported OSHA's use of the General Duty Clause as a way to enforce safe working conditions absent a standard. But the General Duty Clause is burdensome, under attack (in Integra) and OSHA therefore needs a standard. The work practice and environmental controls required in each workplace violence prevention plan will save lives and help decrease the disproportionate number of incidents social workers experience. Congress should also enact the Social Worker Safety Act of 2019, which will provide needed resources so state employers can similarly work to provide safer workplaces for these vital providers. Finally, NASW urges Congress to take further action to address workplace violence by passing the Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act to provide additional resources and continued focus on this issue.

National Social Work Month is just a few days away. During March, NASW will, through our "Elevate Social Work" campaign, raise awareness about the incredibly important role of social workers in this nation. Congress must act now to pass H.R. 1309, the "Social Worker Safety Act", and the "Dorothy I. Height and Whitney M. Young, Jr. Social Work Reinvestment Act" to provide critically needed protection for the 600,000+ professionals who have committed their lives and careers to helping others, despite low pay, little recognition and, increasingly, dangerous working conditions.

Thank you again for the opportunity to testify, and I look forward to answering any questions you may have now or in the future.

Chairwoman ADAMS. Thank you, sir. Mr. Rath, you have 5 minutes, sir.

STATEMENT OF MANESH RATH, PARTNER, KELLER AND HECKMAN

Mr. RATH. Good afternoon, Chairwoman Adams, Ranking Member Byrne, and members of this subcommittee. I am grateful for the opportunity to participate in this hearing on H.R. 1309, Protecting Health Care and Social Service Workers from Workplace Violence. My name is Manesh Rath and I'm a partner at the law firm Keller and Heckman in Washington, DC.

I work with clients every day to develop a sound and effective approach to improving workplace safety and health. In my testimony today, however, I am expressing only my own understanding of the fields of occupational and safety and health law and administrative law, and I am not here as a representative of my firm, its clients, or any other entity. First, let me say we all share a common goal to improve workplace safety and health for health care workers. Furthermore, it should be beyond dispute that employers have an important role to play in addressing the identifiable and manageable risks to health care and social service workers. However, this bill as drafted raises concerns on several grounds. I'll address two.

First, this bill directs OSHA to proceed straight to publishing an enforceable interim final rule without the preliminary step of identifying the causes that are known to be manageable by an employer and any proven employer interventions. This would neglect the longstanding principle that safety and health standards should be based on evidence. The causes of workplace violence in health care are far from understood and the remedy remains unclear.

Stakeholders can help us understand whether a standard is the right approach and if so the proper scope and applicability of that standard and what management programs should be adopted that would be most effective.

Before proceeding to rulemaking to develop a legally binding standard, OSHA should review its experience with its own guidelines that it has published and try and learn what experiences it has gained from having issued citations against employers under its own General Duty Clause of the Occupational Safety and Health Act. In fact, this was the opinion of the Government Accountability Office in a report issued to OSHA and OSHA agreed.

Separately, the Centers for Disease Control issued a separate report suggesting that more research had to be done into the causes and preventions associated with workplace violence. Second, this bill would direct OSHA to adopt and implement an enforceable, interim final rule without the well accepted principle of administrative due process that Congress required the agency to implement under the Occupational and Safety and Health Act and the Administrative Procedure Act. Specifically, the idea that when contemplating a rule, an agency should put out notice to all that the possibility of a rule is forthcoming and then to allow for comments by affected stakeholders and to consider those comments before publishing a final rule. Those are the shared cornerstones of administrative law and have been so for 72 years.

This bill in fact acknowledges the importance of deriving experience and insight from stakeholders. No less than six times in Section 103 of this bill, Section 103 is the section which provides a minimum standard for OSHA to implement. And no less than six times in Section 103, the minimum standard, the standard would require employers to seek input from stakeholders from employees, unions, and co-located employers. And yet, by the same hand that drafted Section 103, this bill would seek to deprive all stakeholders of the opportunity to assist in collaboratively fashioning perhaps a better standard.

And it's not just employers that this bill would seek to silence though employers have amassed a considerable experience through trial and error and through the collaborative process but also employees would be kept from participating in the rulemaking process as stakeholders in the comment and hearing process.

Unions and professional associations that represent those employees and as well security and technology firms who have developed perhaps technologies that have been successful or are further improving on those technologies that could be more successful in the field of workplace violence.

Insurance carriers have amassed a trove of data that would benefit the process of developing a better rule and the scientific and medical communities who perhaps have valuable insight into the etiology of workplace violence and perhaps also into if effective interventional modalities.

Any effort to address the issue of workplace violence in health care should be thoughtful, should be based on data, and on the expertise of those who have experienced it and those who study it. This subcommittee can and should have faith that the collaborative input of those with experience and learning in this field will yield a better approach than the bill we have today.

I thank you for the opportunity to appear before you today and I look forward to addressing any questions you may have.

[The statement of Mr. Rath follows:]

TESTIMONY

OF

MANESH K. RATH

BEFORE THE

WORKFORCE PROTECTIONS SUBCOMITTEE

OF THE

U.S. HOUSE OF REPRESENTATIVES

ON H.R. 1309

"CARING FOR OUR CAREGIVERS: PROTECTING HEALTH CARE AND SOCIAL SERVICE WORKERS FROM WORKPLACE VIOLENCE"

ON FEBRUARY 27, 2019

Good afternoon, Chairwoman Adams, Ranking Member Byrne, and members of this Subcommittee. I am grateful for the opportunity to participate in this hearing.

For over twenty-five years, I have dedicated my life's work to the proposition that well-intentioned employers are uniquely well positioned to improve the welfare, safety, and health of the American workforce.

I am a partner at the law firm Keller and Heckman LLP, here in Washington, D.C. I have represented industries and employers in collaborating with labor, professional associations, the scientific community, and government to develop a safer and healthier workplace. I have taught several thousand safety and health professionals, labor-management professionals, attorneys, and university students on matters involving labor law, OSHA law, litigation, and legal ethics. With a few esteemed OSHA law attorneys, I have co-authored and edited two authoritative books in the field of OSHA law.

In my testimony today, I am expressing only my own understanding of the fields of occupational safety and health law and administrative law, and I am not here as a representative of my firm, our clients, or any other interest.

1. This Bill is a Flawed Approach to Managing a Potential Hazard About Which Stakeholder Knowledge is Essential

We all share a common goal to improve workplace safety and health for healthcare and social service workers. Furthermore, the proposition that employers have an important role to play in addressing the identifiable and manageable risks to healthcare and social service workers should be beyond dispute.

However, this Bill as drafted raises concerns on several grounds. Workplace violence is a complex area of workplace safety that falls outside the scope of traditional rules and predictable human behavior. Despite having issued a guidance document, OSHA's experience in this area is relatively limited and there is no crisis that would justify casting aside the traditional rulemaking due process.

A safety or health standard should be adopted only after gathering input from the affected stakeholder community as to the most effective way to proceed. This is a cornerstone of administrative law.

This Bill would direct the Occupational Safety and Health Administration (OSHA) to adopt and implement a final rule without the traditional rulemaking procedures[1] that Congress required of the Agency under the Occupational Safety and Health Act (OSH Act)[2] or the Administrative Procedure Act (APA)[3].

Congress is empowered to instruct an agency to skip this important element of procedural fairness by enacting its own standard, but Congress should exercise that prerogative with caution and infrequently, and only when (1) the issue to be regulated is fully understood and the remedy is obvious; or (2) there is a national emergency such as an epidemic. Workplace violence for healthcare workers does not meet either of those criteria.

2. The Issue to be Regulated is Far from Understood and the Remedy Remains Unclear

Many of the underlying factors that lead to workplace violence involve influences outside the employer's control. Before proceeding to rulemaking to develop a legally binding standard, OSHA should review its experience with the guidance issued on workplace violence and what has been learned from citing employers for workplace violence hazards under the General Duty Clause[4]. Questions such as these should be explored: What settings and conditions may have been present during the clearest alleged violations? What abatement measures were known or available but unused? What employer abatement approaches were the most successful? What are the known conditions and circumstances that lead to reliable predictions of potential violence that employers can use to evaluate their facilities and development most effective remediation?

The Government Accountability Office (GAO) report referenced in this Bill[5] stops short of calling for a new standard.[6] OSHA, in the previous administration, agreed with GAO that OSHA must develop more information to assist inspectors and assess the efficacy of its current efforts.

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[1] See H.R. 1309 § 101(a)(2)
[2] 29 U.S.C. § 655(b)
[3] 5 U.S.C. § 551 et seq.
[4] 29 U.S.C. 654(a)(1)
[5] H.R. 1309 at §2 Findings.
[6] "Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence," Government Accountability Office (2016). The report found that OSHA "has not fully assessed the results of its efforts to address workplace violence in health care facilities. Without assessing these results, OSHA will not be in a position to know whether its efforts are effective." Id at p. 1.

The Centers for Disease Control in its recently issued National Occupational Research Agenda (NORA) also called for research into the causes and prevention strategies of workplace violence.[7]

Given the widely recognized need for research on this subject, Congress should refrain from dictating to OSHA that a standard should be issued or what should be in that standard, and that OSHA must do so without stakeholder involvement.

3. There is No National Emergency That Would Justify Dispensing With the Traditional Rulemaking Procedures

OSHA may establish an emergency temporary standard until a permanent standard is implemented if workers are in grave danger in the context of exposure to toxic substances or agents determined to be toxic or physically harmful, or from a new hazard.[8] OSHA must also show that an emergency standard is necessary to protect employees from such danger.[9] Workplace violence does not fit either of these two criteria. The phenomenon of workplace violence is neither a toxic substance nor is it a new hazard – indeed OSHA originally issued its voluntary "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" in 1996.[10] Interestingly, OSHA has not yet issued an emergency temporary standard for which the proffered emergency has been sustained by a court that believed the urgency outweighed the importance of following administrative due process.

4. Stakeholder Input Through Traditional Rulemaking Would Greatly Inform OSHA Regarding the Issue to be Regulated and the Appropriate Strategy for Intervention

The Administrative Procedure Act and corresponding procedures in enabling statutes, such as the Occupational Safety and Health Act, recognize that administrative agencies must give the affected stakeholder community an opportunity to comment upon and participate in the development of a regulatory standard.[11] These are well-established principles of administrative due process.

In enacting this statutory rule, Congress specifically adopted the Attorney General's report which stated that, with respect to a regulatory law, the government's "knowledge is rarely complete, and it must always learn the viewpoints of those whom its regulations will affect. Public participation in the rule making process is essential in order to permit administrative agencies to inform themselves…"[12]

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[7] Centers for Disease Control and Prevention National Occupational Research Agenda (NORA) for Healthcare and Social Assistance (Feb. 2019). See, e.g. report at Objective 3, "(i)nvestigate the epidemiology of workplace violence in health care and identify effective strategies for prevention and mitigation."
[8] 29 U.S.C. § 655(c)
[9] Id.
[10] Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers, OSHA 3148-04R (2015), drafted in 1996 and revised in 2004 and 2015
[11] 5 U.S.C. § 551 et seq.
[12] Staff of Senate Judiciary Committee, 79th Cong., Administrative Procedure, p. 19-20 (Comm. Print 1945).

I note that this principle was the result of ten years of Congressional debate before the APA was finally enacted in 1946. Providing stakeholders with an opportunity to comment on a proposed rule has, since then, stood as a universal principle of due process for the last 72 years.

And it is difficult to ignore the irony: this Bill requires employers to seek input from union representatives, employees, and co-located employers, no less than six different times[13] throughout the proposed standard. And while its sponsors should be applauded for recognizing the value gained by stakeholder involvement in the development of an *employer's* safety program, this highlights that stakeholder participation serves a valuable purpose in crafting the standard that they will later be required to implement.

OSHA has relatively limited knowledge and experience in the health care industry and does not profess more. OSHA has not fully assessed the efficacy of its own efforts to address workplace violence in health care facilities and the GAO advised OSHA of this. Stakeholder involvement should therefore be welcomed rather than shunned.

Moreover, depriving stakeholders of the chance to participate in developing a workable standard does not silence only healthcare employers, who have acquired expertise through years of trial and error. It also disenfranchises employees, through their unions and professional associations; security and technology firms, who have developed techniques and solutions that have led to improvements; insurance carriers, who have amassed troves of valuable data; and the scientific and medical communities, who perhaps have insight into the causes of workplace violence and effective intervention modalities.

Under the proposed Bill, none of these constituents will have a chance to lend their acquired wisdom and expertise.

5. Congress has not Established Good Cause to Skip the Rulemaking Step of Seeking Stakeholder Participation

Unless there is good cause to skip the important procedural step of incorporating stakeholder participation in the development of a rule, Congress should permit the Agency to follow this time-honored process.

In the State of California, a similar rule was developed and issued through traditional comment-driven rulemaking. The entire process, from the first notice of a proposed rule to its final implementation, only took fourteen months.[14] This is not an unduly burdensome length of time to make sure that government can gather valuable knowledge from stakeholders.

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[13] See, e.g., H.R. 1309 at §103(1)(A) ("Each Plan shall be developed...with meaningful participation of direct care employees (and) employee representatives"); §103)(1)(B)(ii)((II) (Risk assessment shall be conducted with direct care employees and employee representatives); §103(1)(B)(iv) (post-incident investigation with the participation of employees and their representatives); §103(2)(A)(ii) (solicit input from involved employees and their representatives following a workplace violence incident about the cause); §103(6) (Annual evaluations conducted with full, active participation of covered employees and representatives).

[14] California's Workplace Violence in Healthcare regulation was published as a proposed rule on October 30, 2015. Comments were due Dec. 17, 2015. The public hearing was Dec. 17, 2015. The rule was filed with the secretary

At this moment, OSHA has already stated, in its current Regulatory Agenda, its intention to develop a rule on "prevention of workplace violence in health care and social assistance." Indeed, OSHA has stated that it will initiate a SBREFA[15] panel in March, 2019, so there is no evidence to suggest that the Agency is taking too long.[16]

OSHA's regulatory agenda includes other proposed standards intended to address significant risks in the workplace – including mechanical power presses, lead exposure, communication towers, tree care, cranes and derricks, and powered industrial trucks. This Bill proposes to insert workplace violence in the healthcare industry above others in the absence of evidence to justify that prioritization.

Further, given OSHA's existing history of enforcement against health care employers in instances of workplace violence, together with the Agency's stated intent to promptly implement a rule, the assertion that the Agency's efforts have been "slow" are unfounded.

The Bill's assertion that employer organizations have challenged OSHA's authority to enforce against workplace violence hazards[17] is misleading. The Occupational Safety and Health Review Commission upheld OSHA's use of the General Duty Clause[18] in a number of recent decisions, including just last week.[19] This negates the case for skipping proper rulemaking procedures or that a crisis can be met in no other way than by suspending administrative due process.

6. Conclusion

Any effort to regulate the issue of workplace violence in healthcare should be thoughtful rather than rushed. The process should be inclusive of employers, employees, the security industry, the insurance industry, and the scientific and medical professions.

This subcommittee can and should have faith that the collaborative input of those with experience, training, and learning in this field will yield a better approach than the Bill before us today. Thank you for the opportunity to appear before you, I look forward to addressing any questions you may have.

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of state (finalized) on Dec. 8, 2016. While 48 days is insufficient for meaningful stakeholder participation, the overall time of fourteen months negates this Bill's assertions that "legislation is necessary to ensure the timely development of a standard…"

[15] Small Business Regulatory Enforcement Act of 1996, P.L. 104-121 (Mar. 1996). A SBREFA panel, or SBAR panel, is a preliminary step prior to publishing a proposed rule that meets with representatives of small entities – another critical stakeholder.

[16] RIN 1218-AD08 (Fall 2018), see, e.g. https://www.reginfo.gov/public/do/eAgendaViewRule?pubId=201810&RIN=1218-AD08

[17] HR 1309 at Section 2(11).

[18] 29 U.S.C. 654(a)(1)

[19] See, e.g. *Secretary of Labor v. Integra Health Management, Inc.*, OSHRC No. 13-1124; *Secretary v. BHC Northwest Psychiatric Hospital, LLC et al*, OSHRC Docket No. 17-0063.

Chairwoman ADAMS. Thank you very much. We are going to have to recess to take votes. We are watching the clock out here as well and we will be back immediately after those votes are taken. Thank you very much.

[Recess]

Chairwoman ADAMS. Good afternoon and thank you for your patience. The hearing is called back to order. Dr. Lipscomb, you are recognized for 5 minutes.

STATEMENT OF JANE LIPSCOMB, PROFESSOR OF NURSING AND MEDICINE, UNIVERSITY OF MARYLAND

Dr. LIPSCOMB. Chairwoman Adams, Ranking Member Byrne and members of the subcommittee, my name is Jane Lipscomb. Thank you for this opportunity to present my views on the compelling need to protect frontline workers under the Workplace Violence Prevention for Health Care and Social Service Workers Act.

My training is as a nurse and an epidemiologist. I have spent my career, including the past two decades as a Professor of Nursing and Medicine at the University of Maryland researching and addressing the epidemic of occupational health and safety hazards facing our Nation's health care and social service work force with a focus on work place violence prevention.

Of the range of hazards faced by health care and social service workers, few issues have received less attention than the hazard of workplace violence. This is despite the fact that this work force experiences a higher number of non-fatal assaults than any other work group.

And let me be clear, I am not talking about the random acts of violence that get much media attention. I am referring to the systemic acts of violence that occur every day in these workplaces that are predictable and therefore preventable. The good news is that we know how to prevent much of this type of violence.

In the course of my work I have conducted federally funded research into how to prevent workplace violence in hospitals and other high risk settings. In addition, I have consulted with numerous State and Federal agencies on how to advance workplace violence prevention.

Quite frankly I have had too much firsthand experience working with victims of workplace violence, or in the case of workers who were murdered by patients in their care, their bereaved families.

Fortunately though, the vast majority of assaults on health care and social service workers are non-fatal. The risk of workplace violence that I am most concerned about arises from exposure to individuals, their family members and visitors, who sometimes are violent, in combination with a lack of sufficiently strong violence prevention programs.

Patients, especially those in hospitals and residential settings are often traumatized by the experience, in pain and may have altered cognition due to their illness or treatment, including prescription and illicit drugs. They may not intend to assault their caregiver, but regardless of their intent, an employee is still injured. And as we heard this morning, often both physically and emotionally.

While I believe that patient rights and confidentiality are important and must be respected, health care and social service institutions also need to recognize that workers in these facilities have a legal and moral right to come home safely at the end of the day. My experience and research show that both concerns can be reconciled and H.R. 1309 does that. I am here to testify that workplace violence prevention plans, tailored to the specific risk, workplace, and employee population work.

By contrast, voluntary guidelines such as those that were first published by OSHA in 1996 and updated in 2015, do not protect the vast majority of employees, because they fail to incentivize employers to act voluntarily to address this hazard. I can attest to that fact because the vast majority of health care workers who I have spoken with report that they do not have a workplace violence prevention plan or that they have a paper plan that does little to nothing to protect them from the ongoing risk of violence.

Evidence that workplace violence prevention plans are feasible and work includes research from Wayne State University, the Veterans Health Administration and others, as well as my own research.

Here I would also like to emphasize that worker and patient safety are inextricably linked. When there is an insufficient number of staff to meet patient needs, they act out not only toward their caregivers, but also toward other patients. Ask anyone who has a family member or a friend who has required in patient mental health services and you will hear that is the case.

And finally, I would like to address workplace violence protection afforded under the General Duty Clause. Currently, when an employer fails to address the problem voluntarily, the General Duty Clause is the only tool employees have to advance workplace prevention in their workplace. The General Duty Clause is a cumbersome and ineffective means of seeking protection requiring a very high burden of proof in order to issue such a citation.

In the small number of cases where OSHA has cited an employer, the employer may contest the citation, requiring the Department of Labor and the company or employer to expend resources fighting that citation, rather than investing in preventing the hazard. Such cases end up in a hearing before an administrative law judge. In the two cases where an administrative law judge's decision has upheld the citation, including in Integra Health Management case, the employer has appealed the decision to the OSHA Review Commission, resulting in more costs and delays.

It is my fear that an adverse ruling in either of these appeals would seriously compromise OSHA's ability to enforce future workplace violence protections.

Chairwoman ADAMS. Ms. Lipscomb, can you bring your comments to a close please?

Dr. LIPSCOMB. OK. H.R. 1309 is a relatively modest and straightforward piece of legislation that would do much to stem workplace violence among the hardworking and committed work force for far too long. I urge this subcommittee to act on this important bill. Thank you so much.

[The statement of Dr. Lipscomb follows:]

Testimony of
Dr. Jane A. Lipscomb, PhD, RN
Hearing on "Caring for the Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence."

U.S. House Of Representatives
Committee Education & Labor
Subcommittee on Workforce Protections
February 27, 2019

Good afternoon Chairman Courtney and Members of the House Workplace Protections Subcommittee.

My name is Jane Lipscomb. Thank you for this opportunity to present my views on the compelling need to protect frontline workers under the Workplace Violence Prevention for Health Care and Social Service Workers Act.

My training is as a nurse and epidemiologist. I have spent my career-including the past two decades as a Professor of Nursing and Medicine at the University of Maryland - researching and addressing the epidemic of occupational health and safety hazards facing our nation's health care and social service workforce. Health care workers face higher on-on-job injury and illness rates than workers in mining, manufacturing and construction - yet fail to garner the attention commensurate with this statistic.

Of the range of hazards faced by health care and social service workers, few issues have received less attention than the hazard of workplace violence. This is despite the fact that this workforce experiences a higher number of non-fatal assaults than any other worker group. And let me be clear, I am not talking about the random acts of violence that get much media attention. I am referring to the systemic acts of violence that occur every day in these workplaces that are predictable and therefore preventable. The good news is that we know how to prevent much of this type of violence.

Health care workers want to provide the compassionate and professional care that patients deserve, but such care is compromised when steps to prevent workplace violence are not taken by their employers.

In the course of my work I have conducted federally-funded research into how to prevent workplace violence in hospitals and other high-risk settings. In addition, I have consulted with numerous state and federal agencies on how to advance workplace violence prevention.

Quite frankly I have too much firsthand experience working with victims of workplace violence, or in the case of workers who were murdered by patients in their care, their bereaved families. In many of these cases, these highly skilled individuals were working alone with very dangerous patients in the community.

Judie Scanlon was a registered nurse who was killed by a patient while conducting a home visit in Buffalo NY; Dr. Wayne Fenton and Nicole Castro, both from MD, Marty Smith from Seattle, and Stephanie Moulton from outside Boston - the accounts of those health care workers murdered on-the-job are especially tragic.

Fortunately, the vast majority of assaults on health care and social service workers are non-fatal. The risk of workplace violence that I am most concerned about arises from exposure to individual patients, their family members and visitors, who sometimes are violent, in combination with a lack of sufficiently strong violence prevention programs. Patients, especially those in hospital and residential settings are often traumatized by the experience, in pain and may have altered cognition due to their illness or treatment, including prescription and illicit drugs. They may not "intend" to assault their caregiver, but regardless of intent, an employee is still injured (often both physically and emotionally).

While I believe that patient rights and confidentiality are important and must be respected, health care and social service institutions also need to recognize that workers in these facilities have a legal and moral right to come home safely at the end of the day. My experience and research show that both concerns can be reconciled and HR 1309 does that.

My first encounter with a victim of workplace violence occurred while I was working at UCSF in Northern California. Two physicians from Napa, CA (one who lost his sight in one eye and another who suffered a punctured lung) requested to meet with me after reading a journal article I had published in 1992, describing workplace violence as an occupational hazard amendable to public health interventions. At the time, workplace violence was considered a criminal justice issue and handled as such. Since meeting with the Napa State Hospital physicians, I have heard personal testimony from hundreds of workers who have dedicated their lives to caring for the health of the public, yet suffered serious and even career-ending assaults.

Today, workplace violence is one of the most dangerous occupational hazards facing health care workers. This is in part because of the lack of attention to the prevalence and severity of workers' injuries, but also because of the failure to recognize workplace violence as a public health problem amenable to an occupational health approach to prevention, as well as the view that working with individuals with cognitive impairment, mental illness or a tendency towards violent acts "is part of the job" [1] [2].

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[1] Lipscomb, J.A., Rosenstock, L. (1997). Healthcare workers: Protecting those who protect our health. *Infection Control Hospital Epidemiology,* 18: 397-399.

[2] Lipscomb, J.A., London, M. (2015). Not Part of the Job: How to Take a Stand Against Violence in the Work Setting. American Nurses Association. Silver Spring Maryland.

I am here to testify that workplace violence prevention plans, tailored to the specific risk, workplace and employee population work. By contrast voluntary guidelines, such as those that were first published by OSHA in 1996, and updated in 2015, do not protect the vast majority of employees, because they fail to incentivize employers to act voluntarily to address this hazard. I can attest to that fact because the vast majority to health care workers who I have spoken with report that they do not have a workplace violence prevention plan or that they have a "paper plan" that does little to nothing to protect them from the ongoing risk of violence.

Evidence that workplace violence prevention plans are feasible and work includes research from Wayne State University, the Veteran Health Administration and others, as well as my own research.

My research focused on the feasibility and impact of OSHA's Guidelines using a non-experimental intervention design focused on three state-run in-patient psychiatric hospitals in New York State. This research provided evidence for the feasibility and positive impact of comprehensive violence prevention program in the in-patient mental health workplace[3] (Lipscomb, 2006).

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

Evidence from a randomized, controlled intervention study (the "gold standard" in research methods), published in 2017 by researchers at Wayne State University, demonstrates that a data-driven, worksite-based intervention based on the OSHA Guidelines was effective in decreasing the risk of patient-to-worker violence-related injuries by 60%, 24 months following the intervention[4] (Arnetz, 2017).

I believe that when OSHA finally passes a standard, that health care and social assistance employers will greatly benefit from the regulation. Evidence of the prevalence of the problem and the inadequacy of current voluntary measures are clearly delineated in the 2016 GAO study and report. A 2017 report from the American Hospital Association entitled "Cost of community violence to hospitals and health systems" estimates that in 2016, the proactive and reactive violence response efforts cost U.S. hospitals and health systems approximately $2.7 billion. The largest category of costs was associated with the safety of hospital patients, visitors, and employees[5].

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[4] Arnetz, J.E., Hamblin, L., Russell, J., Upfal, M.J., Luborsky, M., Janisse, J., Essenmacher, L. (2017). Preventing patient-to-worker violence in hospitals: Outcome of a randomized controlled intervention. *J Occup Environ Med.* 59(1) 18-27.

[5] Van Den Bos, J., Creten, N., Davenport, S., Roberts, M., (2017). Milliman Research Report – Cost of community violence to hospitals and health systems: Report for the American Hospital Association.

HR 1309 and a future OSHA standard will focus on employee health and safety, but a well-recognized benefit of such a regulation will be enhanced safety for patients receiving care in hospitals and other covered workplaces. This is especially true in the mental health and social assistance setting, where patients frequent experience assaults perpetrated by other patients.

Here I would like to emphasize that worker and patient safety are inextricably linked. When there is an insufficient number of staff to meet patient needs, they act out not only towards caregivers, but also other patients. Ask anyone who has a family member or friend who required in-patient mental health services.

Finally, I would like to address workplace violence protection afforded by (Section 5(a)(1) of the Occupational Safety and Health Act), OSHA's General Duty Clause. Currently, when an employer fails to address the problem voluntarily, the GDC is the only tool employees have to advance workplace violence prevention in their workplace. The GDC is a cumbersome and ineffective means of seeking protection; requiring a very high burden of proof in order to issue such a citation. In the small number of cases where OSHA has cited an employer, the employer may contest the citation, requiring the DOL and the company to expend resources fighting the citation, rather than investing in preventing the hazard. Because of employer challenges and subsequent legal review, the few workers who have risked filing an OSHA complaint have to wait months to years before

OSHA is able to mandate common senses changes to a workplace via an OSHA citation.

A violation under Section 5(a)(1) states the "employer did not furnish to each of its employees a workplace that is free from recognized hazards that are causing or likely to cause death or serious physical harm." Such cases end up in a hearing before an administrative law judge (ALJ). In the two cases where the ALJ's decision upheld the citations (including the Integra Health Management case) the employer has appealed the decision to the OSHA Review Commission, resulting in more costs and delays. It is my fear that an adverse ruling in either of these appeals will seriously compromise OSHA's ability to enforce future workplace violence protections. Also of note, in one of the recently heard cases, the defense attorney argued that under the GDC, an employer does know when they have met OSHA's criteria for an adequate workplace violence prevention program. I believe that the promulgation of an OSHA standard addressing workplace violence in these industry sectors would provide the specific guidance that is lacking in the use of the GDC.

I am grateful that this committee is finally recognizing violence towards health care and social assistance workers as a major public health problem. Fortunately, there is much that can be done to prevent or minimize the hazard and passage of HR will facilitate such prevention.

H.R. 1309 is a relatively modest and straightforward piece of legislation that would do much to stem this workplace violence epidemic that has been perpetrated on this hardworking and committed workforce for far too long. I urge this subcommittee to act on this important bill.

Thank you and I would be happy to respond to any questions.

Chairwoman ADAMS. And thank you very much. Thank you all for your testimony. Under committee rule 8 (a), we will now question witnesses under the 5 minute rule and I want to recognize myself for 5 minutes.

Ms. Moon-Updike, can you explain to the committee how passage of this bill and issuance of an OSHA standard could have prevented what happened to you? You need to—right.

Ms. MOON-UPDIKE. Yes, thank you, Ms. Chairwoman. Absolutely. This bill provides for increased security. I worked in a facility where there was not enough security for all the units that were in that building. If multiple incidents were going on at one time, that security force was extremely compromised. And at many times of the day, there were multiple incidences going on at one time so you couldn't have the amount that you needed to help with those restraint situations or crisis calls that were going on throughout the day.

Also, the—when my incident happened, that young man had been aggressive throughout the entire day. If he had been—if the staffing was the way that it could have been, he needed to be on a one to one staffing situation. And if management would have taken the initiative to do that, my situation wouldn't have happened at all.

Chairwoman ADAMS. OK. Thank you very much. Mr. Rath, H.R. 1309 requires OSHA to issue an interim final standard on workplace violence within 1 year but then it gives OSHA an additional 30 months to issue a final standard. Yet you state that a safety or health standard should be adopted only after gathering input from the affected stakeholder community.

So can you tell me where in H.R. 1309 OSHA is kept from gathering input from affected stakeholders before it issues a final [standard] or tells OSHA not to adopt and implement a final rule without the traditional rulemaking procedures as you claim in your testimony?

Mr. RATH. Thank you for your question. The proposed standard in Section 102 I believe, and I can point you to it if you're asking, calls for a suspension of it's in Section 101 (a)(2) where it states that the applicability of other statutory requirements shall not apply. One of those is Section 6(b) of the Occupational Safety and Health Act and the other is Chapters 5 and 6 of the Administrative Procedure Act. Those are fundamental—

Chairwoman ADAMS. Excuse me. But that is for the interim standard, not the final standard.

Mr. RATH. Ms. Adams, your question was about the final?

Chairwoman ADAMS. The final standard?

Mr. RATH. The problem with waiting until the final standard to allow stakeholder involvement, is that at that point the interim final standard, which is enforceable, has already been put into place and there will be no suspension of enforcement during that period. So, employers are going to have to expend resources for workplace practices, for engineering controls. And to do so, they will do so temporarily only to have to change those processes again as a final rule is published.

So, it's not—the concern with due process here is not that stakeholders won't get a chance to participate in the development of a

final rule, it's that by that point, it's first of all too late. Second of all that the resources will have already been exhausted during a year during which those interventional modalities will have been nothing more than temporary and perhaps misspent especially if developed in the absence of that stakeholder input in the first place in the development of the interim final report.

Chairwoman ADAMS. OK. You state that the California Workplace Violence Standard took only 14 months to issue. Are you aware of how long on average it takes OSHA to issue a new standard?

Mr. RATH. There are some standards that haven't taken much longer than that. And OSHA has a number of standards that it has been able to effectively implement in less than 2 years. This proposed bill would take about the same amount of time. It would take some time for the bill to be enacted and then after that, OSHA has up to 1 year under the terms of this bill to implement an interim final rule. And it is conceivable that OSHA could publish a, publish a standard in that time.

But much more importantly, OSHA has other tools within its capacity to address the question of workplace violence in addition to promulgating a rule and those should be explored as well.

But haste shouldn't be a substitute for gathering evidence and data from those affected stakeholders. I think that is really one of the most important parts of what is of concern to a large number of stakeholders about this proposed ruling.

Chairwoman ADAMS. Thank you, sir. I'm going to now recognize Dr. Foxx for 5 minutes.

Mrs. FOXX. Thank you for very much, Madame Chairman. Mr. Rath, thank you for being here. Thanks to all the witnesses for being here.

The bill being discussed today would require OSHA to issue an interim final standard without the agency going through the proper rulemaking process and without the agency gathering additional data from employers or affected workers. We have been told as recently as yesterday that the Committee believes in evidence-based policymaking as I do.

Would data from employers and workers on work force—workplace violence in the health care and social service sectors be helpful in crafting an evidence-based policy on this issue?

Mr. RATH. Thank you for that question, Dr. Foxx. I think that the gathering of evidence is one of the most important things that government can do when promulgating a rule. And indeed, in the Occupational Safety and Health Act, that has been written into the requirements for rulemaking both for safety and for health standards and that evidence comes from all directions.

It's a truly bipartisan process of gathering evidence from employees, employee groups like unions and professional associations, the scientific and medical community and as well employees and I'm—I would be remiss if I didn't also mention that the insurance carriers have amassed amazing data that it would be irresponsible to turn our backs on in developing a rule of this type.

Mrs. FOXX. Thank you, Mr. Rath. What's the purpose of an agency skipping to an interim final rule rather than going through

the normal process of issuing a proposed rule first before proceeding?

And if OSHA were to promulgate a workplace violence standard such as the one mandated in H.R. 1309, would it be appropriate to skip to an interim final rule? And I know you have addressed this a little bit earlier but I want to give you a chance to emphasize it.

Mr. RATH. Well, thank you for your question. I think that I can think of very few good reasons why a Congress would mandate that an agency go directly to an enforceable interim final rule without that process of going through due process rulemaking including seeking evidence from stakeholders.

The stated reason in the bill seems to be a sense of haste and a mistrust that the agency will do what it is supposed to do in going through the rulemaking process.

And yet for 40 years, or more, OSHA has faithfully executed its mission and examined the question of whether or not a rule should be promulgated first, as at threshold question. And then where it has believed that rules should be promulgated as it has done so on a number of occasions. The books are filled with OSHA standards but that process should involve the stakeholders that the act calls upon OSHA to seek the opinions of.

Mrs. FOXX. Thank you. Another question. My friends on the other side of the aisle are quick to say that OSHA isn't moving fast enough in issuing the regulation we are discussing at this hearing. However, we have been waiting almost 16 months for the Democrats to stop blocking confirmation of the assistance sectary of OSHA.

If OSHA were to have a confirmed assistant secretary, do you think that would help them and implement policy including regulations such as the one being discussed today?

Mr. RATH. Well, that's a great question and thank you for the question. Without a doubt, and taking nothing away from the acting assistant secretary of OSHA who is doing an outstanding job. The assistant secretary responsible for heading the agency is—plays a significant rule in the development of policy, in the development of prioritizations and there can be no doubt that a more successful and effective process for nominating and putting—installing that person into the position would result in a more efficient rulemaking process as with every other function at the agency.

But I don't think it's safe to say that the agency has not done enough to address this issue. In 2016, it developed a request for information and the year prior it modified its guidance document on workplace safety and health care. Then the following year, it issued the request for information and its gathered information on that and it has put the question of workplace violence in health care on the regulatory agenda and it has called for the convocation of a SBREFA panel as—on its website as early as next month.

And so I think it is by all accounts appears to be moving rapidly on the subject of workplace violence in health care. And I think the best thing we can do is let it take its course in gathering the evidence and to do this process properly.

Mrs. FOXX. Thank you. I had a fourth question but I will submit it for the record. Thank you, Madame Chairman.

Chairwoman ADAMS. Thank you. And thank you very much. I'm going to recognize now the gentlelady from the State of Washington, Ms. Jayapal.

Ms. JAYAPAL. Thank you, Chairwoman Adams, for holding this important hearing today on workplace violence. As we have heard, unfortunately workers across the country face this terrible situation of workplace violence and for health care workers, there are serious risks of violence based injury—nearly 5 times greater than other sectors. These are the people who care for our loved ones and I particularly want to thank Ms. Moon-Updike and Dr. McClain.

We cannot simply accept the risk of violence as quote, "part of the job." We are lucky to have such dedicated workers as the two of you and many others across this country who take on these roles but we can't expect you to put yourselves in harm's way every single day simply because we don't do our job and check that violence.

There are common sense changes that can be implemented and a great deal of this violence and risk can be managed and prevented. For example, Aria Jefferson Health in Philadelphia implemented several different measures that led to a reduction of violence based injuries by 55 percent over just 3 years. This could keep our workers safe and save lives.

So let me start, Ms. Moon-Updike, with you, and I want to thank you so much for your testimony and I'm so sorry that you have had to go through such a traumatic experience.

You said that you and your colleagues talked to management after the injury. What did they do in response to your complaint and do you feel that your voices were heard just when it is a voluntary issue of management taking up these concerns? Just turn on your microphone.

Ms. MOON-UPDIKE. I'm sorry.

Ms. JAYAPAL. There you go.

Ms. MOON-UPDIKE. Actually, management had told us that they were trying their best. And it is often and I don't know how many of the general public are aware that there is a code of silence in the nursing profession that you don't report. It is highly underreported the injuries in the nursing profession. It is and excuse my vernacular, but it is pretty much suck it up and take it.

And it is not—it is not very well tolerated to report when you have been injured because often it falls back onto you as it was your fault for not being careful enough or using a protocol.

So when we approached management, it was what didn't you do properly? Not how can we help you. And often again that is the common response.

Ms. JAYAPAL. OK.

Ms. MOON-UPDIKE. So often that is why it goes under—violence goes under reported.

Ms. JAYAPAL. And as so much violence does.

Ms. MOON-UPDIKE. Right.

Ms. JAYAPAL. Thank you so much for that. Dr. Lipscomb, can you comment on Mr. Rath's testimony that quote, "The bills assertion that employer organizations have challenged OSHA's authority to enforce against workplace violence hazards is misleading?"

Dr. LIPSCOMB. I think the fact that employers that have been cited under the General Duty Clause are contesting those citations in a number of cases is pretty clear evidence of that.

Ms. JAYAPAL. Thank you. And can you discuss some of your specific research and the research of others that discusses the effectiveness of workplace violence prevention programs such as those recommended by OSHA and its guidance and required by H.R. 1309?

Dr. LIPSCOMB. Certainly. I would say most the research that has looked at interventions in the last 10 plus years have all used the OSHA guidelines basically as a template. And fortunately, there was finally a randomized controlled clinical trial which was the gold standard in research that was conducted over a 5-year period of time out of Wayne State University researchers.

They had 7 different hospitals and they randomly assigned an intervention based on the OSHA guideline to 20 units and 20 units didn't get the intervention and they found over the course of 2 years that workplace violence-related injuries were reduced by 60 percent which was very interesting case. It is the same number that you just cited from the Aria Jefferson.

Ms. JAYAPAL. Right. And I'm just running out of time so I am just going to wrap this to say that it sounds like there is a lot of research out there. So let me just ask you my final question. Do you think that these findings and the other data that has been presented by the GAO justify this legislation requiring OSHA to move rapidly on issuing a workplace violence standard?

Dr. LIPSCOMB. I definitely do.

Ms. JAYAPAL. Thank you Ms.—Dr. Lipscomb. I yield back, Madame Chair.

Chairwoman ADAMS. Thank you very much. At this time I want to recognize the Ranking Member Mr. Byrne.

Mr. BYRNE. Thank you. Mr. Rath, I was listening to what Ms. Moon-Updike was saying and what would trouble me is if an employer retaliated against her or other coworkers at that place of employment.

Under OSHA, isn't there a prohibition on employers retaliating against an employee that reports workplace violence or makes any sort of comment about the need for improvement?

Mr. RATH. Thank you for that question, Ranking Member Byrne. Yes, the Occupational Safety and Health Act under Section 11(c) prohibits retaliation for any instance where an employee has exercised their rights under the act and reporting an instance of an injury or an illness is covered as well under a separate regulation as well as under that section for the act.

So there are protections and there is no doubt that the idea that an employee should be protected from retaliation not only is but should be a protection that should exist for employees under that act.

Mr. BYRNE. When OSHA starts a formal rulemaking process, you know, there are several important and necessary opportunities for the regulating community to weigh in on the best approach for a solution that is workable, feasible and effective. Given that this bill requires OSHA to quickly issue an interim final standard would there be any opportunity before the interim final standard

for the public including the employer community to submit comments prior to any of these being subject to that regulation?

Mr. RATH. Thank you for that question. No, and that I think is one of the most troubling parts the bill as it's currently drafted. The bill specifically directs the agency not to seek any input from any stakeholders and informs the agency that a bill which is drafted in template in Section 103 or something at a minimum that looks like that section should be implemented without any stakeholder involvement.

And that not only includes the comment process but it also includes hearings that are typical in the rulemaking process and it includes the small business or the small business panel, the SBREFA panel process. So there is a number of processes where stakeholders get to become involved in a rule that this bill specifically directs social deterrents back upon.

Mr. BYRNE. We know that California was the first State to issue a workplace violence prevention standard covering health care workers back in 2016. Given that the legislation before us today closely mirrors that standard, Mr. Rath, is there—are there any takeaways from the California experience that this committee should be aware of?

Mr. RATH. Well, thank you for that question. The problem first is that there hasn't been enough time to gain experience on the efficacy of that standard. Second of all, there have been perhaps eight States that have developed some similar standard on the subject and it would be better to look at the best elements of each of those standards rather than modeling a standard off of just one State.

And then finally, I would say that if there has been any early feedback, is that rule was too hastily put together without stakeholder involvement and that there are ways to have made that rule or this rule for that matter better in protecting workers from workplace violence and I don't think that haste is the best way to seek out those better opportunities.

Mr. BYRNE. I thank one of the things that concerns me as someone that practiced in this area is that I know that industry has a direct interest in making sure that there is a safe workplace. Because there is significant liability, I know you would agree with that, if industry doesn't do that. So often times, the real experts on what the best predicts are to keep workers safe are the employers themselves and so you look to the employment and the employer community because they are the ones that have the experience.

You also referenced the insurance companies that have a whole lot of data. They're the ones that come forward and say look, we know because we do this all the time. We know what works and what doesn't work. You add to that the experience of people like Ms. Moon-Updike and other people like her, all of that comes in play for the agency to sit down and make a very thorough, well thought out process.

Isn't that the goal here is to have all these people with all these points of information and expertise to give that to the regulating body before they make a decision including interim final rule?

Mr. RATH. Mr. Byrne, I think that is exactly right. Not only so, but as well the scientific and medical communities who understand the science of the causes of workplace violence. But the employers themselves are not to be neglected. It's possible and it's probably true that some employers have not done enough on the question of workplace violence in the health care industry.

But the leading employers in any sector, in any industry have come up with the best practices collaboratively through their industry associations and individually they have come up with leading practices on the management of workplace safety and health hazards and that would be true as well for workplace violence. And to solicit their acquired experience would be I think a route to making this draft standard better.

Mr. BYRNE. Thank you for your testimony and I yield back.

Chairwoman ADAMS. Thank you very much. I want to recognize the chair of the Committee on Education and Labor, the gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you. Thank you, Madame Chair and thank you for holding this hearing. Let me ask a question of I guess Ms. Lipscomb. What kind of initiatives can be adopted that would actually make a difference? What are some examples of those kinds of actions?

Dr. LIPSCOMB. Well, I think it's pretty clear because the 9 State laws that have been passed including the California law, all basically say the same thing. They all call for this process of preparing a workplace violence prevention plan that involves direct care worker input and a number of processes to evaluate the risk in your workplace and then design interventions which are commonsense and specific to the workplace—

Mr. SCOTT. Like what?

Dr. LIPSCOMB [continuing]. to address those problems.

Mr. SCOTT. Like what?

Dr. LIPSCOMB. There are different types of engineering devices. We have heard about the need for security from Ms. Moon-Updike. I have been in a lot of facilities where they have inadequate means for an individual worker to summon support when they are being threatened or attacked. There is certainly the issue of staffing is one that a number of organizations including the one that your colleague mentioned at Aria Hospital in Pennsylvania has invoked.

So there are a whole series of interventions that are outlined in the OSHA guidelines and they have actually even been adopted in the various publications that have come out from the Joint Commission.

So I think there is really a consensus in the field that what is needed is workplace violence prevention plan which is what is outlined in this bill.

Mr. SCOTT. And you have shown through research that when you have such a plan, the injuries go down?

Dr. LIPSCOMB. There is research that indicates that, yes.

Mr. SCOTT. Now we have been working mostly on guidance, it that right?

Dr. LIPSCOMB. Right. So—

Mr. SCOTT. And is guidance enforceable?

Dr. LIPSCOMB. No, guidance is not enforceable.

Mr. SCOTT. Is the interim final rule after 1 year enforceable?

Dr. LIPSCOMB. My understanding is that it would be, yes.

Mr. SCOTT. Mr. Rath, do you know if the final interim rule is enforceable?

Mr. RATH. As the bill is drafted, Mr. Scott, the Section 103 standard would be enforceable without any stakeholder comment but the guidance serves as the baseline or a baseline for enforceability under Section 5(a)1 of the Act. So there is enforceability right now and there has been enforcement.

Mr. SCOTT. But the guidance would be enforceable only as it pertains to an existing regulation.

Mr. RATH. Well, the Section 5(a)1 which is called the General Duty Clause of the OSHA Act allows for enforceability if there are generally accepted hazards that are recognized by the industry and that there are feasible means of abatement that an employer is not taken.

Mr. SCOTT. OK. Dr. Lipscomb, Mr. Rath just suggested that the interim rule would be done without input. Is that in the bill?

Dr. LIPSCOMB. OSHA has already had a request for information around their plan to develop a workplace violence prevention standard. So there certainly was the opportunity in there, I was part of both that hearing public meeting so there has been input that has already been provided. And there has been input from stakeholders all around the country around these other 9 actual laws and as I said, experts in health care safety and patient safety have all written documents that recommend pretty much the same measures that are described in this bill.

So I completely disagree that there hasn't been an opportunity for stakeholder input. In fact, I think there is a consensus in the industry on what is needed.

Mr. SCOTT. Thank you and I yield back.

Chairwoman ADAMS. Thank you. I thank the gentleman for yielding. I want to recognize the gentleman from Virginia, Mr. Cline.

Mr. CLINE. Thank you, Madame Chair. Mr. Rath, transparency is a very important issue for me and one that I have worked on in the State legislature for many years. Another unique step in the OSHA rulemaking process is that the public can request a public hearing on a rulemaking and it seems in keeping with transparency like an important and valuable step in allowing stakeholders to share any concerns or perspectives on an issue.

How would this step help in promulgating a standard such as the one we are discussing here today?

Mr. RATH. Thank you for that question. So the administrative rulemaking process calls for first notice to everybody about a proposed rule and then people get to file comments and then there is often a hearing and the hearing—and the—to answer your question, the hearing serves the valuable role of allowing the agency as well as stakeholders to question the authors of those comments and to question various other critical stakeholders on the sufficiency of their comments to test the reliability of those comments to further understand any ambiguities that might have incidentally arisen from those comments.

And that dedacted process that takes place in those hearings like any rulemaking in any governmental branch is the place where people develop a fuller understanding of what is being proposed and what the comments are about that proposal and this proposed bill would eliminate that critical rulemaking step.

Mr. CLINE. Thank you. And I also see that one of the implications of this bill is that it would allow this particular rulemaking to skip ahead for lack of a better term, in line and in front of all other ongoing OSHA rulemaking efforts.

In your opinion, what are the circumstances under which OSHA should choose to expedite a rulemaking effort in this manner and does this issue demand that level of prioritization above all others?

Mr. RATH. That is a good question. Well, to begin with we have some guidance on when OSHA should choose to move an issue to the top of its rulemaking danger and that comes through emergency temporary standards for example. Where if for toxic substances or for a new hazard, the agency may implement an emergency temporary standard but even then rulemaking, the proper rulemaking process should be observed. It's simply that this gives us some idea of what constitutes an emergency. And in this case, we are not dealing with a new hazard. This is something where OSHA issued its first guidance in 1996.

As to what are the kinds of circumstances here that would permit us to conclude that this is an emergency or deserves to go to the top of the list? Well, I think that is precisely the question that stakeholders should be able to weigh in on and although there are some statistics that have been reported, I think that the rulemaking process where stakeholders participate gets to test the sufficiency of those statistics as against all other OSHA priorities.

It may be that the collective number of cases reduced by all of the other elements of the OSHA agenda may or may not outweigh the urgency dictated by the statistics of the number of cases in the field of workplace violence and health care.

Mr. CLINE. Thank you.

And finally, as you know, OSHA still lacks an assistant secretary to lead the agency more than 2 years in the Trump administration and 16 months after he was nominated to the post. What role does the assistant secretary have in creating and prioritizing OSHA's regulatory agenda and how does this obstruction interfere with that?

Mr. RATH. Well, it's a great question and the assistant secretary has a significant hand in the development of policy as well as prioritization of projects. And in the absence of a secretary, and again, the assistant secretary, the acting assistant secretary has been doing an excellent job. But in the absence of an actual assistant secretary, it is difficult for the agency to move forward on significant initiatives lacking that guidance from a person who has been empaneled in the proper procedure.

Mr. CLINE. Thank you. Madame Chair, I yield back.

Chairwoman ADAMS. Thank you very much. Oh, OK. I want to recognize Mrs. Omar. You are recognized for 5 minutes.

Ms. OMAR. This juggle between committees is an exercise we have to get used to. Thank you. Dr. Lipscomb, in your testimony, you acknowledged that health care workers are more likely to expe-

rience non-fatal assaults than any other worker group. And that to me seems like a scary statistic. And so I wanted to see if you can maybe tell us a little bit within your extensive research, have you been able to collect any data on the rates of violence against workers and in particular, I know that many of the workers within nursing or within hospitals, assistant nurses, tend to be immigrants. And so I wanted to see if you can tell us if you have some data around immigrant workers and how they might be targeted and might be vulnerable in the workplace.

Dr. LIPSCOMB. Thank you for that question. I believe the statistics are that 1 in 6 health care workers are an immigrant so there are obviously make up a substantial proportion of the health care work force.

When it comes to the job titles of nursing assistants or tech or someone who is a personal care assistant in the home, those are extremely high risk kinds of job occupations and they are much more likely to have a larger proportion of immigrants working in the particular roles.

And there is one statistic from the Paraprofessional Health Institute that indicates that 1 in 4 of the workers that provide physical care to, you know, all of our elderly and disabled in the home are immigrants. And I can get you that reference.

Ms. OMAR. Yes. So with about 25 percent of those workers being immigrants, the threat of violence and harassment and the fear of having your status held against you is something that may for these workers know a little too well.

Dr. LIPSCOMB. Right.

Ms. OMAR. And many of these immigrants might be afraid to file complaints against discrimination or harassment or violence they might face in the workplace. So I wonder if you have any suggestions for us here in Congress to provide protections for some of these vulnerable workers that a lot of people don't think about when they're putting protections in place.

Dr. LIPSCOMB. I think that this bill would go a long way in protecting all types of workers. I think one of the elements in the California regulation and it's been incorporated here is, you know, a focus on training so that workers understand the risks that they're facing when they go on the job and importantly, what they can do to minimize these risks and also encouraging them to report to their supervisor or employer when there is the risk or when they've been injured. And, you know, basically make sure that the employer is not going to discriminate in any way.

I know that Mr. Rath has mentioned the part of the OSHA Act that deals with discrimination but it's very hard for most workers even if they know about that opportunity to actually pursue it and there's a huge backlog of those cases.

So I think this piece of legislation and a subsequent OSHA regulation would, you know, definitely reduce the risk to all types of workers.

Ms. OMAR. Thank you. My sister has been a nurse for 18 years and many of my constituents in CD5 in Minnesota, mainly Minneapolis, are people who are PCA's, nurses, assistant nurses and people who love taking care of their patients. And so for us to put the focus on making sure that they themselves are taken are of so

that they can do the work of taking care of our most vulnerable is an important work.

So I thank the committee for prioritizing this bill and putting this into effect and for all of you for coming to share your testimony with us. Thank you. I yield back.

Chairwoman ADAMS. Thank you. The lady yields back. Mr. Courtney, we are going to recognize you and thank you so much for this bill and for joining us today. We will recognize you for 5 minutes.

Mr. COURTNEY. Well, thank you, Madame Chairwoman. And again, I want to thank you for your leadership. Obviously moving this bill within 2 months of the new Congress definitely shows your commitment to responding to what was really I think a very detailed, thorough document from the Government Accountability Office which emanated from this subcommittee.

I was back then along with Congressman Miller, Mr. Scott's predecessor, the ones who requested the GAO report because of the fact that so much anecdotal constituent input was coming in about what's happening out there.

My wife is a pediatric nurse practitioner and works in a specialty clinic that deals with child abuse and again, it's a very intense, highly charged environment that is there and which requires help with security guards and safe design of workplace. So probably every member can talk about a family member or somebody they know that has been experiencing this situation.

And again, the GAO report, which took the years to compile, and again used, you know, tremendous input from experts reviewed studies were cited throughout their document as well as obviously the gathering of data. And again, what I think showed is that we have a situation which is frankly is toxic as any of the emergency situations which Mr. Rath talked about where an interim rule was adopted.

Again, I would just note and I would just ask Dr. Lipscomb just to confirm, I mean, the language in the bill that talks about not later than 1 year the interim final standard should be promulgated. There is nothing in that language which prohibits the gathering of input or data from any stakeholders, isn't that correct?

Dr. LIPSCOMB. That's correct. And I would also add that over a period of a couple years, culminating in some online tools that OSHA produced in 2015, OSHA with a contractor went across the country to identify best practices in violence prevention so they have been collecting that information. And there are great details of these examples of employers really stepping up to the plate to do above and beyond what is in the guidelines that is posted on OSHA's website. Another example of stakeholder input.

Mr. COURTNEY. And again, this is not Terranova, you know, they have had voluntary guidelines going back to the 1990's which as you say have been updated. So this is not some, you know, brand new undertaking.

And again, within that year period for an interim rule, which I think the data from GAO more than justifies, the fact of the matter is there is no prohibition in this bill that says there can't be input from other stakeholders. And again, the bill then goes on to allow

a 42 month period for the final rule which again will be used for the purpose of getting input for a final rule.

There is precedent in OSHA for following that exact step by step process whether its lead-in-construction or hazardous waste and emergency response which again used an interim rule to deal with the situation which I think, you know, most people and the GAO report certainly validates, requires swift action. But not, you know, precipitous action, I mean, that has measured data and experience that the voluntarily guidelines as well as that yearlong period as well as the peer review information that came in from the GAO, isn't that correct?

Dr. LIPSCOMB. That's correct.

Mr. COURTNEY. Yes, thank you. And I want to again thank Dr. McClain and Ms. Moon-Updike for coming here and really putting a human face on this issue. You know, I just thought maybe as a social worker and somebody who was in the field in a behavior health setting, I mean, the uptick in violence which again is, I mean, that trajectory is actually accelerating in terms of what you are seeing out there, is that correct?

Dr. MCCLAIN. Yes. We are seeing, you know, more violence as there is, you know, more substance use and more critical, you know, kind of situations we are going into and we know with the opioid crisis the removal, child welfare removals have gone up 20 percent.

So it's just, you know, working in those environments there's more opportunity or more tendency to confront violence situations.

Mr. COURTNEY. Ms. Moon-Updike, I didn't know if you wanted to share your experience?

Ms. MOON-UPDIKE. Absolutely. We are also seeing more violent youth come in to our behavioral health divisions. We are seeing an increase in homelessness and with mental health issues so with more violent tendencies.

And if I can also go back to one other thing that was stated previously. I am from the State of Wisconsin and the facility that I worked in, there was no OSHA oversight and there was no stage agency oversight. So this bill would provide that for us because right now there is none.

Mr. COURTNEY. Great. Well, than you again to all the witnesses for being here—

Ms. MOON-UPDIKE. Thank you.

Mr. COURTNEY [continuing]. today. I yield back.

Chairwoman ADAMS. I am going to recognize Mr. Khanna from California.

Mr. KHANNA. Thank you, Chair Adams. I want to thank you for your leadership and for allowing me to join this hearing of the Education and Labor Committee. I also want to thank our chair, Bobby Scott, for championing such an issue. And of course my colleague, Representative Joe Courtney for introducing this bill to make the workplace safer for health care and social workers. Thank you for your leadership.

And then I want to recognize the California Nurses Association and National Nurses United for leading this effort in California back in 2014.

You know, I was so surprised to hear, I would go into rooms with nurses and I would say how many of you have faced violence at the workplace? And the majority of hands would go up. You know, we work in Congress and it's not civil but we don't face violence. I mean, it is a tough job being a health care worker or a social service worker and it is about time we had legislation to address this.

I think this legislation goes a long way. It incorporates some of the law that was a part of California in updating the OSHA rule and it is a comprehensive solution that will help not just nurses but also health care workers and social service workers more generally.

I would now like to ask a few questions to Dr. Lipscomb. What States have effective models in violence prevention? You don't have to mention my State of California if you, but you can. What would you say?

Dr. LIPSCOMB. So California of course comes to mind and I think each of these States have learned what previous States have promulgated and then have improved upon them. So I would also mention New York State has a very good workplace violence prevention law. New Jersey, Oregon, Washington State.

We have one in Maryland that doesn't have a lot of teeth but there are many, many good models out there.

Mr. KHANNA. And could you explain the advantages of passing this legislation rather than just letting OSHA move forward on its normal regulatory pace? I know Chair Adams discussed this earlier but would love your insight.

Dr. LIPSCOMB. Well, I think what we heard from the chairwoman is that on average it takes 7 years for a standard and it can take up to 20. And I think if you think about the testimony that you heard today from Ms. Moon-Updike and you multiply that story by tens of thousands of health care workers all around the country that experience this on a daily basis, you will realize why we need this mechanism to encourage OSHA to make this a priority and promulgate an interim final standard and a final standard in the shortest amount of time possible.

And again, because the other States have gone through the process of collecting stakeholder input and a lot of the voluntary professional organizations are recommending the same thing, I think that is the difference.

Mr. KHANNA. And I want to thank you, Ms. Moon-Updike, for being here and overcoming such a tragedy to be active and push for change. I really admire that.

Dr. Lipscomb, do you think if we had a standard like New York or a law like Mr. Courtney's that we could have prevented the type of tragedy that befell Ms. Moon-Updike?

Dr. LIPSCOMB. Yes, I think so based on her account of it. There are inevitably some incidents that might not be preventable but I think the vast majority of them are and now we have one very strong study, methodologically and examples elsewhere where over a couple years, year period of time there has been a reduction in the range of like 40 to 60 percent.

Mr. KHANNA. You know, I want to give Ms. Moon-Updike the last word. I mean, Ms. Moon-Updike, what inspires you to be here

and fight for this and what would you like to see from the United States Congress?

Ms. MOON-UPDIKE. Thank you for your question, sir. I didn't know when I would be ready to do this, to help other health care workers. And about 3 weeks ago at our medical trauma center in Milwaukee, Wisconsin, we lost a nurse and she was killed in the place that she worked. And she was raped. She was beaten and then she was run over with her car in the parking structure where she worked. And she was left there to freeze on the ground. And she died.

She was a nurse practitioner in the oncology unit. Her name was Carly. Sorry. And she was not found for 2 hours. She was found by a snowplow crew. She was not found by security. And the administration said when asked why the security cameras did not find her, the administration said because the campus is too big for all the areas to be watched and for every—and for security guards to be—take every employee out. That could have been me. I almost died the day that I was injured. And she did die. She was 33 years old. And at that point I was angry.

So I decided that it was time to get off my rear end, excuse my vernacular again, and do something and make, try to make sure that didn't happen again and that somebody was accountable for Carly dying. Because there is a sisterhood and a brotherhood of nurses and we put ourselves out there to help people.

We help your mothers, your brothers, your daughter, your sons, your wives, your husbands. We do that. And who is helping us? Who was there for her but a plow drier. That's why I am here.

Mr. KHANNA. Well, I just want to thank you again, Ms. Moon-Updike for taking such grief and heartbreak and turning it into a positive purpose. It is citizens like you that give me hope for our country. Thank you.

Ms. MOON-UPDIKE. Thank you. Thank you.

Chairwoman ADAMS. Thank you very much. I want to remind my colleagues pursuant to committee practice, materials for submission to the hearing record must be submitted to the clerk within 14 days following the last day of the hearing. Materials must be submitted—must address the matter of the hearing and only a member of the committee or invited witnesses may submit materials. Documents are limited to 50 pages. Any pages longer than that will be incorporated into the record via internet.

I want to thank again all the witnesses for your participation today and for your testimony and what we have heard is extremely valuable to us. And members of the committee may have some additional questions for you. We ask them to please respond to those in writing and the hearing record will be held open for 14 days in order to receive those responses.

I remind my colleagues that pursuant to committee practice, witness questions for the hearing record must be submitted to the majority committee staff or committee clerk within 7 days. The questions submitted must address the subject matter of the hearing. I want to now recognize the—my ranking member for his closing statement.

Mr. BYRNE. Thank you, Madame Chairman, and thank you all the witnesses today. Good testimony. I think it helps all of us understand this better.

Ms. Moon-Updike, I hope the perpetrator of the crime you just told us about is prosecuted to the fullest extent of the law. I really hope that whoever did this is caught and we do with him as the fullest extent that we can do with someone that commits a crime like that.

Dr. McClain, thank you for pointing out something that we should all be aware of and that is that the drug crisis in this country and the mental health crisis in this country is spiraling out of control and you all are on the front lines and the victims of what that means.

Mr. Rath, I thank you for reminding us that there are procedures here that we are here to—that we are supposed to follow before we put out laws and regulations in this country and the reasons beyond all of that although it sounds like a lot of process stuff, the process stuff is important.

And Dr. Lipscomb, thank you for the findings that you have made over the years. I would like for you to have an input into this regulation which is why I think we need to get OSHA moving.

I doubt that this bill is going to become law in this Congress and I don't want to wait that long so I'm going to make an offer to Mr. Courtney, my good friend and to Ms. Adams, the Chairman of the Subcommittee. Maybe we should get the folks from OSHA to come over here and talk to us about what we can do between now and the end of this Congress to get OSHA to speed this process up and get something done here.

And with that, ladies and gentlemen, you will have to excuse me I have got a five o'clock I have to go get. Thank you.

Chairwoman ADAMS. Thank you very much. I want to get unanimous consent to submit to the record the testimony of the National Nurses United—the United—National Nurses United which is before the House of Education and Labor Committee today. All right.

I want to thank the ranking member and everyone who came out today. And particularly I want to say to all of our witnesses, thank you first of all for your patience and the fact that we had to go vote and you are still here. We appreciate that very much.

I want to now recognize myself for closing statements. Again thank you. Your testimony has been very valuable and your expertise as well.

I think I speak for all for the members of the subcommittee when I say that we learned an enormous amount of valuable information from you today. I am an educator by training. I taught 40 years. But I know that education is an ongoing process and so I am going to—I am continuing to learn and I have learned from you.

But I think for me in terms of personal reference, my mom had a care giver. I was a partial caregiver for her. She lived until she was age 90, passed away a couple of years ago. So I understand the work that you do. I appreciate the work that you do.

And as a matter of fact, I worked in a nursing home to work myself through college so I certainly have a lot of empathy for the things that we brought today.

We have heard compelling evidence this afternoon that workplace violence is a serious and life threatening problem for this Nation's front line health care and social service workers. This hazards—these hazards are not only predictable but they are also preventable.

Mr. Courtney, thank you for your leadership with this bill. I think that we can all agree that going to work shouldn't mean getting hurt at work.

H.R. 1309 which we have discussed today would provide the protection that these workers need and that they deserve. And to clarify again H.R. 1309 allows OSHA to go through its full rulemaking process including public input before issuing a final standard.

Now given that, I believe that we all share our witnesses concerns about the seriousness of these threats and I hope that we will be able to work together on a bipartisan basis to move this legislation forward.

And if there is no further business? I don't hear any. All right. Without objection the committee stands adjourned.

[Additional submissions by Chairwoman Adams follow:]

Statement by the
American Federation of State, County and Municipal Employees (AFSCME)
on
"Caring for Our Caregivers:
Protecting Health Care and Social Service Workers from Workplace Violence"
Subcommittee on Workforce Protections
Committee on Education and Labor
U.S. House of Representatives

February 27, 2019

We submit this testimony on behalf of the members of the American Federation of State, County and Municipal Employees (AFSCME) for the official record of the "Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence" hearing before the Subcommittee on Workforce Protections, Committee on Education and Labor.

People need healing. Families need care. Whether it is the nurse in the hospital emergency room, or the psychiatric technician helping an individual with mental health concerns, or the social worker in child protective services – these workers never stop. It is not just a job. It's a calling. Nobody works on the front lines of health care or social service assistance to get rich. It's hard work and largely unsung. The work matters because it means something to help people and make a community better, stronger, more resilient and healthier. In fact, it means everything. AFSCME believes that every person working to sustain their community deserves respect. Fundamental to that respect is safety on the job. Workers should not experience workplace violence. But they do.

Health care and social service assistance workers are at a high risk of experiencing violence on the job. In fact, 70 percent of all nonfatal workplace assaults typically occur in these two sectors. The violence can range from verbal abuse, intimidation, harassment, other threatening disruptive behavior, physical assault, rape and even homicide. Indeed, workplace violence is the third-leading cause of death on the job. In 2017, 807 workers died from work-related violence.

The Bureau of Labor Statistics (BLS) reported that in 2017, state government health care and social service workers are more likely to be injured by an assault than private-sector health care workers at a rate of 128.9 vs. 14.7 per 10,000 workers. In state government, psychiatric aides experienced injuries caused by violence at a rate of 693.4 per 10,000 workers; psychiatric technicians at 591.4 per 10,000 workers; nursing, psychiatric and home health aides at 339.9 per 10,000 workers; health care support occupations at 256.0 per 10,000 workers; and nursing assistants at 155.2 per 10,000 workers.

In state government, social workers experienced injuries caused by violence at a rate of 64.6 per 10,000 workers; counselors and other community and Social Service Specialists at 61.8 per 10,000 workers; and Social and Human Service Assistants at 90.9 per 10,000 workers. Health and safety experts believe that the occurrence of violence is probably much higher than reported because many incidents are not reported. Underreporting is due in large part to the persistent perception

within the health care and social service sectors that assaults are just part of the job routine. Underreporting may also reflect institutional reporting policies, employee beliefs that reporting will not benefit them, or worker fears that employers may deem assaults the result of worker negligence or poor job performance.

Even with underreporting the frequency and scale of workplace violence is alarmingly high. But no single statistic – even a startling rate of workplace violence – can fully reflect the pain, loss, suffering and the disruption to a life, a workplace and community caused by these incidents.

This month marks the one-year anniversary of the death of AFSCME Local 448 member, Pamela Knight, a state Department of Children and Family Services (DCFS) child protection specialist. She had been sent to take a two-year-old child into protective custody from an abusive father. As she got out of her car, Knight was attacked by the boy's father. Brutally beaten, Knight suffered blunt force trauma to her head and spent the next four months largely unresponsive as she underwent multiple surgeries and hospital transfers. After 11 years on the job, she paid the ultimate price for protecting children from abuse and neglect. She died on February 8, 2018 as a result of her on-the-job injuries.

Knight and her fellow DCFS employees are the front line of defense in protecting children in Illinois. In this vital work to help children, they can encounter families in crisis stemming from poverty, substance abuse, mental illness, domestic violence and other challenges. These workers, as part of their job, must insert themselves into stressful, sometimes dangerous situations in order to keep kids safe. The threats, harassment and violence on the job are being exacerbated by rising income inequality, and a lack of services exacerbate problems of untreated addiction and mental illness. While this Congress must act to address these root causes of challenges to families, we must also recognize that more needs to be done to improve employee safety.

AFSCME Council 31 has acted at the state and agency level to honor Knight's memory by working to change policies towards preventing workplace violence. AFSCME Council 31 succeeded in getting the state legislature to pass legislation that for the first time requires DCFS and three other state agencies — Corrections, Human Services and Juvenile Justice — to fully document assaults and their consequences for employees. DCFS and the other agencies are now required to make quarterly reports to the Illinois General Assembly that provide a clear accounting of each assault that occurs in the line of duty, the nature of any injuries incurred, and any time lost from work as a result. But more can be done at the national level.

The Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1309) is needed and important legislation. It would require the Occupational Safety and Health Administration (OSHA) to issue a federal workplace violence prevention standard. This federal standard would require employers in the health care and social service sectors to develop and implement a plan to protect workers from workplace violence. By requiring that the prevention plans be tailored to the specific workplace and employee population, the legislation addresses a very dangerous myth that workplace violence is essentially random, unpredictable, and therefore, not preventable. There is a degree of uncertainty but workplace violence, in both health care and social service assistance settings, has clear patterns and identifiable risk factors. The bill ensures front line workers have a seat at the table as employers identify and implement controls such as

training, personal alarm devices, surveillance and monitoring systems, or other evidence-based practices to keep workers safe.

A recent decision by an administrative law judge for the Occupational Safety and Health Review Commission (OSHRC) in the Arbour-HRI Hospitals Inc.'s case, highlights the need for swift enactment of H.R. 1309, which requires a specific workplace violence prevention standard. OSHRC recognized that a general duty requirement under occupational safety and health law indeed covers workplace violence but found that OSHA needed to prove that the abatement and control measures set forth by OSHA would reduce the hazard. The OSHRC decision shows the limits of the general duty clause for addressing workplace violence, and the urgent need for a specific OSHA standard proposed in H.R. 1309 to adequately reduce the exposure of workers to workplace violence.

An OSHA standard is not meant to address patient care and quality; however, we believe that a workplace violence prevention standard will improve the safety and quality of patient care, particularly in mental health settings. In many mental health settings, understaffing increases the risk of violence and jeopardizes patient-centered care due to longer wait times and workers working alone with individuals that would be better served by a team to help de-escalate situations.

A clear enforceable standard is needed to prevent the types of violence that occurs in too many of our hospitals, nursing homes, and social service settings and we believe it will also improve patient care. We urge the subcommittee to pass this legislation.

STANDARDS PRESENTATION
TO
CALIFORNIA OCCUPATIONAL SAFETY AND HEALTH STANDARDS BOARD

PROPOSED STATE STANDARD,
TITLE 8, CHAPTER 4

Add new Title 8 Section 3342 to read:

§3342. Workplace Violence Prevention in Health care.

(a) Scope and Application.
(1) Scope. This section applies to work in the following health care facilities, service categories, and operations:
(A) Health facilities, as defined below;
(B) Home health care and home-based hospice;
(C) Emergency medical services and medical transport, including these services when provided by firefighters and other emergency responders;
(D) Drug treatment programs;
(E) Outpatient medical services to the incarcerated in correctional and detention settings.
(2) Application.
(A) Employers with employees in operations identified in subsections (a)(1)(A) through (a)(1)(E) shall comply with subsections (c), (d), (e), (f), and (h).
(B) General acute care hospitals, acute psychiatric hospitals, and special hospitals shall also comply with subsection (g).
(3) The employer shall provide all safeguards required by this section, including provision of personal protective equipment, training, and medical services, at no cost to the employee, at a reasonable time and place for the employee, and during the employee's paid time.
(4) Implementation. Employers with employees in operations identified in subsections (a)(1)(A) through (a)(1)(E) shall implement subsections (d), and (h) by [insert the effective date]. General acute care hospitals, acute psychiatric hospitals, and special hospitals shall also implement subsection (g) by [insert the effective date]. Employers with employees in operations identified in subsections (a)(1)(A) through (a)(1)(E) shall implement the requirements of subsections (c), (e), and (f) by [insert one year after the effective date].
EXCEPTION 1: This section does not apply to the following facilities operated by the California Department of Developmental Services (DDS) and scheduled to close by the end of 2021: (1) Porterville Developmental Center General Treatment Area; (2) Fairview Developmental Center; and (3) Sonoma Developmental Center. These facilities shall still comply with Section 3203 during the closure process. Any DDS facility or portion of a DDS facility that is not closed by the end of 2021 or is not planned to be closed by the end of 2021 must comply with this section.
EXCEPTION 2: This section shall not apply to facilities operated by the California Department of Corrections and Rehabilitation. These facilities shall still comply with Section 3203.

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(b) Definitions.

"Acute psychiatric hospital" (APH) means a hospital, licensed by the California Department of Public Health as such meeting the definition provided in Health and Safety Code Section 1250(b) or California Code of Regulations, Title 22, Section 71005; and all services within the hospital's license.

"Alarm" means a mechanical, electrical or electronic device that does not rely upon an employee's vocalization in order to alert others.

"Chief" means the Chief of the Division of Occupational Safety and Health of the Department of Industrial Relations, or his or her designated representative.

"Dangerous weapon" means an instrument capable of inflicting death or serious bodily injury.

"Division" means the Division of Occupational Safety and Health of the Department of Industrial Relations.

"Emergency" means unanticipated circumstances that can be life-threatening or pose a risk of significant injuries to the patient, staff or public, requiring immediate action.

"Emergency medical services" means medical care provided pursuant to Title 22, Division 9, by employees who are certified EMT-1, certified EMT-II, or licensed paramedic personnel to the sick and injured at the scene of an emergency, during transport, or during inter-facility transfer.

"Engineering controls" means an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between the worker and the hazard. For purposes of reducing workplace violence hazards, engineering controls include, as applicable, but are not limited to: electronic access controls to employee occupied areas; weapon detectors (installed or handheld); enclosed workstations with shatter-resistant glass; deep service counters; separate rooms or areas for high risk patients; locks on doors; furniture affixed to the floor; opaque glass in patient rooms (protects privacy, but allows the health care provider to see where the patient is before entering the room); closed-circuit television monitoring and video recording; sight-aids; and personal alarm devices.

"Environmental risk factors" means factors in the facility or area in which health care services or operations are conducted that may contribute to the likelihood or severity of a workplace violence incident. Environmental risk factors include risk factors associated with the specific task being performed, such as the collection of money.

"General acute care hospital" (GACH) means a hospital, licensed by the California Department of Public Health as such meeting the definition provided in Health and Safety Code Section 1250(a) or California Code of Regulations, Title 22, Section 70005, and all services within the hospital's license.

"Health facility" means any facility, place, or building that is organized, maintained, and operated for the diagnosis, care, prevention, or treatment of human illness, physical or mental, including convalescence and rehabilitation and including care during and after pregnancy, or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer. (Ref: Health and Safety Code Section 1250). For the purposes of

this section, a health facility includes hospital based outpatient clinics (HBOCs) and other operations located at a health facility, and all off-site operations included within the license of the health facility. The term "health facility" includes facilities with the following bed classifications, as established by the California Department of Public Health:

(1) General acute care hospital
(2) Acute psychiatric hospital
(3) Skilled nursing facility
(4) Intermediate care facility
(5) Intermediate care facility/developmentally disabled habilitative
(6) Special hospital
(7) Intermediate care facility/developmentally disabled
(8) Intermediate care facility/developmentally disabled-nursing
(9) Congregate living health facility
(10) Correctional treatment center
(11) Nursing facility
(12) Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)
(13) Hospice facility

"Patient classification system" means a method for establishing staffing requirements by unit, patient, and shift based on the assessment of individual patients by the registered nurse as specified in Title 22, Sections 70053.2 and 70217, for General Acute Care Hospitals.

"Patient contact" means providing a patient with treatment, observation, comfort, direct assistance, bedside evaluations, office evaluations, and any other action that involves or allows direct physical contact with the patient.

"Patient specific risk factors" means factors specific to a patient that may increase the likelihood or severity of a workplace violence incident, such as use of drugs or alcohol, psychiatric condition or diagnosis associated with increased risk of violence, any condition or disease process that would cause confusion and/or disorientation, or history of violence.

"Threat of violence" means a statement or conduct that causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.

"Work practice controls" means procedures, rules and staffing which are used to effectively reduce workplace violence hazards. Work practice controls include, as applicable, but are not limited to: appropriate staffing levels; provision of dedicated safety personnel (i.e. security guards); employee training on workplace violence prevention methods; and employee training on procedures to follow in the event of a workplace violence incident.

"Workplace violence" means any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

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(A) The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;

(B) An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;

(C) Four workplace violence types:

1. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
2. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.
3. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.
4. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

(c) Workplace Violence Prevention Plan. As part of the Injury and Illness Prevention Program (IIPP) required by Section 3203, the employer shall establish, implement and maintain an effective workplace violence prevention plan (Plan) that is in effect at all times in every unit, service, and operation. The Plan shall be in writing, shall be specific to the hazards and corrective measures for the unit, service, or operation, and shall be available to employees at all times. The written Plan may be incorporated into the written IIPP or maintained as a separate document, and shall include all of the following elements:

(1) Names or job titles of the persons responsible for implementing the Plan.

(2) Effective procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing the Plan, including their participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating workplace violence incidents.

(3) Methods the employer will use to coordinate implementation of the Plan with other employers whose employees work in the same health care facility, service, or operation, to ensure that those employers and employees understand their respective roles as provided in the Plan. These methods shall ensure that all employees are provided the training required by subsection (f) and shall ensure that workplace violence incidents involving any employee are reported, investigated, and recorded.

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(4) Effective procedures for obtaining assistance from the appropriate law enforcement agency during all work shifts. The procedure may establish a central coordination procedure. This shall also include a policy statement prohibiting the employer from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs.

(5) Effective procedures for the employer to accept and respond to reports of workplace violence, including Type 3 violence, and to prohibit retaliation against an employee who makes such a report.

(6) Procedures to ensure that supervisory and non-supervisory employees comply with the Plan in accordance with Section 3203(a)(2).

(7) Procedures to communicate with employees regarding workplace violence matters, including:

(A) How employees will document and communicate to other employees and between shifts and units, information regarding conditions that may increase the potential for workplace violence incidents;

(B) How an employee can report a violent incident, threat, or other workplace violence concern;

(C) How employees can communicate workplace violence concerns without fear of reprisal;

(D) How employee concerns will be investigated, and how employees will be informed of the results of the investigation and any corrective actions to be taken.

(8) Procedures to develop and provide the training required in subsection (f). Employees and their representatives shall be allowed to participate in developing the training.

(9) Assessment procedures to identify and evaluate environmental risk factors, including community-based risk factors, for each facility, unit, service, or operation. This shall include a review of all workplace violence incidents that occurred in the facility, service, or operation within the previous year, whether or not an injury occurred.

(A) For fixed workplaces: Procedures to identify and evaluate environmental risk factors for workplace violence in each unit and area of the establishment, including areas surrounding the facility such as employee parking areas and other outdoor areas. Assessment tools, environmental checklists, or other effective means shall be used to identify locations and situations where violent incidents are more likely to occur. Procedures shall specify the frequency with which such environmental assessments will take place. Environmental risk factors shall include, as applicable, but shall not necessarily be limited to, the following:

1. Employees working in locations isolated from other employees (including employees engaging in patient contact activities) because of being assigned to work alone or in remote locations, during night or early morning hours, or where an assailant could prevent entry into the work area by responders or other employees;

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2. Poor illumination or blocked visibility of areas where possible assailants may be present;
3. Lack of physical barriers between employees and persons at risk of committing workplace violence;
4. Lack of effective escape routes;
5. Obstacles and impediments to accessing alarm systems;
6. Locations within the facility where alarm systems are not operational;
7. Entryways where unauthorized entrance may occur, such as doors designated for staff entrance or emergency exits;
8. Presence of furnishings or any objects that can be used as weapons in the areas where patient contact activities are performed;
9. Storage of high-value items, currency, or pharmaceuticals.

(B) For home health care and home-based hospice: Procedures to identify and evaluate – during intake procedures, at the time of the initial visit, and during subsequent visits whenever there is a change in conditions – environmental risk factors such as the presence of weapons, evidence of substance abuse, or the presence of uncooperative cohabitants.

(C) For emergency medical services and medical transport: Procedures for communicating with dispatching authorities to identify any risk factors present at the scene and ensure that appropriate assistance will be provided by cooperating agencies if needed.

(10) Procedures to identify and evaluate patient-specific risk factors and assess visitors or other persons who are not employees. Assessment tools, decision trees, algorithms, or other effective means shall be used to identify situations in which patient-specific Type 2 violence is more likely to occur and to assess visitors or other persons who display disruptive behavior or otherwise demonstrate a risk of committing workplace violence. This includes, as applicable, procedures for paramedic and other emergency medical services to communicate with receiving facilities, and for receiving facilities to communicate with law enforcement and paramedic and other emergency medical services, to identify risk factors associated with patients who are being transported to the receiving facility. Patient-specific factors shall include, as applicable, but not necessarily be limited to, the following:

(A) A patient's mental status and conditions that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively;

(B) A patient's treatment and medication status, type, and dosage, as is known to the health facility and employees;

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(C) A patient's history of violence, as is known to the health facility and employees;
(D) Any disruptive or threatening behavior displayed by a patient.

(11) Procedures to correct workplace violence hazards in a timely manner in accordance with Section 3203(a)(6). Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible. The employer shall take measures to protect employees from imminent hazards immediately, and shall take measures to protect employees from identified serious hazards within seven days of the discovery of the hazard, where there is a realistic possibility that death or serious physical harm could result from the hazard. When an identified corrective measure cannot be implemented within this timeframe, the employer shall take interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures. Corrective measures shall include, as applicable, but shall not be limited to:

(A) Ensuring that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. A staff person is not considered to be available if other assignments prevent the person from immediately responding to an alarm or other notification of a violent incident.
(B) Providing line of sight or other immediate communication in all areas where patients or members of the public may be present. This may include removal of sight barriers, provision of surveillance systems or other sight aids such as mirrors, use of a buddy system, improving illumination, or other effective means. Where patient privacy or physical layout prevents line of sight, alarm systems or other effective means shall be provided for an employee who needs to enter the area.
(C) Configuring facility spaces, including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms, so that employee access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.
(D) Removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where patients who have been identified as having a potential for workplace Type 2 violence are reasonably anticipated to be present.
(E) Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1 or Type 2 violence. This shall include monitoring and controlling designated public entrances by use of safeguards such as weapon detection devices, remote surveillance, alarm systems, or a registration process conducted by personnel who are in an appropriately protected work station.
(F) Maintaining sufficient staffing, including security personnel, who can maintain order in the facility and respond to workplace violence incidents in a timely manner.
(G) Installing, implementing, and maintaining the use of an alarm system or other effective means by which employees can summon security and other aid to defuse or respond to an actual or potential workplace violence emergency.

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(H) Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.

(I) Establishing an effective response plan for actual or potential workplace violence emergencies that includes obtaining help from facility security or law enforcement agencies as appropriate. Employees designated to respond to emergencies must not have other assignments that would prevent them from responding immediately to an alarm to assist other staff. The response plan shall also include procedures to respond to mass casualty threats, such as active shooters, by developing evacuation or sheltering plans that are appropriate and feasible for the facility, a procedure for warning employees of the situation, and a procedure for contacting the appropriate law enforcement agency.

(J) Assigning or placing sufficient numbers of staff, to reduce patient-specific Type 2 workplace violence hazards.

(12) Procedures for post-incident response and investigation, including:

(A) Providing immediate medical care or first aid to employees who have been injured in the incident;

(B) Identifying all employees involved in the incident;

(C) Making available individual trauma counseling to all employees affected by the incident;

(D) Conducting a post-incident debriefing as soon as possible after the incident with all employees, supervisors, and security involved in the incident;

(E) Reviewing any patient-specific risk factors and any risk reduction measures that were specified for that patient;

(F) Reviewing whether appropriate corrective measures developed under the Plan – such as adequate staffing, provision and use of alarms or other means of summoning assistance, and response by staff or law enforcement – were effectively implemented;

(G) Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause of the incident, and whether any measure would have prevented the injury.

(d) Violent Incident Log. The employer shall record information in a violent incident log (Log) about every incident, post-incident response, and workplace violence injury investigation performed in accordance with subsection (c)(12). Information about each incident shall be based on information solicited from the employees who experienced the workplace violence. The employer shall omit any element of personal identifying information sufficient to allow identification of any person involved in a violent incident, such as the person's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the person's identity. The Log shall be reviewed during the annual review of the Plan required in subsection (e). The information recorded in the Log shall include, but not necessarily be limited to:

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(1) The date, time, specific location, and department of the incident;
(2) A detailed description of the incident;
(3) A classification of who committed the violence, including whether the perpetrator was a patient/client/customer, family/friend of a patient/client/customer, stranger with criminal intent, coworker, supervisor/manager, partner/spouse, parent/relative, or other perpetrator;
(4) A classification of circumstances at the time of the incident, including whether the employee was completing usual job duties, working in poorly lit areas, rushed, working during a low staffing level, in a high crime area, isolated or alone, unable to get help or assistance, working in a community setting, working in an unfamiliar or new location, or other circumstances;
(5) A classification of where the incident occurred, including whether it was in a patient or client room, emergency room or urgent care, hallway, waiting room, restroom or bathroom, parking lot or other area outside the building, personal residence, break room, cafeteria, or other area;
(6) The type of incident, including whether it involved:
  (A) Physical attack, including biting, choking, grabbing, hair pulling, kicking, punching, slapping, pushing, pulling, scratching, or spitting;
  (B) Attack with a weapon or object, including a gun, knife, or other object;
  (C) Threat of physical force or threat of the use of a weapon or other object;
  (D) Sexual assault or threat, including rape/attempted rape, physical display, or unwanted verbal/physical sexual contact;
  (E) Animal attack;
  (F) Other.
(7) Consequences of the incident, including:
  (A) Whether medical treatment was provided to the employee;
  (B) Who, if anyone, provided necessary assistance to conclude the incident;
  (C) Whether security was contacted and whether law enforcement was contacted;
  (D) Amount of lost time from work, if any;
  (E) Actions taken to protect employees from a continuing threat, if any.
(8) Information about the person completing the Log including their name, job title, phone number, email address, and the date completed.

(e) Review of the Workplace Violence Prevention Plan. The employer shall establish and implement a system to review the effectiveness of the Plan for the overall facility or operation at least annually, in conjunction with employees and their representatives regarding the employees' respective work areas, services, and operations. Problems found during the review shall be corrected in accordance with subsection (c)(11). The review shall include evaluation of the following:

PROPOSED STATE STANDARD,
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(1) Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence;
(2) Sufficiency of security systems, including alarms, emergency response, and security personnel availability;
(3) Job design, equipment, and facilities;
(4) Security risks associated with specific units, areas of the facility with uncontrolled access, late-night or early morning shifts, and employee security in areas surrounding the facility such as employee parking areas and other outdoor areas.
(5) The Plan, in accordance with Section 3203(a)(4)(B) and (C), as it applies to units within a facility, the facility as a whole, or the particular operation, shall also be reviewed for the unit, facility or operation, and updated whenever necessary as follows:
(A) To reflect new or modified tasks and procedures which may affect how the Plan is implemented, such as changes in staffing, engineering controls, construction or modification of the facilities, evacuation procedures, alarm systems and emergency response;
(B) To include newly recognized workplace violence hazards;
(C) To review and evaluate workplace violence incidents which result in a serious injury or fatality; or
(D) To review and respond to information indicating that the Plan is deficient in any area.
(E) When a revision to the Plan is needed for only part of the facility or operation, the review process may be limited to the employees in the unit(s) or operation(s) affected by the revision, independently of the annual review for the Plan for the facility as a whole.

(f) Training. The employer shall provide effective training to employees, as specified in subsections (f)(1) through (f)(3), that addresses the workplace violence risks that the employees are reasonably anticipated to encounter in their jobs. The employer shall have an effective procedure for obtaining the active involvement of employees and their representatives in developing training curricula and training materials, participating in training sessions, and reviewing and revising the training program. Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.
(1) All employees working in the facility, unit, service, or operation shall be provided initial training as described in subsection (f)(1)(A) when the Plan is first established and when an employee is newly hired or newly assigned to perform duties for which the training required in this subsection was not previously provided, and shall also be provided additional training as described in subsection (f)(1)(B).
(A) Initial training shall address the workplace violence hazards identified in the facility, unit, service, or operation, and the corrective measures the employer has implemented and shall include:

PROPOSED STATE STANDARD,
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1. An explanation of the employer's workplace violence prevention plan, including the employer's hazard identification and evaluation procedures, general and personal safety measures the employer has implemented, how the employee may communicate concerns about workplace violence without fear of reprisal, how the employer will address workplace violence incidents, and how the employee can participate in reviewing and revising the Plan;
2. How to recognize the potential for violence, factors contributing to the escalation of violence and how to counteract them, and when and how to seek assistance to prevent or respond to violence;
3. Strategies to avoid physical harm;
4. How to recognize alerts, alarms, or other warnings about emergency conditions such as mass casualty threats and how to use identified escape routes or locations for sheltering, as applicable;
5. The role of private security personnel, if any;
6. How to report violent incidents to law enforcement;
7. Any resources available to employees for coping with incidents of violence, including, but not limited to, critical incident stress debriefing or employee assistance programs;
8. An opportunity for interactive questions and answers with a person knowledgeable about the employer's workplace violence prevention plan.

(B) Additional training shall be provided when new equipment or work practices are introduced or when a new or previously unrecognized workplace violence hazard has been identified. The additional training may be limited to addressing the new equipment or work practice or new workplace hazard.

(C) Training not given in person shall fulfill all the subject matter requirements of subsection (f)(1) and shall provide for interactive questions to be answered within one business day by a person knowledgeable about the employer's workplace violence prevention plan.

(2) Employees performing patient contact activities and those employees' supervisors shall be provided refresher training at least annually, applicable to those employees, to review the topics included in the initial training and the results of the review(s) required in subsection (e). Refresher training shall include an opportunity for interactive questions and answers with a person knowledgeable about the employer's workplace violence prevention plan. Training not given in person shall fulfill all the subject matter requirements of subsection (f)(2) and shall provide for interactive questions to be answered within one business day by a person knowledgeable about the employer's workplace violence prevention plan.

PROPOSED STATE STANDARD,
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(3) Employees assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior shall be provided training on the following topics prior to initial assignment and at least annually thereafter. This is in addition to the training required in subsection (f)(1). This additional training shall include:
(A) General and personal safety measures;
(B) Aggression and violence predicting factors;
(C) The assault cycle;
(D) Characteristics of aggressive and violent patients and victims;
(E) Verbal intervention and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior;
(F) Strategies to prevent physical harm;
(G) Appropriate and inappropriate use of restraining techniques in accordance with Title 22;
(H) Appropriate and inappropriate use of medications as chemical restraints in accordance with Title 22;
(I) An opportunity to practice the maneuvers and techniques included in the training with other employees they will work with, including a meeting to debrief the practice session. Problems found shall be corrected.

(g) Reporting Requirements for General Acute Care Hospitals, Acute Psychiatric Hospitals, and Special Hospitals.
(1) Every general acute care hospital, acute psychiatric hospital, and special hospital shall report to the Division any incident involving either of the following:
(A) The use of physical force against an employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
NOTE: "Injury," as used in subsection (g)(1)(A), means an injury meeting the criteria in Section 14300.7(b)(1).
(B) An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.
NOTE to (g)(1): These reports do not relieve the employer of the requirements of Section 342 to immediately report a serious injury, illness, or death to the nearest Division district office.
(2) The report to the Division required by subsection (g)(1) shall be made within 24 hours, after the employer knows or with diligent inquiry would have known of the incident, if the incident results in injury, involves the use of a firearm or other dangerous weapon, or presents an urgent or emergent threat to the welfare, health, or safety of hospital personnel. For purposes of this reporting process:

PROPOSED STATE STANDARD,
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(A) "Injury" means a fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.

(B) An "urgent or emergent threat to the welfare, health, or safety of hospital personnel" means that hospital personnel are exposed to a realistic possibility of death or serious physical harm.

(3) All other reports to the Division required by subsection (g)(1) shall be made within 72 hours.

(4) Reports shall include, at a minimum, the following items:

(A) Hospital name, site address, hospital representative, phone number, and email address, and the name, representative name, and contact information for any other employer of employees affected by the incident;

(B) Date, time, and specific location of the incident;

(C) A brief description of the incident, including but not limited to, the type of attacker, the type of physical assault, the type of weapon or object used by the attacker, if any, working conditions at the time of attack, and whether the assaulted employee was alone or isolated immediately prior to the incident;

(D) The number of employees injured and the types of injuries sustained;

(E) Whether security or law enforcement was contacted, and how security or law enforcement assisted the employee(s);

(F) Whether there is a continuing threat, and if so, what measures are being taken to protect employees by engineering control modifications, work practice modifications, or other measures;

(G) A unique incident identifier;

(H) Whether the incident was reported to the nearest Division district office as required in Section 342.

(I) The report shall not include any employee or patient names. Employee names shall be furnished upon request to the Division.

(5) The employer shall provide supplemental information to the Division regarding the incident within 24 hours of any request.

(6) Reports shall be provided through a specific online mechanism established by the Division for this purpose.

(h) Recordkeeping.

(1) Records of workplace violence hazard identification, evaluation, and correction shall be created and maintained in accordance with Section 3203(b)(1), except that the Exception to Section 3203(b)(1) does not apply.

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(2) Training records shall be created and maintained for a minimum of one year and include training dates, contents or a summary of the training sessions, names and qualifications of persons conducting the training, and names and job titles of all persons attending the training sessions. Section 3203(b)(2) EXCEPTION NO. 1 does not apply to these training records.

(3) Records of violent incidents, including but not limited to, violent incident logs required by subsection (d), reports required by subsection (g), and workplace violence injury investigations conducted pursuant to subsection (c)(12), shall be maintained for a minimum of five years. These records shall not contain "medical information" as defined by Civil Code Section 56.05(j).

(4) All records required by this subsection shall be made available to the Chief on request, for examination and copying.

(5) All records required by this subsection shall be made available to employees and their representatives, on request, for examination and copying in accordance with Section 3204(e)(1) of these orders.

(6) Records required by Division 1, Chapter 7, Subchapter 1, Occupational Injury or Illness Reports and Records, of these orders shall be created and maintained in accordance with those orders.

Authority: Labor Code Section 142.3. Reference: Labor Code Sections 142.3 and 6401.8.

Statement of the Emergency Nurses Association in Support the Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1309)

Hearing on "Caring for our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence"

House Committee on Education and Labor Subcommittee on Workforce Protections February 27, 2019

Chairman Adams, Ranking Member Byrne, members of the Subcommittee on Workforce Protections, the Emergency Nurses Association would like to thank you for the opportunity to submit testimony in support of H.R. 1309, the Workplace Violence Prevention for Health Care and Social Service Workers Act.

ENA is the largest professional health care organization dedicated to improving emergency nursing care. With more than 43,000 members throughout the United States and around the world, ENA advocates for patient safety, develops industry-leading practice standards and guidelines, and guides emergency health care public policy.

ENA strongly supports the Workplace Violence Prevention for Health Care and Social Service Workers Act of 2019. Workplace violence against health care workers, like emergency nurses, is a national crisis. The Occupational Safety and Health Administration (OSHA) found that that although workers in the health care sector accounted for only 20% of workplace injuries, they make up about 50% of all victims of workplace assault. Between 2002 and 2013, serious incidents of workplace violence were four times more common for workers in the health care sector than for all other workers in the U.S.

Nurses and other health care workers are punched, kicked, spat on, stabbed and shot across the country daily. Some even die from their injuries. Many suffer physical and emotional trauma that drives them away from the critical work of emergency nursing. Research has found that one-third of emergency nurses have considered leaving the profession due to workplace violence. Most incidents go unreported and even fewer get prosecuted.

Emergency departments (EDs) are open 24 hours a day, seven days a week and under the Emergency Medical Treatment and Labor Act (EMTALA), they are required to stabilize and treat all patients. Often, emergency nurses interact with members of the public when emotions run high and their behavior can sometimes

become violent. Studies show that emergency nurses and other personnel in the ED experience a violent event about once every two months.

OSHA is charged with assuring safe and healthful working conditions for men and women in the United States. They do this by setting and enforcing standards to maintain safety and prevent injuries, including those related to workplace violence. Although federal research demonstrates that workplace violence is a serious concern for the nation's 15 million health care workers, there is no national standard in place aimed at preventing and responding to workplace violence in health care facilities.

The development of a national standard relating to workplace violence in health care would ensure that employers assess factors such as the physical security of their facilities, staffing issues related to security, training for employees on mitigating and responding to violence and support for workers when they are assaulted. A national standard would ensure that all health care employers take similar steps to protect their workers from violence and support them when assaults do occur.

The Workplace Violence Prevention for Health Care and Social Service Workers Act will ensure that covered health care employers take specific steps to prevent workplace violence and ensure the safety of patients and workers. Importantly, H.R. 1309 will require health care employers, primarily hospitals and outpatient clinics, to develop and implement a comprehensive a workplace violence prevention plan. Such a plan would need to –

- Develop processes to identify and respond to risks that make settings vulnerable to violence;
- Implement protocols to document and investigate violence;
- Create an environment that supports employees who report incidents of violence, including non-retaliation policies;
- Ensure that employees are appropriately trained in identifying and addressing hazards; and
- Obtain buy-in from employees, including emergency nurses, in the development and implementation of new policies.

To lower the risks associated with workplace violence in health care, we must take comprehensive and responsible steps to address its root causes, mitigate its effects and respond appropriately to help victims when violence occurs. The Workplace Violence Prevention for Health Care and Social Service Workers Act will ensure that emergency nurses and other health care workers have a safe working environment and receive support in addressing the widespread problem of workplace violence in health care.

We would like to express our appreciation to Rep. Joe Courtney for introducing H.R. 1309 and for the House Education and Labor Committee and the Subcommittee on Workforce Protections for scheduling this hearing on this important public safety issue.

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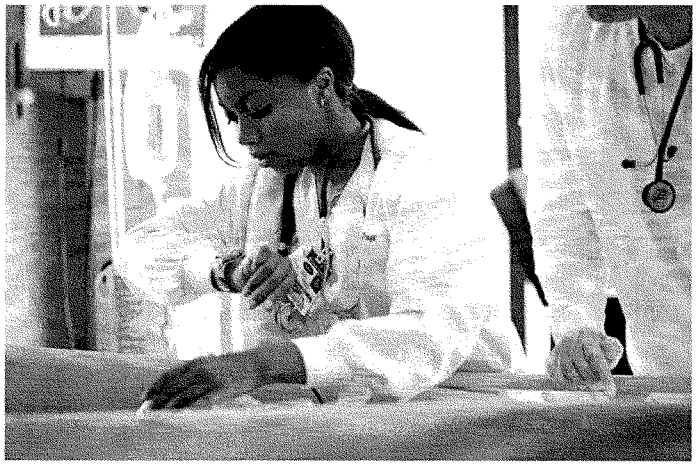
Epidemic of Violence against Health Care Workers Plagues Hospitals

Hospital administrations and the judicial system do little to prevent assaults against nurses and other caregivers by patients

By Roni Jacobson on December 31, 2014



Emergency room and psychiatric nurses and workers involved in elder and in-home care are at an especially high risk. *Credit: COD Newsroom via flickr*

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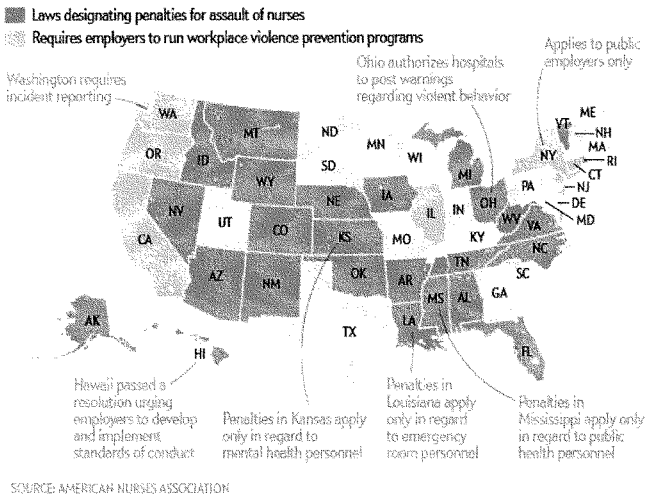
In a harrowing video that surfaced last month, a 68-year-old hospital patient attacks a group of nurses with a pipe pulled from his bed. They flee through a nearby door in a streak of rainbow scrubs, but the patient pursues and lands several more blows on one fallen nurse in the hallway.

This assault is far from an isolated incident. Health-care workers are hit, kicked, scratched, bitten, spat on, threatened and harassed by patients with surprising regularity. In a 2014 survey, almost 80 percent of nurses reported being attacked on the job within the past year. Health-care workers experience the most nonfatal workplace violence compared to other professions by a wide margin, with attacks on them accounting for almost 70 percent of all nonfatal workplace assaults causing days away from work in the U.S., according to data from the Bureau of Labor Statistics.

And attacks show no sign of slowing down.

There is little movement toward stopping the assaults. "There is a top-to-bottom cultural assumption that violence is part of the job" for ER nurses and health-care workers, says Lisa Wolf, a registered nurse and research director for the Emergency Nurses Association. "It goes from the bedside up to the judicial system."



Credit: Jen Christiansen

But organizations such as the ENA and the American Nurses Association as well as government agencies involved in occupational safety say this doesn't have to be the case.

After the episode in Minnesota, the hospital initiated a training program to teach workers how to recognize and de-escalate potentially violent situations. Many hospitals lack this basic safety measure, however—an oversight that leaves caregivers vulnerable. Better violence-prevention plans—including training and incident reporting—can lessen the risk, but their adoption is stymied by indifference from police, prosecutors, judges and hospital administrations. The general disregard discourages health-care workers from reporting assaults, thus compounding the problem.

"As you get more and more distance from the epicenter of the problem in the ER, people really feel like their administrations are way less engaged in mitigating violence," Wolf says. "It makes people less invested in the work that they do because they feel less supported."

Nurses often have to get uncomfortably close with extremely stressed-out people, so an element of aggression is perhaps inevitable. Some assaults come from people experiencing psychosis or other mental crises. Dementia and in-home-care patients are also frequent sources. Much of the violence is less explainable, however. In the 2014 survey, almost 50 percent came from patients and family members who were drunk or on drugs. Plenty of people attack nurses out of simple frustration.

Rita Anderson, an Arizona-based nurse who was instrumental in passing New York State's violence-against-nurses legislation, tried to bring charges after a girl in her late teens broke the nurse's jaw. "When I spoke to her later in the evening, she said she was just tired of waiting," Anderson says.

Police and prosecutors "don't necessarily feel that this is a big issue unless someone is hurt very severely, even though there are felony laws against it," she says. Her suit was eventually scuttled.

Nurses who have reported attacks say that acceptance of the violence runs through hospital administrations as well as the judicial system. An article, "Nothing Changes, Nobody Cares," published this July in the *Journal of Emergency Nursing,* sums up the general sentiment among health-care workers who are attacked on the job. Wolf and colleagues interviewed 46 ER nurses who described sympathetic supervisors but passive hospital administrations. In a 2011 ENA survey, about half of nurses said that the hospital took no action after they were assaulted, and in another 20 percent of cases, the perpetrator was issued a warning. Ten percent of nurses said they were blamed for the incident.

Jeaux Rinehart, a registered nurse for more than 30 years, was working at Virginia Mason Medical Center in 2008 when a patient seeking methadone attacked him with

a billy club, breaking his cheekbone. He says that hospitals tacitly discourage nurses from pressing charges, and describes two incidents in which colleagues were reprimanded for their assault. "There is a constant message being sent to nurses that they are responsible, that places the blame on nurses for their attack," Rinehart says. "It comes from a lot of institutions."

The lukewarm response from management deters workers from reporting incidents, further obscuring the issue. Studies suggest that more than half of physical assaults on nurses and up to 80 percent of verbal abuse goes unreported.

At the same time that nurses are blamed, hospitals do little to prepare them for what lies ahead. "We keep hearing the recurring theme that we aren't getting any workplace-violence-prevention training in our nursing curriculum, we're not learning it at our institutions," says Daniel Hartley, an epidemiologist and the National Institute for Occupational Safety and Health (NIOSH) coordinator for workplace-violence-prevention research. "There's nothing worse than a novice nurse going into health care and not realizing that he or she will encounter physical and verbal abuse on the very first day on the job."

Violence-prevention programs reduce the risk of assault by training workers to recognize frequent cues, such as drug use and threatening body language, and educating them about strategies to help defuse situations. Accurate incident reporting is a crucial part of this type of intervention, as it helps hospitals identify specific hazards, such as poor lighting, understaffing, and inadequate safety training, and take steps to remedy them.

In a 2011 ENA study on workplace violence, hospitals with mandatory reporting policies experienced half the rate of physical violence as hospitals without reporting policies. The Veterans Health Administration has successfully reduced assaults in its hospitals by electronically flagging high-risk offenders, such as people who have been abusing drugs and alcohol and those with a history of attacks on caregivers, who are then treated with extra precautions.

The Occupational Safety and Health Administration (OSHA) issues guidelines for violence-prevention programs, but there is no federal statute requiring hospitals to

adopt them. Several states have passed laws making it a felony to assault a health-care worker, but only a few have included provisions for violence-prevention training and incident reporting. Hospitals are generally left to monitor themselves.

Since the government doesn't collect the statistics, it's impossible to know exactly how many hospitals lack adequate safety protocols, but ENA surveys suggest that the number could be substantial. Some hospitals have comprehensive violence-prevention programs, but many nurses report that they receive minimal to no workplace-safety training and must learn on their feet when a situation turns violent.

Before his assault in 2008, Rinehart recalls one half-day training session about five years earlier on how to protect yourself in the event of an attack, "like how to get out of a choke hold," but it lacked elements such as how to recognize and defuse aggression. "The prevention piece was completely missing," he says.

NIOSH developed a free online training program that went live last year. Hartley reports that they've had more than 8,000 people complete the module so far, but individuals must seek out the training on their own time. NIOSH could not say whether any institutions have made the module part of their workplace-violence curriculum. They have done some hospital outreach, but it has mostly been "nursing associations bringing [the module] to management," Hartley says.

And buy-in is still an issue.

When Anderson was working on the New York State Violence Against Nurses law in the 1990s, the state senator sponsoring the bill "recommended that we just get legislation passed that made it a felony to assault a nurse and didn't require all kinds of education and training programs," she says. "He said it would be very costly and make it harder to get the legislation passed," and predicted opposition from hospitals. The New York law now requires institutional workplace-violence prevention, but only from public employers.

The cost of violence prevention is small, however, when compared to the amount that hospitals lose in worker-compensation lawsuits every year and in time off due to

injury—roughly a third of which is patient-inflicted, according to OSHA statistics.

"There needs to be a cultural change that it's not okay to hit a nurse," Wolf says. "Until then, any intervention that is attempted is unlikely to be accepted."

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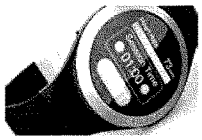

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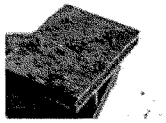

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UNITED STATES OF AMERICA

OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

THOMAS E. PEREZ, SECRETARY OF LABOR, Complainant, v. INTEGRA HEALTH MANAGEMENT, INC., Respondent.	))))))))))	OSHRC DOCKET NO. 13-1124 REGION IV INSPECTION NO. 781282

SECRETARY'S POST-HEARING BRIEF

Complainant Secretary of Labor, United States Department of Labor ("the Secretary"), files his Post-Hearing brief pursuant to Occupational Safety and Health Review Commission ("Commission") Rule of Procedure 2200.74, 29 C.F.R. § 2200.74, and the Judge's Order.

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II. STIPULATIONS

In the Joint Prehearing Statement dated April 10, 2014, the parties agreed that the following facts were admitted:

> Integra, based in Owings Mills, Maryland, performs mental and physical health assessments and coordinates case management via contracts with various insurance companies. These assessments are performed by employees known as "community service coordinators." Integra performs these services in four states: Tennessee, Pennsylvania, Maryland, and Florida. There are no company offices in Florida; service coordinators work from their homes or in the field. The Integra service coordinator program focuses on helping clients receive appropriate medical care. Service coordinators are assigned a caseload of clients and are responsible for calling them and for face to face meetings during which the clients are assessed and encouraged or persuaded to register for services. Insurance companies apparently refer these clients to companies such as Integra due to chronic difficulties in contacting them. Many of the clients suffer from mental illness.
>
> On December 13, 2012, an inspection was initiated when the OSHA Tampa Area Office received an anonymous phone call reporting a workplace violence fatality. Three days earlier, on December 10, 2012, [redacted] an Integra service coordinator, was fatally stabbed by a mentally ill client. The victim was meeting the assailant at his house for a required face to face visit to conduct an initial assessment.

Joint Prehearing Statement, p. 8.

III. FACTUAL BACKGROUND

This case is the result of an inspection conducted by the Occupational Safety and Health Administration ("OSHA"), Tampa Area Office, following a workplace fatality involving Respondent Integra Health Management, Inc. ("Respondent" or "Integra") on December 10, 2012.

OSHA Compliance Safety and Health Officer ("CSHO") Jason Prymmer conducted a fatality-related safety and health inspection (pursuant to the Occupational Safety and Health Act of 1970, as amended) of Respondent as a result of the workplace death of [redacted] (Prymmer, Tr. 77). As a result of his findings and recommendations, on June 6, 2013, OSHA

issued one "Serious" Citation alleging a violation of the OSH Act's general duty clause with a proposed penalty of $7,000, and one "Other Than Serious" Citation alleging a violation of regulation set forth at 29 C.F.R. § 1904.39(a), with a proposed penalty of $3,500. OSHA contends that (1) Integra did not furnish employment and a place of employment which were free from recognized hazards that were causing or likely to cause death or serious physical harm to employees, in that employees were exposed to the hazard of being physically assaulted by members with a history of violent behavior (OSHA § 5(a)(1)); and (2) Integra did not report to OSHA the work-related death of its employee [redacted] (29 C.F.R. § 417(b)). Integra contested the Citations and proposed penalties and a hearing was held on May 6-9, 2014, in Tampa, Florida, before Judge Dennis L. Phillips.

IV. FINDINGS OF FACT

1. Jurisdiction of this action is conferred upon the Commission by §10(c) of the Occupational Safety and Health Act of 1970, 29 U.S.C. § 651, et seq. (hereinafter "the Act"). *See* Complaint, ¶ I, Answer, ¶ I.

2. Integra is an employer engaged in a business affecting commerce within the meaning of §3(5) of the Act. *See* Complaint, ¶ II, Answer, ¶ II.

3. Integra's principal place of business is at 10055 Red Run Boulevard, Suite 105, Owings Mill, Maryland 21117. *See* Complaint ¶ III and Answer ¶ III.

4. On December 10, 2012, [redacted] an employee of Respondent Integra, was fatally stabbed in the course of her employment by [redacted] a member serviced by the Integra program. Joint Prehearing Statement, p. 8.

5. Integra did not report the fatality to OSHA; rather, the fatality was reported to OSHA by an anonymous caller. (Prymmer, Tr. 82, 86).

Service Coordinator Job Description and Conditions

6. In Florida, Integra contracted with Amerigroup, a medical insurance company. (Rochelle, Tr. 270).

7. Amerigroup provided clients to Integra who were "high utilizers", meaning they often used the hospital's emergency rooms for medical treatment. (Rochelle, Tr. 271).

8. Integra's service coordinators ("SCs") coordinate services for people with medical and mental health issues. The purpose of the program is to get members connected with doctors for their treatment. The program's goal is to prevent the members from over utilizing hospital emergency rooms for their treatment. Service coordinators were to build a rapport with members to get them to consent to receive these services from Integra. (Rochelle, Tr. 250).

9. Between May and October of 2012, SCs in Florida were supervised by Laurie Rochelle ("Rochelle"), a licensed mental health counselor. (Rochelle, Tr. 243, 245)

10. Rochelle supervised the nine SCs in the Florida area. (Rochelle, Tr. 245, 287).

11. Rochelle reported to Integra Vice President Melissa Arnott ("Arnott") and her duties included training, caseload assignment and geographical assignments. (Rochelle, Tr. 245, 246).

12. SCs did not work out of an office and communicated with their supervisors by telephone and email. (Rochelle, Tr. 269, 288). Weekly meetings were conducted by telephone. (Rochelle, Tr. 269).

13. Rochelle attempted to assign SCs to geographical areas that were familiar to them. Rochelle believed this was an important safety precaution. However, her supervisor Arnott told her that assigning cases based on geographical area was unnecessary. (Rochelle, Tr. 254, 255)

14. Rochelle assigned SCs to work in neighborhoods and areas that were not familiar to them. SCs told Rochelle that there were not comfortable with these assignments. (Rochelle, Tr. 260)

15. SCs were required to make at least two face to face contacts with clients each month. (Rochelle, Tr. 255).

16. SCs primarily worked alone. (Schneider, Tr. 452).

17. Rochelle assigned SCs a very large caseload. (Rochelle, Tr. 260). The SCs caseloads started off at about 25 to 30 cases, but increased to as high as 50 to 60 per SC. (Schneider, Tr. 454).

18. The SCs job duties included going out into the community to visit clients and to assist them with getting medical treatment/medications, and a variety of other services such as obtaining transportation, public assistance and housing. (Rentz, Tr. 369).

19. "Locating them was the first priority. To do whatever we could to located them. Go in wherever, no matter what the conditions looked like, no matter what the situation was to try and locate them." (Daniel, Tr. 436).

20. When asked to describe the members she serviced, service coordinator Kimberly Daniel stated, "Dual diagnosis, mental illness and medical...was how it was presented. Come to find out later that they would also have ... violent histories, robbery, armed robbery, sexual assault backgrounds that weren't always – were not disclosed to us." (Daniel, Tr. 436).

21. Integra's ultimate goal was to reduce hospital and crisis stabilization admissions. (Schneider, Tr. 450).

22. Melissa Arnott told SCs to locate members "at any cost necessary" (Daniel, Tr. 437).

23. SCs were to make sure that members were taking their prescribed medications. (Stevens, Tr. 416). If the members were not compliant with their doctors' orders, SCs were instructed to find out why. (Daniel, Tr. 437-38)

24. SCs spent 15 to 20 percent of their time driving members in the SCs' personal vehicles to doctor's visits, psychiatric visits and mental health facilities. (Schneider, Tr. 452-453; Stevens, Tr. 417; Hinman, Tr. 809).

25. It was mandatory for SCs to drive members in the SCs' personal vehicles to psychiatric appointments. (Stevens, Tr. 430).

26. Employees did not feel safe driving certain mentally ill members in their personal vehicles because these members were not always taking their medications. (Stevens, Tr. 418-19).

27. Service Coordinators went to hospitals, mental health facilities, clients' homes, homeless shelters and restaurants to meet and find clients. (Rochelle, Tr. 251).

28. Service coordinators would meet with members alone in areas off the beaten path, in areas where the general public could not see them; e.g., trailer parks, government housing projects, and high crime areas. (Prymmer, Tr. 134:20-25; 135:1-4).

29. SCs would usually attempt to locate clients by going to their homes first. (Rentz, Tr. 369). They would also visit homeless shelters, "abandoned looking buildings that looked like they should be condemned" and go to unfavorable parts of the city. (Rentz, Tr. 374) (Daniel, Tr. 436-437). They also visited hospitals. (Schneider, Tr. 451).

30. SCs had to do two face to face contacts with each member per month and two phone calls per month. (Rentz, Tr. 369) (Schneider, Tr. 462). The purpose of the face to

face contact was to determine the member's needs. (Rentz, Tr. 369) (Daniel, Tr. 439) (Schneider, Tr. 462).

31. SCs were required to perform an initial assessment of each member that addressed the member's medical, psychiatric, and living conditions and then develop a care plan that would set realistic goals for the member's specific situation. (Schneider, Tr. 459-60).

32. SCs experienced a great deal of stress and pressure "to produce an unrealistic goal in an unrealistic time frame." (Schneider, Tr. 494).

33. Service coordinators were not hired to provide counseling; they were hired to coordinate medical and mental services. (Rochelle, Tr. 252).

34. Integra said that the assessments performed by SCs were not clinical, but Integra manager Rochelle admitted that SCs were doing assessments of the client's needs, i.e., whether they should receive counseling and the extent of any substance abuse. (Rochelle, Tr. 265).

35. The initial assessment form Integra requires SCs to complete calls for the application of clinical tools, such as a brief mental status exam, clinical observations, BPRS (brief psychiatric rating scale), and GAF (global assessment of functioning). These tools are used by trained clinicians to diagnose a patient for mental illness and to assess that patient's level of functioning. (Nelson, Tr. 590-593, 1097-1098; Ex. 34).

36. The ability to do an accurate clinical assessment of a mentally-ill member would better allow the service coordinator to assess the member's propensity for violence. (Nelson, Tr. 599, 1100).

37. Service coordinators – who were not required to have any previous experience or training as clinicians or social workers – did not have the experience or knowledge necessary to accurately apply the clinical tools described in the assessment form. (Nelson, Tr. 1099-1100).

38. In part, service coordinators perform the jobs of clinical social workers. (Nelson, Tr. 1103-1104).

39. SCs knew very little about a member's background before being assigned a case. Initially, SCs were not even given a diagnosis. Rochelle asked for a diagnosis from Amerigroup and saw that some members had serious mental health issues. (Rochelle, Tr. 255-56).

40. Amerigroup generally provided only one diagnosis, but many members had multiple diagnoses. (Rochelle, Tr. 257).

41. SCs were pressured to find members. (Rochelle, Tr. 269).

42. SCs filled out progress note reports for every contact or attempted contact with a member. The progress notes were for documentation purposes. These notes described when contact was made with a client and what happened. (Rochelle, Tr. 272).

43. Rochelle reviewed and approved the SCs' progress note reports. (Rochelle, Tr. 272).

44. Sometimes, progress note reports entered in the Integra database system would disappear. (Rochelle, Tr. 297). Rochelle made several complaints to her supervisors about the database. (Rochelle, Tr. 298).

45. If two face to face contacts were not made each month, Integra would not get paid by the insurance companies. (Rochelle, Tr. 260).

46. Rochelle felt pressured by her supervisors to make face to face contacts with members. (Rochelle, Tr. 260).

Characteristics of the Members Integra Serviced

47. Rochelle knew that the majority of Integra's members had mental illness and criminal backgrounds. (Prymmer, Tr. 133:12-18).

48. Rochelle noticed that Integra had a lot of members who were getting out of jail and Integra required SCs to continue to serve them. (Rochelle, Tr. 247).

49. Chief Operating Officer ("COO") Dee Brown admitted to CSHO Jason Prymmer that "most members have a criminal background." (Prymmer, Tr. 89:9-12).

50. Vice President Melissa Arnott admitted to CSHO Jason Prymmer that "these members have criminal backgrounds and they're severely mentally ill." (Prymmer, Tr. 89:13-15).

51. SCs provided services to members who were drug users and who were involved in criminal activity. (Rochelle, Tr. 252).

52. SCs provided services to member who had severe mental health issues such a schizophrenia and bi-polar personality disorders. (Rochelle, Tr. 252).

53. SCs serviced members with a history of violence and who were volatile. (Rochelle, Tr. 253).

54. SCs interacted with members with severe mental illnesses; fifteen to twenty percent of the SCs' caseloads carried members with bipolar and multiple personality disorders. (Schneider, Tr. 451, 469-70; Stevens, Tr. 417-18; Daniel, Tr. 436).

55. Some members had violent histories like robbery, armed robbery, and sexual assault backgrounds that were not disclosed to SCs. (Daniel, Tr. 436).

56. Clients included people who were chronically admitted to crisis destabilization units because they did not have access to their medications. (Schnieder, Tr. 451).

57. Neither Integra nor Amerigroup provided service coordinators with criminal background information for the members. (Rochelle, Tr. 257).

58. Integra did not perform criminal background checks on members. (Prymmer, Tr. 109:14-16).

59. Rochelle was afraid, at times, to go into clients' homes. (Rochelle, Tr. 252)

60. Rochelle assigned SC Annie Hinman to a member who had served prison time for burning down his mobile home. Hinman visited the member four or five times before she found out on her own about his criminal history. (Rochelle, Tr. 258).

Hiring and Qualifications of Service Coordinators

61. As part of her duties, Rochelle interviewed prospective SCs and made hiring recommendations to Melissa Arnott. (Rochelle, Tr. 247).

62. In 2012, Integra did not require its service coordinators to have any specialized education or certification; only a bachelor's degree was required. (*See* Ex. 9 and 10) (Prymmer, Tr. 104:5-105:13).

63. Because the starting salary for SCs was "very low," Integra encouraged Rochelle to hire people with only a bachelor's degree who were just getting out of college. (Rochelle, Tr. 247-248).

64. Experience visiting the homes of clients should have been a job qualification for the SC position, but was not a requirement. (Rochelle, Tr. 249). Rochelle would have preferred to hire SCs with at least six months experience visiting the homes of clients. (Rochelle, Tr. 249).

65. [redacted] had her Bachelor's degree when she was hired by Integra. (Prymmer, Tr. 105:14-16). [redacted] had no previous experience working with the mentally ill or any previous experience or certifications in social work. (Prymmer, Tr. 105:17-22).

Integra's Inadequate Safety Policies and Procedures and Training

66. SCs did not have panic buttons or alarms. (Rochelle, Tr. 258)

67. There was no sign in/sign out procedures for SCs. (Rochelle, Tr. 259). Integra supervisors did not know where SCs were at any given time. (Rentz, Tr. 375).

68. SCs attempted to schedule appointments with members prior to face to face visits, but if a member did not have a phone, Integra required SCs to go the member's house unannounced and knock on the door. (Rochelle, Tr. 259).

69. Integra did not require SCs to perform their own background checks on members. (Prymmer, Tr. 109:18-20); (Hinman, Tr. 825).

70. In practice, SCs did not regularly perform background checks on members. (Prymmer, Tr. 109:21-110:2).

71. Integra did not require SCs to take a partner or buddy with them; rather, Integra told service coordinators to "consider" taking another service coordinator with them if they, in their subjective opinions, believed it would be useful. (Prymmer, Tr. 111:11-20); Ex. 16; Ex. 19).

72. Integra had a voluntary "buddy system," but it was very difficult to implement because employees often did not have the time to partner up with another SC because of the heavy case loads. (Rochelle, Tr. 266).

73. Integra assigned members to SCs through the computer system. (Rentz, Tr. 372). Integra provided very little information to the SCs about the members. (Rentz, Tr. 373). SCs received the telephone number and address of the member. (Rentz, Tr. 373). Sometimes they received medical diagnosis and mental health diagnosis. (Daniel, Tr. 437).

74. Integra provided SCs with little information about the members so SCs had to be "detectives and hunt them down by any means". (Schnieder, Tr. 451).

75. Some SCs worked at night to locate members for the face to face contact. (Rentz, Tr. 374). They worked in areas that were unsafe and that made them nervous. (Rentz, Tr. 374-75).

76. SCs did not know if the members they were visiting had a history of violence because Integra provided so little information about the members. (Rentz, Tr. 376).

77. Integra developed an on-line training program for its new service coordinators, referred to as the "Neumann Training." (Prymmer, Tr. 105:23-106:2).

78. The Neumann Training was developed by Integra's Vice President of Behavioral Health, Melissa Arnott. (Prymmer, Tr. 106:1-2).

79. The Neumann Training was intended to be 40 hours long and consisted of power point slides, reading assignments, and on-line discussion board posts. (Prymmer, Tr. 106:3-6).

80. Session Eight of the Neumann Training, entitled "In-Home & Community Safety," included two power point presentations entitled "Safety in the Community" and "Screening the Dangerous Member." (Prymmer, Tr. 108:1-3); Ex. 15, 16, and 17.

81. The "Screening the Dangerous Member" power point identifies that service coordinators may encounter "dangerous" members and "dangerous situation(s)". Ex. 16.

82. In the "Safety in the Community" power point, Integra identifies certain "high risk behaviors" a member may exhibit, including "history of violence or self-harm, substance abuse, verbal threats, criminal behavior, paranoia, suspiciousness, psychosis, confusion." (Prymmer, Tr. 114:17-25; 115:1-9); Ex. 17.

83. Integra expected SCs to identify these "high risk behaviors" while interacting face-to-face with the members; Integra did not take steps to identify whether members exhibited these behaviors before assigning a SC to their file. (Prymmer, Tr. 114:20-25; 115:20-23; 116:6-8; Arnott, Tr. 350-351).

84. These power points demonstrate that Integra recognized that the member posed a hazard of workplace violence against the SCs. (Prymmer, Tr. 110:4-8; 116:21-25; 117:1-5).

85. Rochelle worked at Integra for 5 1/2 months before she took the Neumann training. (Rochelle, Tr. 261).

86. The Neumann training was inadequate. (Rochelle, Tr. 262). It was "a joke" and basic, it did not teach SCs to be "savvy", or about real life safety skills and situations related to the job. (Rochelle, Tr. 262). For example, the training did not teach how to get members to come outside their doorways, or teach SCs not to go into a member's home in certain situations. (Rochelle, Tr. 262).

87. It took Rochelle two days to complete the Neumann Training. (Rochelle, Tr. 264).

88. Annie Hinman, a service coordinator, completed the Neumann Training in only eight hours. (Prymmer, Tr. 119:16-25; 120:1-2).

89. Ellen Elaine Rentz, a service coordinator, did not complete the Neumann Training before being assigned a caseload and going out into the field to do face-to-face visits with members. (Prymmer, Tr. 123:22-25; 124:1-7). (Rentz, Tr. 371). She contacted her supervisor, Rochelle, about the lack of training. (Rentz, Tr. 371). Rochelle told Rentz to call Scott Schneider, one of the other team members. (Rentz, Tr. 371).

90. Rochelle stated in a letter to COO Dee Brown dated December 3, 2012, that "the Neumann training [] was embarrassingly a cut and paste of the SAMSA website and not what service coordinators really need to do their job 'the Integra way." (Prymmer, Tr. 118:11-21; Ex. 14).

91. Rochelle knew that the service coordinators had safety concerns regarding potential violence from members and/or the communities they serviced. (Prymmer, Tr. 133:12-21).

92. Integra provided an employee handbook to service coordinators. (Prymmer, Tr. 120:7-9; Ex. 18).

93. This employee handbook contains one page entitled "Workplace Violence" which generally states that violence by an employer or anyone else against an employee, supervisor or member of management will not be tolerated. (Prymmer, Tr. 122:1-7; Ex. 18, p. 96 of 107).

94. The "Workplace Violence" page of the employee handbook does not identify the specific types of workplace violence to which service coordinators were most likely to be exposed, i.e., violence from a mentally ill member with a history of violent behavior. (Prymmer, Tr. 122:11-14).

95. Some SCs would shadow other more experienced SCs for a day or a few days, but such shadowing was not uniformly required for all new SCs. (Prymmer, Tr. 122:15-25; 123:1-24).

96. Integra did not have a policy regarding the preparation of incident reports. (Rochelle, Tr. 299). Rochelle was not required to prepare an incident report of significant events. (Rochelle, Tr. 299).

97. SCs learned their jobs through "trial and error". (Daniel, Tr. 435). SCs had to figure out a lot of their duties "as they went along". (Schneider, Tr. 455). One SC (Scott Schneider) stated that whenever he asked his supervisors questions, he "never really got an answer." (Schneider, Tr. 456).

98. Neumann training did not cover much, it was basic. It did not help employees do their jobs. (Daniel, Tr. 435)

99. SC Schneider testified that he did not receive safety training prior to [redacted] death. (Schneider, Tr. 456). SC Daniels stated, "I wouldn't consider anything I received safety training". (Daniel, Tr. 436).

100. Integra did not provide safety training to its employees. (Rochelle, Tr. 261).

101. Integra did not provide much information about safety to its employees. (Rentz, Tr. 371). Some computerized safety training, the Neumann Training, was given to SCs online. (Rentz, Tr. 370). It took about 6-9 hours for employees to do the training. There was not a lot of information given to employees about workplace violence. (Rentz, Tr. 370).

102. At the end of the Neumann training, SCs were asked questions that were "totally irrelevant" to the actual instruction modules. (Schneider, Tr. 454).

103. The weekly telephone rounds with Integra medical director Dr. Krajewski ("Dr. K") were not a forum to discuss safety issues. The purpose of the rounds was to get services for the members. They discussed getting members food, housing and medical attention. (Rentz, Tr. 394).

104. There was no support from management in terms of training new employees; the SCs depended upon each other to figure things out. (Schneider, Tr. 487).

105. It was "up in the air" whether Integra would remove a member from the service list if a SC expressed a safety concern about interacting with the client. (Schneider, Tr. 460).

106. During corporate training in September 2012, SCs did not engage in role playing. (Hinman, Tr. 817).

107. There was no real buddy system or partnering for safety reasons. (Rentz, Tr. 382). Kimber Daniel requested a buddy for a home visit and her request was denied because no one was available because everyone was too busy with his or her own caseload. (Daniel, Tr. 439-440)

108. Integra claims it had a "shadowing" program, however, some employees (Rentz and Daniels) were not "shadowed" or partnered with a supervisor or experienced employee when they began working for the company. (Daniels, Tr. 434-435) (Rentz, Tr. 373). Schneider also did not shadow a more experienced SC. (Schneider, Tr. 488).

109. The portion of the Neumann training regarding workplace safety was vague and lacked depth; it offered no "how-tos" or experiential process. (Nelson, Tr. 609).

110. The "shadowing" practiced by Integra, to the extent SCs participated in it, was on-the-job training of the most minimal kind. (Nelson, Tr. 613).

111. The "workplace violence" page in the employee handbook was a general statement which did not adequately prepare SCs to prevent workplace violence. (Nelson, Tr. 608).

112. Integra's failure to provide adequate safety training contributed to the risk of workplace violence. (Nelson, Tr. 614).

113. Integra provided SCs with laptop computers with GPS, but Integra did not use this GPS function for realtime check-in or tracking of the SCs; the intended use of the GPS function was to locate a SC if he went missing. (Arnott, Tr. 1013).

114. On October 16, 2012, SC Andy Macaluso asked Integra if it would provide take-down training and "hands on crisis de-escalation training" because he has had "to transport or visit more than one member who has a history of violence towards others resulting in severe bodily injury." (Macaluso Tr. 505-506, Exhibit 31, p. 1).

115. Prior to [redacted] death, Integra did not teach its SCs any de-escalation techniques. (Nelson, Tr. 613).

116. SC Schneider complained to supervisors Melissa Arnott and Laurie Rochelle about the safety issues he encountered when interacting with members. (Schneider, Tr. 491).

117. SC Schneider told Melissa Arnott about one member on his case list who was violent and aggressive. (Schneider, Tr. 491; Exhibit 29, p. 24). Integra would not remove the member from the case list and he was required to continue to make face to face contact. (Schneider, Tr. 491-492).

118. Integra would not "roll off", i.e., remove from the program, too many members because it would cause the company to lose money. (Schneider, Tr. 492).

119. [redacted] was exposed to a heightened risk of workplace violence due to her inexperience and the fact that she was expected to apply clinical tools she was not qualified to apply. (Nelson, Tr. 601).

120. SCs often worked alone, traveling by car to do home visits with members, which contributes to the risk of workplace violence. (Nelson, Tr. 602).

121. It is particularly dangerous for a SC to do an unscheduled visit to a member's home. (Nelson, Tr. 619).

122. Integra's employees wrongly believed Integra was doing what was necessary to ensure their safety – such as pre-screening members – and was not sending them into a dangerous work environment. (Rentz, Tr. 380 "I didn't say anything to anybody about safety because I assumed we were safe. We were working for a company. I felt I was safe to go out there. They had already done the legwork necessary to make sure they were not sending me into harm's way.") (Schnieder, Tr. 457 "I think I was really naïve, and I believed that the company had my best interest at heart, they properly screened these people, and I never really thought about it, you know.").

SC [redacted] [redacted] Interactions with Assailant [redacted]

123. [redacted] the member who fatally stabbed Integra service coordinator [redacted] was previously incarcerated for aggravated battery with a deadly weapon, aggravated assault with a weapon, and battery against a police officer or first responder. *See* Ex. 25; (Prymmer, Tr. 136:22-25; 137:1-4; 139:6-21).

124. When (b) (b)(6) case was assigned to (b)(6) Amerigroup provided (b) (b) with (b) (b)(6) diagnosis (schizophrenia and cardiovascular disease), his date of birth, and his home address; Amerigroup did not provide Integra or (b)(6) with any information about (b) (b)(6) history of violent behavior. (Arnott, Tr. 357; Ex. 7, p. 1).

125. (b)(6) had three face-to-face interactions with (b)(6) at his home prior to his fatal attack of her on December 10, 2012. (See Ex. 7; Prymmer, Tr. 139-140).

126. After her first visit with (b)(6)(b)(6) on October 12, 2012, (b)(6) reported in her Progress Note Report that (b)(6) "said a few things that made SC uncomfortable, so SC asked member to be respectful or she would not be able to work with him. Because of this situation, SC is not comfortable being inside alone with member and will either sit outside to complete assessment or ask another SC to accompany her." Ex. 7, p. 5.

127. Integra COO Dee Brown, Integra Vice President Melissa Arnott, and Integra manager Laurie Rochelle all read and were aware of (b)(6)(b)(6) comments regarding her interaction with (b)(6) on October 12, 2012. (Prymmer, Tr. 143, 148. Ex. 19). (Arnott, Tr. 356-358).

128. Integra did not assign an employee to go with (b)(6) to visit (b)(6) at any time. (Rochelle, Tr. 278).

129. Referring to this Progress Note Report from October 12, 2012, CSHO Prymmer asked COO Brown what Integra did to ensure that "staffing resources would be made available to address (b)(6)(b)(6) concerns"; (b) Brown responded that "we do not make certain people are doing their jobs. There is an entire team available to accompany someone and if staff feel they are in need of a buddy visit, they arrange it or report to their supervisor so that the supervisor can intervene to assist if they cannot arrange it. Staff are trained not to go alone if they feel they need another person with them." Ex. 19, p. 3-4.

130. After reading (b)(6) progress note report from October 12, 2012, Arnott never asked (b)(6) what made her feel uncomfortable. Arnott did not follow up with Rochelle or (b)(6) to determine how (b)(6) intended to service (b)(6) in the future. (Arnott, Tr. 358-359).

131. Integra did not conduct a safety assessment after (b)(6) described feeling uncomfortable with (b)(6)(b)(6) (Rochelle, Tr. 278).

132. Integra knew that (b)(6) had been prescribed injectable antipsychotic medication. (Arnott, Tr. 360). Integra did not have confirmation from (b)(6) psychiatrist whether (b)(6) was properly monitored and medicated for his schizophrenia. (Arnott, Tr. 360).

133. On October 15, 2012, [redacted] had a second face-to-face visit with [redacted] at his home; [redacted] notes from this visit do not indicate that she had another service coordinator with her, or that she stayed outside of the home during the visit. Ex. 7, p. 6. (Prymmer, Tr. 149:21-25; 150:1-4).

134. During the October 15, 2012 visit with [redacted] notes that "member showed SC a print of the Last Supper, crediting it to Michelangelo. He pointed to the depiction of Jesus and said, 'This is my father.' He pointed to someone else in the picture and said, 'This is me.' He then pointed to a few others in the picture and described them as people in the community, such as the waitress who works down the street, etc. This was also interwoven with conversation about his trespassing charges, people who owe him money, and how he will behave in his upcoming court date." Ex. 7, p. 6.

135. The October 15, 2012 Progress Note Report was reviewed by Integra manager Laurie Rochelle on October 15, 2012. Ex. 7, p. 6. (Prymmer, Tr. 150:5-6).

136. [redacted] told Dr. K about [redacted] strange comments concerning the Lord's Supper. Rochelle saw the strange comments as a red flag. (Rochelle, Tr. 292-93).

137. Rochelle approved the progress notes involving the encounter. (Rochelle, Tr. 293-94).

138. Arnott did not know whether [redacted] took another SC with her when she visited [redacted] on October 15, 2012. Arnott never inquired as to whether [redacted] was following the plan she outlined in her October 12, 2012 progress note report. (Arnott, Tr. 360-61).

139. Integra did not discipline [redacted] for failing to bring another SC with her on her visits to [redacted] (Rochelle, Tr. 285-286).

140. Arnott admitted that [redacted] comments about the Lord's Supper could indicate delusional or paranoid behavior. (Arnott, Tr. 362). Delusions and paranoia are identified in Integra's training as "high risk" behaviors. (Arnott, Tr. 362).

141. On November 14, 2012, [redacted] had a third face-to-face visit with [redacted] at his home; [redacted] notes from this visit do not indicate that she had another service coordinator with her. Ex. 7, p. 7. (Prymmer, Tr. 151:17-20).

142. During the November 14, 2012 visit with [redacted] notes that "Member answered the door and pretended to be his own twin brother" and "Member also told SC to get a cowboy hat and go to a rodeo." Ex. 7, p. 7.

143. Arnott reviewed the November 14, 2012, progress note report prepared by [redacted] Integra did not follow-up with [redacted] to determine whether [redacted] was following

the plan she outlined in her October 12, 2012 progress note report. (Arnott, Tr. 364-365).

144. Arnott claimed to believe that [redacted] notes about [redacted] pretending to be his twin brother indicated that he did not want "to deal with" [redacted] hat day and that [redacted] was "kind of playing" with her. (Arnott, Tr. 365).

145. According to Integra's policy, [redacted] had 30 days from receiving signed consent from [redacted] in which to complete her initial assessment of him. (Arnott, Tr. 366). After two face to face visits, [redacted] still had not completed an initial assessment and had no information about [redacted] history of violent behavior. (Arnott, Tr. 366).

146. During these three face-to-face visits, [redacted] did not perform her "initial assessment" of [redacted] (Prymmer, Tr. 151:14-16). Ex. 7, p. 9.

147. After three face-to-face visits, [redacted] was still unaware of [redacted] history of violent behavior. (Arnott, Tr. 366).

148. On [redacted] next face-to-face visit to [redacted] home, on December 10, 2012, [redacted] attacked [redacted] and stabbed her to death with a knife. (Arnott, Tr. 366).

Previous Incidents of Workplace Violence and/or "Close Calls"

149. Yahaydra Stevens described two incidents in which she was in the car with mentally ill patients who were not taking their medications. She was in the car, along with supervisor Whitney Ferguson, for two hours with a mentally ill member who made her feel uncomfortable. The member was fidgety during the drive. (Stevens, Tr. 419-20). She also recalled driving another member with Ferguson who stated that he was uncomfortable driving with her because of her ethnicity. (Stevens, Tr. 420).

150. Prior to [redacted] death, SC Ellen Rentz visited a member's home to get the member's signature for the Integra consent form. The member was agitated about the timing of the visit. Later, after [redacted] death, Rentz learned that the member had a criminal background that involved a weapons charge. (Rentz, Tr. 376-77, 395).

151. Prior to [redacted] death, a schizophrenic client threatened to assault SC Scott Schneider while Schneider met with him to perform an initial assessment. (Schneider, Tr. 458; Ex. 29, p. 6).

152. Prior to [redacted] death, SC Schneider met with a member whose personality appeared to change quickly. At some point during the meeting, the member grabbed a kitchen knife and began twirling it. (Schneider, Tr. 470; Ex. 29, p. 18). This incident occurred in the member's home. After this meeting, Schneider continued to meet with the member, but conducted the meetings outside the home. (Schneider, Tr. 470).

153. Prior to (b)(6) death, Schneider reported in his progress notes that one of his members had "physically assaulted" her boyfriend; this member "has a serious addiction to meth and becomes violent and thins she is God." (Schneider, Tr. 471-472; Ex. 29, p. 24). Schneider reported to his supervisor, Laurie Rochelle, that this member "scared the bejesus out of me" and he would only meet her in public places; he would not meet her at her home. (Schneider, Tr. 472).

154. Prior to (b)(6) death, SC Scott Schneider was chased by dogs while attempting to contact a member for a face to face visit. (Rochelle, Tr. 267). Rochelle told him not to risk his life. (Rochelle, Tr. 267)

155. Prior to (b)(6) death, Schneider attempted to visit a member who resided in a broken down trailer where there were vicious dogs tied up near the front door. (Schneider, Tr. 495-96). Schneider was concerned about being bitten by the dogs. He reported the situation during round calls to his supervisors. His supervisors told him to continue to go to the home. (Schneider, Tr. 496).

156. Prior to (b)(6) death, SC Annie Hinman conducted several face to face meetings with a member who had burned down his home. (Hinman, Tr. 830-31). She transported the member to provider appointments. During one appointment, the member's therapist asked him if he had homicidal thoughts. The member pointed to Hinman and told the therapist that he had thoughts of wanting to kill Hinman. (Hinman, Tr. 831). Annie Hinman told her supervisor, Laurie Rochelle, that this member admitted to having thoughts of killing her. (Rochelle, Tr. 268). Integra required Hinman to continue servicing this member after the incident. (Hinman, Tr. 832).

157. Prior to (b)(6) death, Andy Macaluso told his supervisor, Rochelle, that he was uncomfortable being alone with a member who had expressed homicidal ideations and had access to a firearm. (Macaluso, Tr. 507, Ex 31, p. 3). Later, the member threatened to kick Macaluso's ass. (Macaluso, Tr. 51-15; Exhibit 31, p. 2). Macaluso informed Integra Vice President Melissa Arnott and supervisor Whitney Ferguson about this incident. (Macaluso, Tr. 515, Ex. 31, p. 2).

158. Arnott admits she was aware that a member verbally threatened Andy Macaluso, but she did not create an incident report on this instance of workplace violence. (Arnott, Tr. 1010).

Employer Recognition of Hazard of Workplace Violence

159. Dr. Melissa Arnott is the Vice-President of Community programs for Integra Health Management. (Arnott, Tr. 340).

160. Arnott supervised the team lead in each location. (Arnott, Tr. 340).

161. Integra defined threatening communications as a type of workplace violence. (Arnott, Tr. 341).

162. Integra's members would say threatening things to SCs "every once in a while." (Arnott, Tr. 343). People do curse. (Arnott, Tr. 343).

163. Arnott stated, "I don't think it's workplace violence if a member is saying, you know, get the F out of here, or I don't F'king like you... That's the normal talk that we... hear sometimes from certain members..." (Arnott, Tr. 343).

164. Arnott admits that "if another SC made the same comments to another SC, [she] would consider that to be a threatening communication or instance of workplace violence." (Arnott, Tr. 343).

165. According to Arnott, SCs decide if they feel threatened by a member's conduct and need to call their supervisors. (Arnott, Tr. 344). It is up to the SC to identify a threatening situation. (Tr. 344).

166. The Neumann training contained a Power Point slide entitled, "Screening the Dangerous Member". (Exhibit 16; Arnott, Tr. 345).

167. Integra recognized that certain members might be dangerous and could present a threat to an SC. (Arnott, Tr. 345).

168. Integra felt it was necessary to instruct SCs on how to identify and assess dangerous members because SCs would be working directly with mentally ill members. (Arnott, Tr. 346).

169. Integra did not provide SCs with information about a member's previous unsafe behavior. (Arnott, Tr. 346). Integra did not require SCs to obtain this information. (Arnott, Tr. 346).

170. Integra did not make the buddy system mandatory; it only "suggested" the use of the buddy system. (Arnott, Tr. 347-48).

171. The Neumann Training included information about certain high risk behaviors that a Service Coordinator should be looking for in its members. (Arnott, Tr. 349). The training listed the high risk behaviors as a history of violence or self-harm, paranoia, suspiciousness, psychosis, confusion, substance abuse, hopelessness, verbal threats, lack of future plans, and criminal behavior. (Arnott, Tr. 349; Exhibit 17).

172. SCs were required to identify these behaviors while doing their initial assessment of the member. (Arnott, Tr. 349). These behaviors are included on Integra's official assessment form. (Arnott, Tr. 349).

173. Integra relied on members to self-report their criminal behavior, mental state, and history of violence. (Arnott, Tr. 350).

174. Integra required SCs to correctly identify high risk behaviors of the members they serviced. SCs were expected to find out about issues like antisocial personality, head injury, family history of violence, history of impulsive behavior, noncompliance, loud manic behavior, and possession of weapons. (Arnott, Tr. 350).

175. Integra recognized that members might have criminal histories, including felony convictions. (Arnott, Tr. 352).

176. Integra left it up to the SCs to determine if they needed a buddy for safety reasons. (Arnott, Tr. 353). Integra did not routinely assign buddies to SCs and had no written procedure for requesting a buddy. (Arnott, Tr. 354).

177. Prior to (b)(6) death, Integra in Pennsylvania had a policy of partnering two SC's for each visit. (Arnott, Tr. 354-55).

178. Arnott supervised the team leads and reviewed and approved progress notes. (Arnott, Tr. 356).

Industry Recognition of Hazard of Workplace Violence

179. Integra is a part of the social services/healthcare industry. (Prymmer, Tr. 160; Nelson, Tr. 1103-1104).

180. Workplace violence is a recognized hazard in the social services/healthcare industry. (Prymmer, Tr. 161; Nelson, Tr.555-557, 575, 605; Ex. 32 and 33).

181. Violence against social service workers and home healthcare providers is a well-recognized problem in this industry. (Prymmer, Tr. 362; *see* Ex. 32, p. 44-46).

182. Social service workers, such as Integra's service coordinators, are particularly at risk of violence because they work with volatile, unstable people; they work alone or in isolated areas; they provide in-home care and services; and they may work at night and in areas with high crime rates. (Ex. 33, p. 8; Nelson, Tr. 605-606).

183. OSHA recognizes "healthcare and social service settings" as an industry in which workers are at high risk of workplace violence. Ex. 32 and 33, p. 10.

Feasible Abatement

184. OSHA has published a directive regarding workplace violence listing a series of potential methods to abate workplace violence, both generally and in the social services industry. (Prymmer, Tr. 164; Ex. 33, p. 29-34).

185. The abatement methods listed in OSHA's directive are based on studies indicating that using any combination of listed abatement methods may materially reduce or eliminate the hazard of workplace violence. (Prymmer, Tr. 164; Ex. 33, p. 29, 36-38).

186. The proposed abatement found in Citation 1, Item 1, was gleaned from the OSHA directive and lists effective methods for abating the hazard of workplace violence that are applicable to Integra. (Prymmer, Tr. 165, Ex. 33, p. 33-38; Nelson, Tr. 672-673).

187. If an employer is serving seriously mentally ill individuals that may have criminal backgrounds, it is advisable to conduct background checks before allowing employees to enter their home. (Nelson, Tr. 722).

188. Lost cost methods of abatement for preventing workplace violence to SCs include: establishing a safety committee; assigning the committee to write field safety procedures; developing safety plans and practice them; assigning clients/caseloads considering client risk, race, gender, language and culture; having home visit itineraries and call-in requirements to monitor location of employees; establishing a system to communicate to employees all incidents of threats or violence; developing code words to indicate when there is a problem; supplying employee training in de-escalation and self-defense. (Nelson, Tr. 644-666; Ex. 27, p. 12).

189. Integra could have feasibly implemented any or all of the safety measures outlined above prior to December 10, 2012. (Nelson, Tr. 666).

190. Criminal background checks are often available on-line; in Florida, the Department of Corrections has a free on-line database that can be searched by name. (Nelson, Tr. 617).

191. Social service workers may partner with local law enforcement to discover relevant criminal background of members before interacting directly with the members. (Nelson, Tr. 617).

192. Knowing a member's criminal history may reduce the risk of violence. (Nelson, Tr. 675)

193. Training in self-defense – including de-escalation and non-harming escape techniques – is an effective method of abating the hazard of workplace violence against social service workers. (Nelson, Tr. 675, 1094-1095).

194. Integra begin performing background checks and "red-flagging" certain members in the system after [redacted] death. (Rentz, Tr. 389) (Prymmer, Tr. 160, 166).

195. Integra now "rolls off" members whose criminal backgrounds indicate a history of violent behavior. (Prymmer, Tr. 160, 166-167).

196. Integra has "rolled off" at least eight members because their criminal histories indicated that they were too dangerous to service. (Prymmer, Tr. 160).

197. After [redacted] death, Integra updated the safety training it provides to SCs.

198. After [redacted] death, SCs discussed safety concerns with Dr. K at rounds meeting. (Schneider, Tr. 484).

199. After [redacted] death, Integra created a written workplace violence prevention program. (Prymmer, Tr. 166).

200. On or about May 1, 2013, Integra provided de-escalation training called "CPI" to its service coordinators. (Macaluso, Tr. 521-522, 525; Nelson, Tr. 676).

V. ARGUMENT

Congress enacted the Occupational Safety and Health Act (the Act), 29 U.S.C. § 651 et seq., in response to millions of workplace accidents and occupational illnesses, which it found excessively costly, in terms of both dollars and of human suffering. *National Realty and Constr. Co. v. OSHRC and Secretary*, 489 F.2d 1257, 1260-61 & n. 7 (D.C. Cir. 1973). The goal of the Act is to prevent the first injury that might result from unsafe conditions. *Mineral Indus. & Heavy Constr. Co. v. OSHRC*, 639 F.2d 1289, 1294 (5th Cir. 1981).

A. The Secretary has established each element of Citation 1, Item 1, which alleges a Section 5(a)(1) violation.

In Citation 1, the Secretary cites Integra for violating Section 5(a)(1) of the Occupational Safety and Health Act of 1970, as amended (the "Act"), which provides:

> (a) Each employer –
>
> (1) shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees;

29 U.S.C. § 654(a)(1). Under Commission precedent, a citation alleging a violation of Section 5(a)(1) – "the general duty clause" – is appropriate only when a specific OSHA standard does not apply to the facts. *Waldon Health Care Center*, 16 BNA OSHC 1052, 1060, 1993 WL 119662 (No. 89-2804, 1993). There is no dispute here that no specific OSHA standard applies to the facts of this case.

To establish a violation of Section 5(a)(1), the Secretary must prove that (1) a condition or activity in the employer's workplace presented a hazard to employees, (2) the cited employer or the employer's industry recognized the hazard, (3) the hazard was causing or likely to cause death or serious physical harm, and (4) feasible means existed to eliminate or materially reduce the hazard. *Id.* at 1058 (citing *Kastalon, Inc.*, 12 BNA OSHC 1928, 1931 (Nos. 79–3561, 1986) (consolidated); *Pelron Corp.*, 12 BNA OSHC 1833, 1835 (No. 82–388, 1986)).

1. Existence of a hazard

"A 'hazard' is defined in terms of conditions or practices deemed unsafe over which an employer can reasonably be expected to exercise control." *Valley Interior Systems, Inc.*, 21 BNA OSHC 2224, 2007 WL 2127305 at *3 (No. 06-1395, 2007) (*citing Morrison-KnudsenCo./Yonkers Contacting Co., A Joint Venture*, 16 BNA OSHC 1105, 1121 (No. 88-572, 1993)). "There is no requirement that there be a 'significant risk' of the hazard coming to fruition, only that if the hazardous event occurs, it would create a 'significant risk' to employees." *Id.* "A 'hazard' has been defined to mean 'a condition or practice in the workplace' which introduces an element of danger into the work environment." *Foseco, Inc.*, 10 BNA OSHC 1949, 1982 WL 22452 at *13 (No. 81-944, 1982) (citing *Empire–Detroit Steel Div., Detroit Steel Corp. v. OSHRC*, 579 F.2d 387 (6th Cir. 1978)).

The Secretary must show that the cited condition actually poses a hazard to employees, but "[t]here is no mathematical test to determine whether employees are exposed to a hazard

under the general duty clause." *Waldon Healthcare Center*, 1993 WL 119662 at *11 (citing *National Realty & Constr. Co. v. OSHRC*, 489 F.2d 1257, 1265 n. 33 (D.C. Cir. 1973)). "Rather, the existence of a hazard is established if the hazardous incident can occur under other than a freakish or utterly implausible concurrence of circumstances." *Waldon Healthcare Center*, 1993 WL 119662 at *11. In establishing that a hazard presents a significant risk to employees, the Secretary is not required to show that previous injuries or deaths from the hazard occurred; the goal of the Act is to prevent the first accident. *See American Phoenix, Inc.*, __ BNA OSHC __ (No. 11-2969, Mar. 13, 2014) ("The goal of the Act is to prevent the first accident, not to serve as a source of consolation for the first victim or his survivors.") (citing *Mineral Industr. & Heavy Constr. Group,* 639 F.2d at 1294 (which also stated that "no proof of specific instances where employees were exposed to the hazardous condition is necessary to support the finding of a violation")); *Waldon Healthcare Center*, 1993 WL 119662 at *10 ("Since the goal of the Act is to prevent the first accident, [] the absence of any recorded case of HBV transmission from nursing home resident to nursing home employee is not dispositive.") (citation omitted).

In this case, the cited condition is the hazard of a service coordinator being physically assaulted by a member with a history of violent behavior. The evidence amply establishes the existence of this hazard. First, the evidence establishes that Integra's operations in Florida were geared towards members who suffered from chronic mental illness, and that many of these members possessed criminal records and histories of substance abuse. (Prymmer, Tr. 89, 133; Rochelle, Tr. 247, 252; Stevens, Tr. 417-18; Snyder, Tr. 451). Many members were not compliant with their doctor's orders or their prescriptions. (Daniel, Tr. 437-38; Stevens, Tr. 416). In addition, the evidence establishes that many members, including the member who attacked and fatally stabbed [redacted] had histories of violent behavior which included physical assaults,

batteries, and armed robbery. (Ex. 25; Prymmer, Tr. 136-137, 139; Rochelle, Tr. 258; Daniel, Tr. 436). Integra required employees in the service coordinator position to conduct face-to-face visits at these members' homes, and to transport members to hospitals and other appointments in their personal vehicles. (Rochelle, Tr. 255; Rentz, Tr. 369; Schneider, Tr. 452, 462; Stevens, Tr. 417; Hinman, Tr. 809). Often, visiting members meant traveling into dangerous neighborhoods or homeless shelters. (Rentz, Tr. 374; Daniel, Tr. 436-437; Rochelle, Tr. 251). The fact that most members suffered from mental illness does not necessarily mean that all members possessed violent tendencies, but service coordinators had reported to management that certain members made them uncomfortable. (Arnott, Tr. 1010). Several "close calls" had occurred, during which members behaved belligerently or aggressively towards service coordinators. (Schneider, Tr. 458; Ex. 29, p. 6; Schneider, Tr. 470; Ex. 29, p. 18; Schneider, Tr. 471-472; Ex. 29, p. 24; Hinman, Tr. 831; Rochelle, Tr. 268; Macaluso, Tr. 507, Ex 31, p. 3). The company's own training concedes that employees may occasionally deal with "dangerous" members and dangerous situations. (Prymmer, Tr. 108:1-3; Ex. 15, 16, and 17). Furthermore, the evidence establishes that service coordinators themselves were inexperienced and did not possess the skills necessary to accurately assess a member's propensity for violence. (Nelson, Tr. 590-593, 1097-1100; Ex. 34). Under these circumstances, violence resulting in serious injury to a service coordinator would not require "a freakish or utterly implausible concurrence of circumstances." See *Waldon* at *11.

In *Megawest Financial, Inc.*, the only previously litigated case alleging a violation of the general duty clause on the basis of workplace violence, the Court found that the hazard of violence against the staff of an apartment complex by one of its tenants was present "[b]ecause the responsibilities of the office staff led to adversarial relationships with the tenants, the staff

was not trained to diffuse anger, the residents often directed intimidating threats or conduct towards the staff, that conduct was not sanctioned, and [] there were no positive measures in effect to discourage attacks."[1] *Megawest Financial Inc.*, 17 BNA OSHC 1337 (No. 93-2879, 1995). Based on this evidence, the Court held that "a future violent incident leading to serious physical harm was neither freakish nor implausible." *Id.* Similarly, the evidence in this case establishes that service coordinators' work regularly placed them alone in crime-prone neighborhoods, that members were known to behave erratically and had previously been actively hostile towards the service coordinators, that many members were mentally ill and had histories of violent and/or criminal behavior, and that service coordinators were not adequately trained or experienced to prevent or anticipate acts of violence. Accordingly, the Secretary has established that the hazard existed as cited.

Indeed, on December 10, 2012, Integra service coordinator [redacted] was attacked and stabbed to death by [redacted] a schizophrenic member with a criminal history including aggravated battery with a deadly weapon and aggravated assault with a weapon, while she was performing a visit to his home. Clearly, the evidence establishes that [redacted] was exposed to the hazard of being physically assaulted by a member with a history of violent behavior, as alleged in Citation 1, Item 1.

2. Recognition of the hazard

A hazard is deemed "recognized" when the potential danger of a condition or practice is either actually known to the particular employer or generally known in the industry. *Pepperidge Farm, Inc.*, 17 BNA OSHC 1993, 2003 (No. 89-0265, 1997); *Kansas City Power & Light Co.*,

[1] Although she found that the hazard of workplace violence did exist in *Megawest*, Judge Spies ultimately decided that the hazard of workplace violence was not recognized by either the employer or the relevant industry (i.e., apartment leasing offices), and that therefore a violation of the general duty clause had not been established. As set forth in Section 2, *infra*, the facts of *Megawest* relevant to recognition of the hazard are clearly distinguishable from the facts of this case. Moreover, *Megawest* is an unreviewed ALJ decision with no precedential value for the Commission.

10 BNA OSHC 1417 (No. 76-5255, 1982). In this case, both Integra and the general industry of social service and healthcare workers recognize the risk of workplace violence.

a. ***Integra's Recognition of the Hazard***

The evidence establishes that Integra recognized the hazard of violence against service coordinators from the members they served. Integra's own training and handbook identified the hazard and Integra's managers knew that many members suffered from mental illness and substance abuse issues, that many members had criminal histories, and that members had previously behaved aggressively or violently towards service coordinators.

Employer recognition of a hazard can be established by evidence of safety precautions taken by the employer in conjunction with other evidence, such as warnings by or to company personnel regarding existence of a hazard. *See Ted Wilkerson Inc.*, 9 BNA OSHC 2012, 2016, 1981 CCH OSHD ¶ 25,551, p. 31,856 (No. 13390, 1981) (employer's work rule establishes recognition of hazard under general duty clause); *St. Joe Minerals Corp. v. OSHRC*, 647 F.2d 840 (8th Cir. 1981) (actual knowledge of a hazard may be gained by means of prior accidents, prior injuries, employee complaints, and warnings communicated to the employer by an employee.) As the Commission stated in *Beverly Enterprises, Inc.*, 19 BNA OSHC 1161, 2000 WL 34012177 at *28 (No. 91-3144, 2000):

> While an employer's safety precautions alone do not establish that the employer believed that those precautions were necessary for compliance with the Act, *Wheeling-Pittsburgh Steel Corp.*, 16 BNA OSHC 1218, 1221-22, 1993-95 CCH OSHD ¶ 30,050, p. 41,291 (No. 89-3389, 1993), precautions taken by an employer can be used to establish hazard recognition in conjunction with other evidence. *Waldon*, 16 BNA OSHC at 1061-1062, 1993-95 CCH OSHD at p. 41, 154-55 and cases cited therein. Moreover, as the Commission observed in *Pepperidge Farm*, 17 BNA OSHC at 2007, 1995-97 CCH OSHD at p. 44,018, warnings by or to company personnel regarding the existence of a hazard are more persuasive on the issue of recognition than purely voluntary safety precautions..

Integra clearly recognized that members could pose a threat of violence to the service coordinators. Section 8 of the Neumann Training provided to new service coordinators outlines the risks of working with "dangerous members" (Ex. 16); the assessment form used by service coordinators asks members to assess the members for traits and behaviors identified as creating a "high risk" for violence (Ex. 17 and Ex. 34); the employee handbook identifies "workplace violence" as a potential hazard (Ex. 18, p. 96); and Integra instructed its service coordinators to consider bringing a "buddy" with them if they "suspect that there is potential danger," (Ex. 16, p. 4), despite the fact that the service coordinators categorically did not have the training or experience to make such determinations. As such, Integra's own training, handbook, and existing policies establish that it recognized that its service coordinators were exposed to the hazard of workplace violence. (Prymmer, Tr. 110:4-8; 116:21-25; 117:1-5).

Moreover, the evidence establishes that, prior to the fatal attack on (b)(6) Integra managers were aware of several instances of violence or aggression by members against service coordinators. In particular, service coordinators Andy Macaluso, Scott Schneider, and Annie Hinman had all reported to their supervisors particular instances in which members acted aggressively, threateningly, or so strangely as to raise safety concerns. (Schneider, Tr. 458; Ex. 29, p. 6; Schneider, Tr. 470; Ex. 29, p. 18; Schneider, Tr. 471-472; Ex. 29, p. 24; Hinman, Tr. 831; Rochelle, Tr. 268; Macaluso, Tr. 507, Ex 31, p. 3). This prior history of workplace violence clearly put Integra on notice that its employees were exposed to the hazard of workplace violence.

A reasonable inference from the evidence also establishes that Integra indeed recognized that (b)(6) presented a specific threat to the victim, (b)(6) Integra performed no

background check on [redacted] to determine if he possessed violent tendencies,[2] and took no action when the victim's progress note reports described her discomfort and his alarming, delusional behavior. (Rochelle, Tr. 278). The victim noted that the member made her so "uncomfortable" that she did not want to be alone in his house with him. (Ex. 7, p. 5). She stated that she planned to bring another individual with her on the next visit or to remain outside the member's home. (Id.) Although Integra managers admit to reading this note, Integra took no steps to assess the risk posed by [redacted] and made no follow-up to ensure that [redacted] took either measure she outlined to protect her safety. (Prymmer, Tr. 143, 148; Ex. 19; Arnott, Tr. 356-359; Rochelle, Tr. 278). Integra also did not discipline [redacted] for failing to bring a partner on her subsequent visits to [redacted] and/or for failing to remain outside his home. (Rochelle, Tr. 285-286). Integra made no inquiries into whether the victim's interactions with the assailant had improved or changed since her initial visit. (Arnott, Tr. 358-359, 364-365). Thereafter, [redacted] performed three additional face-to-face visits with [redacted] (See Ex. 7; Prymmer, Tr. 139-140). During these visits, [redacted] notes indicate that [redacted] exhibited behaviors that could indicate delusional or paranoid behavior. (Arnott, Tr. 362). Delusions and paranoia are identified in Integra's training as "high risk" behaviors. (Arnott, Tr. 362). [redacted] progress note reports, accordingly, would have caused Integra to recognize that she was exposed to the hazard of workplace violence. On her fourth face-to-face visit to [redacted] home, on December 10, 2012, [redacted] attacked [redacted] and stabbed her to death with a knife. (Arnott, Tr. 366).

Respondent may contend that working in close contact with persons with mental illness, substance abuse issues, and/or histories of violent behavior does not necessarily present a

[2] A simple search of [redacted] name on the Florida Department of Corrections website would have shown that he had an existing criminal history including aggravated battery with a deadly weapon and aggravated assault. (Ex. 25; Prymmer, Tr. 136-137, 139).

recognized hazard to its employees, because of the difficulty of predicting the criminal behavior of non-employees. Respondent may seek to rely upon *Megawest Financial Inc.*, 17 BNA OSHC 1337 (No. 93-2879, 1995), in support of its position. *Megawest* is an unreviewed ALJ decision with no precedential value for the Commission. In that case, Judge Spies vacated a § 5(a)(1) citation where the alleged recognized hazard was workplace violence inflicted on apartment complex management personnel by tenants of the apartment complex. In vacating the citation, Judge Spies states:

> In the past, employers have been required to reduce hazards they could anticipate and reduce or eliminate. The problem with predicting workplace violence is the unpredictability of human behavior. In this case, the Secretary is asking Megawest to predict the criminal behavior of non-employees. Additionally, the anger and frustration that drives a resident to become violent may be fueled by a variety of factors.

Id. at 1341.

Megawest is distinguishable from this case for several reasons. First, unlike the employer in *Megawest,* the evidence establishes that Integra did actually recognize the hazard of violence by one of its members against its employees. As part of the training for new service coordinators (called "the Neumann training"), Integra identified certain dangers that employees might face in the execution of their duties, including "Screening the Dangerous Member," "Risk Factors," and "High Risk Behaviors." Second, several employees – including the victim [redacted] – had informed management that certain clients' behavior made them feel uncomfortable or unsafe. Furthermore, unlike the leasing-office workers in *Megawest* who interacted in an office setting with residents similar to members of the general public, the service coordinators interacted daily with a population known by Integra to be mentally ill and substance abusers, and many of which had a violent criminal record. In addition, service coordinators traveled, usually alone, to these members' homes and communities to meet with them; they were not meeting them in the

relatively secure and stable environment of an office. While the behavior of such members is still "unpredictable" in a specific sense, Integra clearly recognized that violence by one of these individuals was a hazard and cannot credibly deny having such recognition. *See SeaWorld of Florida, LLC v. Perez*, 748, F.3d 1202, 1209 (D.C. Cir. 2014) (dismissing SeaWorld's argument that close contact with whales "was not a recognized hazard because all whales behave differently", explaining that "even though SeaWorld had not recorded incident reports on all of its killer whales, a substantial portion of SeaWorld's killer whale population had at least one reported incident" and that "SeaWorld management personnel, including corporate curators of animal training, [] described the need for caution around killer whales generally, not only around certain killer whales").

b. Industry Recognition of the Hazard

Integra's industry recognizes the hazard of workplace violence against employees. The Commission and courts have held that expert testimony and other sources such as industry publications and standards can demonstrate that the hazard is recognized in the employer's industry. *American Phoenix*, supra (citing decisions that recognize ANSI standards reflect industry consensus).

A relevant expert's testimony is sufficient evidence in and of itself to establish that a particular industry recognizes a hazard. *See Kelly Springfield Tire Co., Inc. v. Donovan*, 729 F.2d 317, 322 (5th Cir. 1984) (holding that expert testimony established recognition of hazard); *National Realty*, 489 F.2d at 1265 n.32 (holding that recognition standard centers on "the common knowledge of safety experts who are familiar with the circumstances of the industry or activity in question."). In this case, the testimony of Janet Nelson, recognized by the Court as an expert in "personal safety skills and safety programs for health and human service workers"

(Nelson, Tr. 584), establishes that the social services industry recognizes that workplace violence is a known hazard. (b) Nelson testified that, in the past ten years, several high profile murders of social service workers have raised awareness within the industry of the hazards faced by social service workers. (Nelson, Tr. 555-556). (b) Nelson has dedicated the majority of her career to teaching self-defense and safety skills to social service and other community outreach workers, and has been hired by multiple chapters of the National Association of Social Workers across the nation to teach these skills. (Nelson, Tr. 558-561).

In addition to (b) Nelson's testimony, the Secretary presented evidence of multiple industry publications recognizing the hazard of workplace violence in the social services and home healthcare industry. Specifically, the OSHA directive on workplace violence (Exhibit 33), and the OSHA publication offering Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (Exhibit 32), both list multiple publications within the social services and healthcare industry addressing the recognized hazard of workplace violence. [3]

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[3] OSHA, in its Violation Worksheet entered as Exhibit 6, also identified the following publications as evidence of the industry's recognition of the hazard of workplace violence:

- OSHA Publication 3148-11R 2004 Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
- OSHA Workplace Violence Factsheet
- NIOSH Publication No. 2001-101, Violence: Occupational Hazards in Hospitals
- NIOSH Publication No. 2006-144, Workplace Violence Prevention Strategies and Research Needs
- NIOSH Publication No. 2004-100D (DVD), Violence on the Job
- NIOSH Publication No. 2002-101, Violence Occupational Hazards in Hospitals
- NIOSH Publication No. 96-100, Violence in the Workplace
- NIOSH Publication No. 93-109, Preventing Homicide in the Workplace
- NIOSH Publication No. 92-103, Homicide in U.S. Workplaces: A Strategy for Prevention and Research
- FBI Workplace Violence: Issues In Response
- Journal of Teaching Social Work (2000) "Encountering Violence in Field Work: A Risk Reduction Model"
- The Journal of Baccalaureate Social Work (2001) "The Power of Collaboration: Developing a safety training program for student interns"

(*See* Ex. 32, p. 25 and 44-46; Ex. 33, p. 36-38). Both of these documents explain that social service workers are particularly susceptible to the hazard of workplace violence because they work with volatile, unstable people; work alone or in isolated areas; provide in-home services and care; and work late at night or in areas with high crime rates. (Ex. 32, p. 8-9; Ex. 33, p. 8).

Courts and the Commission have also looked to industry standards and guidelines to determine whether a particular industry recognizes the hazard cited. *See Bethlehem Steel Corp. v. OSHRC & Marshall*, 607 F.2d 871 (3d Cir. 1979) (safety officer admitted that advisory ANSI standard represented industry consensus); *Betten Processing Corp.*, 2 BNA OSHC 1724 (No. 2648, 1975) (holding judge erred in failing to consider ANSI standard as evidence of industry recognition). "Where a practice is plainly recognized as hazardous in one industry, the Commission may infer recognition in the industry in question." *Arcadian Corp.*, 20 BNA OSHC 2001, 2997, 2004-2009 CCH OSHD ¶ 32,756, p. 52,074 (No. 93-0628, 2004) (citing *Kelly Springfield*, 729 F.2d at 317). The evidence establishes that the National Association of Social Workers has published a set of "Guidelines for Social Worker Safety in the Workplace."[4] These Guidelines address the hazard of workplace violence specifically for social workers, and set forth

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- Journal of Social Work Education (2008) "Developing Student Knowledge and Skills for Home Visiting"
- The New Social Worker (2011) "Tips for Making Home Visits"
- The Clinical Supervisor (2007) "Home Visits in a Violent World"
- Social Work (2005) Conflict in the workplace: Social workers as victims and perpetrators"
- Social Work (2003) "Client Violence Toward Social Workers: The role of management in community mental health programs"
- The Provider (2008) The need to make safety a priority"
- Archives of General Psychiatry (2009) "The Intricate link between violence and mental disorder"

See Exhibit 6, p. 8.

[4] The Secretary's expert, Janet Nelson, contributed to the creation of these industry guidelines. (Nelson, Tr. 588, 723).

suggested methods of abatement, many of which were also recommended in this case by OSHA and (b) Nelson. (Nelson, Tr. 723-730).

Respondent may argue that service coordinators are not trained social workers and, therefore, the NASW guidelines and other industry publications relevant to social service workers do not establish recognition of the hazard by Integra's industry. The evidence establishes, however, that Integra's service coordinators, despite their lack of formal training, perform the work of social workers. (Nelson, Tr. 590-593, 599, 1097-1100, 1103-1104; Ex. 34). Furthermore, it is beyond dispute that the service coordinators work under conditions recognized by the social service industry as creating a higher risk of workplace violence; namely, the service coordinators, like many social service workers, work with volatile, unstable people; work alone or in isolated areas; provide in-home services and care; and work late at night or in areas with high crime rates.[5] Accordingly, regardless of which "industry" Integra claims to belong to, because the conditions of the service coordinators' work are plainly recognized by the social work industry as creating the hazard of workplace violence, the Court should "infer recognition [of the hazard] in the industry in question." *Arcadian Corp.*, 20 BNA OSHC 2001 at *11.

3. The hazard is causing or likely to cause death or serious physical harm

To prove a 5(a)(1) violation, the Secretary must show that the alleged hazard was causing or likely to cause death or serious physical harm. In determining whether employee exposure exists, the Commission has held that the Secretary must prove that "employees either while in the course of their assigned working duties, their personal comfort activities while on the job, or their normal means of ingress-egress to their assigned workplaces, will be, are or have been in a zone of danger." *Fabricated Metal Products, Inc.*, 18 O.S.H. Cas. (BNA) 1072 (No. 93-1853,

[5] Indeed, (b) Nelson testified that the service coordinator's lack of formal social work training actually increases their risk of workplace violence, because they lack the experience and clinical knowledge necessary to adequately assess a member's propensity towards violence. (Nelson, Tr. 1100).

1997) (citing *Gilles & Cotting, Inc.*, 3 BNA OSHC 2002 (No. 504, 1976)). *See also Con Agra Flour Milling Co.*, 16 O.S.H. Cas. (BNA) 1137 (No. 88-1250, 1993) ("[t]he Commission's test for determining access is whether in the course of the employee's duties, it is 'reasonably predictable' that they will be, are or have been in a 'zone of danger'") (citations omitted).

This case involves the violent killing of one of Integra's employees, [redacted] by a member with a history of violent behavior. This tragic event establishes that the hazard of work place violence caused the threat of serious physical harm or death.

4. The Secretary's proposed abatement is feasible and will eliminate or materially reduce the cited hazard.

The final element in establishing a general duty clause violation is the Secretary's showing that the proposed abatement will "eliminate or materially reduce the hazard." *Cardinal Operating Company*, 11 BNA OSHC 1675 (No. 80-1500, 1983). "The proposed method of abatement is judged by what a reasonable person familiar with the conditions of the industry would have instituted." *Valley Interior Systems, Inc.*, 2007 WL 2127305 at *7. "Feasible means of abatement are established if 'conscientious experts, familiar with the industry' would prescribe those means and methods to eliminate or materially reduce the recognized hazard." *Arcadian*, 20 BNA OSHC 2001 at *13 (quoting *Pepperidge Farm, Inc.*, 17 BNA OSHC 1993, 2032 (No. 89-0265, 1997)). "[T]he Secretary need only show that the abatement method would materially reduce the hazard, not that it would eliminate the hazard." *Morrison-Knudsen*, 16 BNA OSHC at 1122.

In the Citation item, the Secretary proposes that Respondent could abate the hazard of workplace violence through (1) implementing a written workplace violence prevention program

containing specified elements[6]; (2) determining the behavioral history of new/transferred members and establish a system – such as a chart, log book, or report – to identify members with assaultive behavior problems and to communicate such information to all potentially exposed employees; (3) establishing procedures for communicating any incident of workplace violence to all staff; (4) updating and overhauling the safety training; (5) implementing a buddy system as appropriate based upon a complete hazard assessment which includes procedures for all staff to request and obtain double coverage when necessary; (6) providing all staff with a reliable way to rapidly summon assistance when needed; and (7) establishing a liaison with law enforcement representatives. (Ex. 1, p. 6-8). CSHO Prymmer testified that he developed the list of proposed abatement from the OSHA directive itself, which lists engineering and administrative controls shown to minimize the risk of workplace violence within the healthcare and social services industries. (Prymmer, Tr. 165; Ex. 33, p. 33-38). He further explained that "the more robust [workplace violence prevention] program you have, a written comprehensive program, the lower incidence of workplace violence you're exposed to." (Prymmer, Tr. 164). (b) Nelson, recognized by the Court as an expert in "personal safety skills and safety programs for health and human service workers", testified that performing background checks, implementing certain administrative and engineering controls,[7] and providing employee training in de-escalation and non-harming self-defense techniques, would be low-cost to Integra and would materially reduce the risk of workplace violence. (Nelson, Tr. 617, 644-666, 675, 1094-1095; Ex. 27, p. 12). She also testified that the abatement recommended by OSHA was feasible and would materially

[6] These elements are set forth in the Citation itself.
[7] Examples of such controls include establishing a safety committee; assigning the committee to write field safety procedures; developing safety plans and practice them; assigning clients/caseloads considering client risk, race, gender, language and culture; having home visit itineraries and call-in requirements to monitor location of employees; establishing a system to communicate to employees all incidents of threats or violence; and developing code words to indicate when there is a problem.

reduce instances of workplace violence. (Nelson, Tr. 672-673). This portion of (b) Nelson's testimony was unchallenged by Integra, which provided neither lay nor expert opinion testimony claiming that these abatement measures were infeasible or would not reduce the hazard of workplace violence.

Indeed, since the death of (b)(6) Integra has implemented several of the abatement methods proposed by OSHA. For example, Integra has created a written workplace violence prevention program which includes some of the above-referenced administrative and engineering controls. (Prymmer, Tr. 166-167). Integra began performing background checks and "red-flagging" certain members in the system after (b)(6) death. (Rentz, Tr. 389; Prymmer, Tr. 160, 166). Integra now "rolls off" members whose criminal backgrounds indicate a history of violent behavior, and has "rolled off" at least eight members because their criminal histories indicated that they were too dangerous to service. (Prymmer, Tr. 160, 166-167). On or about May 1, 2013, Integra provided de-escalation training called "CPI" to its service coordinators. (Macaluso, Tr. 521-522, 525; Nelson, Tr. 676). Accordingly, the evidence establishes that many of the measures outlined by OSHA, including background checks of new clients and more robust training, are reasonable to implement, are economically and technologically feasible, and materially reduce the instances of workplace violence.

Integra may claim that its existing policies and procedures were sufficient to address the hazard of workplace violence. *See Waldon*, 16 BNA OSHC at1063 ("[T]he employer may defend against a general duty clause citation by demonstrating that it was using an abatement method that is as effective as the one suggested by the Secretary."). However, the evidence established that Integra's safety training program was inadequate and it did not have or enforce a workplace violence prevention program. Prior to (b)(6)(b)(6) death, Integra's policies establish

that it was *aware* of the hazard of workplace violence, but they fail to provide enforceable work rules or administrative or engineering controls which could adequately prevent workplace violence. The evidence establishes that, before (b)(6)(b)(6) death, Integra attempted to shift its own responsibilities for safety to its employees by instructing its service coordinators to leave a situation "if [they] feel there is any risk" or to bring a "buddy" if they "suspect that there is potential danger." (Ex. 16, p. 2 and 4). Integra may claim that this instruction – which was part of the on-line Neumann training power points – sufficiently protected its employees from exposure to workplace violence. This argument, however, must fail because Integra's entire "safety program" was dependent upon the service coordinator's accurate assessment and identification of potential danger. (Prymmer, Tr. 111). Further, service coordinators testified that they felt pressured by management to complete the goals of making face to face contact with members in unrealistic time frames, regardless of the workplace conditions. (Schnieder, Tr. 494; Daniel, Tr. 436; Rochelle, Tr. 269). (b) Nelson also testified that service coordinators, because they were not clinically trained or experienced in working with mentally ill patients, were ill-equipped to make the type of "assessment" of a member that would reasonably predict his propensity towards violence. (Nelson, Tr. 1099-1100). Integra's reliance on its service coordinators to recognize potential danger and thereby prevent violent behavior by the members runs counter to the requirements of the Act. *See Sea World of Florida, LLC*, 24 O.S.H. (Cas.) BNA 1303 (2012), *affirmed by SeaWorld of Florida, LLC*, 748, F.3d 1202 (stating that employer's reliance on employees to recognize precursors and prevent unpredictable behavior is inconsistent with the requirements of the Act). "The duty to comply with section 5(a)(1), however, rests with the employer. An employer cannot shift this responsibility to its employees

by relying on them to, in effect, determine whether the conditions under which they are working are unsafe." *Armstrong Cork Company*, 8 BNA OSHC 1070, 1074 (No. 76-2777, 1980).

B. **The Secretary has established each element of Citation 2, Item 1, which alleges a violation of 29 C.F.R. § 1904.39(a).**

The regulation at Section 1904.39(a) provides that "within eight (8) hours after the death of any employee from a work-related incident . . ., you must orally report the fatality [] by telephone or in person to the Area Office of the Occupational Safety and Health Administration (OSHA), U.S. Department of Labor, that is nearest to the site of the incident." It is undisputed that [redacted] an employee of Respondent, was fatally injured from a work-related incident on December 10, 2012. It is also undisputed that Respondent did not report the fatality to OSHA at all. (Prymmer, Tr. 82, 86). Accordingly, the undisputed facts establish a violation of 29 C.F.R. § 1904.39(a).

C. **The Secretary has established that violation in Citation 1, Item 1 was "serious" in nature, and that the violation in Citation 2, Item 1 was "other-than-serious".**

Under section 17(k) of the Act, a "serious" violation exists if there is a "substantial probability that death or serious physical harm could result from a condition which exists...." *See* 29 U.S.C. § 666(k). Whether a violation is serious is determined not by whether an accident would likely occur, but whether in the event an accident occurred it could result in bodily harm or possibly death. *Whiting-Turner Contracting Co.*, 13 BNA OSHC 2155, 2157 (No. 1238, 1989). There is no dispute that on December 10, 2012, [redacted] was fatally injured as a result of workplace violence. Therefore, the "serious" classification for Citation 1, item 1, should be upheld. *See Trinity Yachts, LLC*, 2001 WL 1682627, *24 (Feb. 22, 2011) (noting, "as demonstrated by the fatality here", the violation was properly characterized as serious).

Similarly, there is no dispute that Integra's failure to report the death of [redacted] in violation of OSHA's regulations, did not create a substantial probability of death or serious physical harm. Accordingly, the Secretary appropriately classified Citation 2, Item 1, as "other-than-serious."

D. **The proposed penalty for each Citation item is appropriate in light of the gravity of the violations established and any mitigating factors.**

Section 17(j) of the Act, 29 U.S.C. 666(j) requires the Secretary to consider four factors in proposing penalties: the gravity of the violation and the employer's good faith, history, and size. The Act does not prescribe how or what weight to apply to the factors. *Atlas Roofing Co. v. OSHRC*, 518 F.2d 990, 1001 (5th Cir. 1975), *aff'd*, 430 U.S. 442 (1977) (OSHA penalties are meant to "inflict pocket-book deterrence"). Penalty assessment requires application of administrative discretion. *D.S. Grading Co., Inc. v. Secretary of Labor*, 899 F.3d 1145, 1148 (11th Cir. 1990). Usually, the gravity of the violation is the factor of greater significance. *Caterpillar, Inc.*, 15 BNA OSHC 2153, 2178 (No. 97-922, 1993). "The Commission is the final arbiter of penalties in all contested cases. In determining an appropriate penalty, the Commission is required to consider the size of the employer's business, history of previous violations, the employer's good faith, and the gravity of the violation. Gravity is generally the principal factor to be considered." *Reynolds Packaging Kama, Inc.*, 22 BNA OSHC 1952, 1960 (No. 08-1554, 2009).

The final total penalty of $10,500.00 should be upheld. CSHO Prymmer appropriately recommended an initial penalty of $7,000.00 for the "Serious" violation and appropriately did not make any reductions based on Respondent's size and history of violations within last 3 years. He did not further adjust the penalty for "good faith" based on his finding that the violation was

of "high" severity and "greater" probability, which was also appropriate in light of the nature of the hazards and severity of the injuries sustained. (See Prymmer Tr. 168-170). The evidence developed at trial supports CSHO Prymmer's recommendation to award no reduction for good faith. Respondent ignored a clear and obvious hazard, in the face of multiple reports – regarding [redacted] and other potentially violent members – that service coordinators faced a serious hazard of workplace violence from the members they served. Its failure to provide even minimal administrative controls to protect its employees establishes bad faith for which no reduction should be granted. CSHO Prymmer also appropriately recommended a penalty of $3,500 for the "Other-than-Serious" violation, based on a reduction for size, and no reduction for history or good faith. Therefore, the final, adjusted penalty should also be affirmed.

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VII. CONCLUSION

The Secretary submits that, for all of the above reasons, he has met his burden of proving by preponderant evidence that the Citations should be affirmed, with the associated proposed penalties and classifications.

Respectfully submitted, this 21st day of July, 2014.

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SOL Case No. 13-00965

CERTIFICATE OF SERVICE

I certify that all parties have consented that all papers required to be served in this action may be served and filed electronically. I further certify that a copy of the foregoing Secretary's Post-Hearing Brief was filed electronically and a copy was served via electronic mail this 21st day of July 2014 on the following counsel for Respondent:

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UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

OSHRC Docket No. 13-1124

Secretary of Labor,

Complainant,

v.

Integra Health Management, Inc.

Respondent.

BRIEF OF AMICI CURIAE NATIONAL ASSOCIATION OF SOCIAL WORKERS, NATIONAL COUNCIL FOR OCCUPATIONAL SAFETY AND HEALTH, and SERVICE EMPLOYEES INTERNATIONAL UNION IN SUPPORT OF COMPLAINANT, SECRETARY OF LABOR

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INTRODUCTION

Pursuant to the Commission's September 18, 2015 briefing notice, the National Association Social Workers (NASW), the National Council for Occupational Safety and Health (NCOSH), and the Service Employees International Union (SEIU) respectfully submit this brief in support of Complainant, Secretary of Labor. This brief address the question, raised in the Commission's briefing notice, of whether Respondent's industry recognized the hazard of workplace violence and the role of the Occupational Safety & Health Administration's (OSHA's) Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers (the "Guidelines").[1]

Statement of Interest of Amici Curiae

Established in 1955, the National Association of Social Workers (NASW) is the largest association of professional social workers in the United States with over 130,000 members in 55 chapters. Part of NASW's mission is to promote, develop, and protect the practice of social work and social workers. In alignment with this mission, NASW establishes professional standards, guidelines and resources to support quality social work practice. NASW supports the development of policies and procedures designed to eliminate violence at social work agencies and the conduct of research to document the extent of the problem. NASW has developed, "Guidelines for Social Worker Safety in the Workplace" to address safety and risk factors

[1] OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION, GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTH CARE AND SOCIAL SERVICE WORKERS (2004). The Guidelines were introduced into evidence below and marked as Ex. 33.

associated with social work practice.[2] These guidelines are a resource to communities, private and public agencies, and local, state, and federal policymakers committed to creating a safer work environment for social workers and related professionals.[3] Indeed, an Integra manager testified she relied upon NASW standards in developing training for the company's service coordinators. (ALJ Decision at 24).

The National Council for Occupational Safety and Health (National COSH) is a federation of local and statewide "COSH" groups--Committees/Coalitions on Occupational Safety and Health. COSH groups are private, non-profit coalitions of worker organizations, health and technical professionals, and others interested in promoting and advocating for worker health and safety. COSH groups assist workers who face threats of violence in their healthcare and social service jobs. The health and safety of the workers on whose behalf COSH groups advocate will be jeopardized if OSHA's authority to rely on the general duty clause, 29 U.S.C. §654(a)(1), to address workplace violence is curtailed.

The Service Employees International Union (SEIU) is a labor union representing two million workers across the United States, including over one million healthcare, public health, social service and home care workers who work in both institutional healthcare settings, as well as the homes of service recipients. These members frequently face the hazards of workplace

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[2] NAT'L ASS'N OF SOC. WORKERS, GUIDELINES FOR SOCIAL WORKER SAFETY IN THE WORKPLACE (2013), *available at* https://www.socialworkers.org/practice/naswstandards/safetystandards2013.pdf.

[3] NAT'L ASS'N OF SOC. WORKERS, POLICY STATEMENT: WOMEN IN THE SOCIAL WORK PROFESSION 320, 328 (10th ed. 2012).

violence. Over the past twenty years, SEIU has worked to address these hazards, for example by conducting workplace violence prevention training for employers of home care workers in New York and Illinois, through advocacy for state laws and regulations to protect workers from workplace violence, and by assisting with Federal OSHA inspections at workplaces where employers fail to address these hazards. Most recently, SEIU is advocating for a California OSHA Standards Board proposed Workplace Violence Prevention Standard for Healthcare Workers which will cover public health workers who go into the field to perform their duties. The health and safety of more than one million workers represented by SEIU will be jeopardized if OSHA's authority to rely on the general duty clause, 29 U.S.C. §654(a)(1), to address workplace violence is curtailed.

SUMMARY OF ARGUMENT

OSHA's Guidelines summarize the agency's approach to regulating workplace violence in certain high risk industries. The Guidelines announce OSHA's statutory interpretation that workplace violence represents a hazard within the scope of the general duty clause. 29 U.S.C. §654(a)(1). This interpretation of the scope of the Occupational Safety & Health Act (OSH Act) is entitled to deference. *Chevron U.S.A. v. Natural Resources Defense Council,* 467 U.S. 837 (1984). The Guidelines collect and summarize available literature on the scope of the violence problem in the health care and social service industries. This professional literature demonstrates that, within these industries, workplace violence is recognized as a hazard to workers. OSHA's conclusion that violence is a recognized hazard in some industries is also entitled to deference. *See Skidmore v. Swift & Co.,* 323 U.S. 134 (1944). The Guidelines alert the public that OSHA intends to regulate workplace violence by issuing citations in appropriate cases under the general

duty clause. OSHA has unreviewable discretion to choose between standard setting and enforcement as the best means to protect workers from violence. Finally, the Guidelines describe feasible methods of abating the risk of workplace violence. They provide a roadmap for employers who wish to avoid citation. For all these reasons, the Guidelines represent a reasonable interpretation of the Act and its application to violence. The Commission should defer to the Guidelines and make clear that, in appropriate case, the general duty clause demands action by employers to protect workers from this recognized hazard.

ARGUMENT

OSHRC MUST DEFER TO OSHA'S RESONABLE INTERPRETATION THAT THE GENERAL DUTY CLAUSE PROTECTS EMPLOYEES FROM WORKPLACE VIOLENCE

OSHA's Guidelines, updated several times since 2004, serve four different functions. First, the Guidelines make plain the Secretary's view that workplace violence is a hazard within the meaning of the Occupational Safety & Health Act. Second, the Guidelines announce that "after careful review," OSHA has concluded there is ample evidence that the hazard of workplace violence is recognized by the health care and social service industries. Third, the Guidelines alert the public that OSHA will rely on citations under section 5(a)(1), rather than rulemaking, to protect workers from this recognized hazard. Finally, the Guidelines suggest feasible abatement measures employers can take to prevent workplace violence and avoid citation. The statutory interpretations and policy choices contained in the Guidelines are OSHA's to make. Each is reasonable under the law. The Guidelines are entitled to deference under both *Chevron U.S.A. v. Natural Resources Defense Council,* 467 U.S. 837 (1984) and *Skidmore v. Swift & Co.,* 323 U.S. 134 (1944).

A. OSHA'S GUIDELINES SUMMARIZE THE OVERWHELMING PROFESSIONAL LITERATURE RECOGNIZING WORKPLACE VIOLENCE AS A HAZARD.

The Guidelines summarize the available literature on risk to health care and social service employees from workplace violence and provide employers with information on effective tools to minimize the risk. The guidelines are quite narrow and specific. They address violence in health care and social service settings; they do not address violence across all workplaces. OSHA focuses its attention on these workplaces because they "have faced significant risk of job-related violence" and "assaults represent a serious safety and health hazard within these industries." *Guidelines* at 5. The Guidelines address the hazards posed to health care and social service workers in hospital and clinical settings as well as the hazard faced by home care workers who visit patients' homes. *Id.* at 8. OSHA's Guidelines are further limited to addressing violence from "internal" sources, identified as co-workers and patients, and not violence from "external" sources, such as muggers or robbers. *Id.* at 3. [4]

The Guidelines recognize that not every instance of workplace violence can be eliminated. *Id.* at 3. Instead, the Guidelines focus on reducing the risk of violence to workers. When factors suggesting an increased risk of workplace violence are present, the Guidelines recommend that employers develop and implement a workplace violence prevention program. *Id.* at 5. Among the risk factors suggesting that a workplace violence prevention program is necessary are "solo work, often in remote locations" and "lack of training." *Id.* at 6.

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[4] Thus, contrary to the argument made by Integra (Integra Br. At 17) and the Chamber of Commerce (Chamber) (Chamber Br. At 11) the Guidelines do not portend OSHA regulation of customer/employee interactions across all industries. *See* ALJ Dec. at 64.

Administrative Law Judge Phillips (ALJ) found these risk factors should have alerted Integra to the need for workplace violence prevention programs. ALJ Dec. at 67-69.

The Guidelines suggest a variety of controls to effectively reduce the risk of violence. The recommendations are consistent with OSHA's well-known hierarchy of controls. When feasible, the Guidelines recommend that employers first seek to reduce the hazard of workplace violence through reliance on system solutions, including engineering controls, such as physical barriers. When an employer cannot physically alter the workplace, a problem Integra claims limited its response to workplace violence, the Guidelines recommend that employers implement administrative and work practice controls to reduce the risk of workplace violence. *Id.* at 15-17. The Guidelines specifically recommend several of the abatement measures that ALJ Phillips found would have been feasible for Integra to implement, such as determining the behavioral history of new patients and establishing a buddy system for workers when visiting patients with a history of violence or mental illness. *Id.* at 17.

OSHA's Guidelines mirror the recommendations of other organizations which warn that health care and social service workers face a threat of workplace violence from patients and other clients. Between 2003-2012, the Bureau of Labor Statistics reported more than 154,460 nonfatal occupational injuries and illnesses involving days away from work resulting from workplace violence, two-thirds of these injuries occurred among healthcare and social assistance workers. The National Institute for Occupational Safety & Health (NIOSH) issued a Current Intelligence Bulletin in 1996 identifying an increased risk of injury for workers in health care, community services, and retail from workplace violence.[5] NIOSH's Bulletin advises employers

[5] THE NAT'L INST. FOR OCCUPATIONAL SAFETY AND HEALTH PUB. NO. 96-100, VIOLENCE IN THE WORKPLACE (1996), *available at* http://www.cdc.gov/niosh/docs/96-100/

in these industries to protect workers from this risk. NIOSH has several additional publications, which the Secretary entered into the record below, that describe the risk health care and social service workers face from workplace violence. [6] In addition, several states have adopted laws or regulations increasing the protections for healthcare workers exposed to workplace violence. [7]

Professional organizations in the health care and social services industries have likewise published guidelines and training materials to alert workers and others to the increased risks these workers face of violent assaults from patients. NASW has developed "Guidelines for Social Worker Safety in the Workplace." [8] These professional standards were adopted because social workers, particularly female social workers, face a serious risk of workplace violence in caring for patients. [9] A study of social workers found that 44 percent reported facing personal safety issues on the job. [10] NASW has a variety of other resources available to employers and

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[6] *See* NAT'L INST. FOR OCCUPATIONAL SAFETY AND HEALTH PUB NO. 2006-144, WORKPLACE VIOLENCE PREVENTION STRATEGIES AND RESEARCH NEEDS (2006), *available at* http://www.cdc.gov/niosh/docs/2006-144/; NAT'L INST. FOR OCCUPATIONAL SAFETY AND HEALTH PUB NO. 2004-100D, VIOLENCE ON THE JOB (CD-ROM, 2004), *available at* http://www.cdc.gov/niosh/docs/video/violence.html; NAT'L INST. FOR OCCUPATIONAL SAFETY AND HEALTH PUB. NO. 2001-101, VIOLENCE OCCUPATIONAL HAZARDS IN HOSPITALS (2001); NAT'L INST. FOR OCCUPATIONAL SAFETY AND HEALTH PUB NO. 93-109, PREVENTING HOMICIDE IN THE WORKPLACE (1995); NAT'L INST. FOR OCCUPATIONAL SAFETY AND HEALTH PUB NO. 92-103, HOMICIDE IN U.S. WORKPLACES: A STRATEGY FOR PREVENTION AND RESEARCH *available at* http://www.cdc.gov/niosh/pdfs/92-103.pdf

[7] For more information on state and local laws or regulations addressing workplace violence, *see* American Nurses Ass'n, *Workplace Violence*, NURSINGWORLD.ORG, http://nursingworld.org/workplaceviolence (last updated Sept. 2015).

[8] NAT'L ASS'N OF SOC. WORKERS, GUIDELINES. The Secretary cited these professional standards in urging the ALJ below to find that the social service industry of which Integra was a part recognized the risk of workplace violence.

[9] NAT'L ASS'N OF SOC. WORKERS, POLICY STATEMENT: WOMEN IN THE SOCIAL WORK PROFESSION, STRESSORS FOR WOMEN IN SOCIAL WORK, 320, 323 (10th ed. 2012).

[10] WHITAKER T. WHITAKER, TOBY WEISMILLER & ELIZABETH J. CLARK, NAT'L ASS'N OF SOC. WORKERS, ASSURING THE SUFFICIENCY OF A FRONTLINE WORKFORCE: A NATIONAL STUDY OF

others aimed at recognizing the risks social workers face, identifying high hazard work environments, and protecting social workers from these risks. http://www.socialworkers.org/practice/social_work_safety/default.asp Integra relied upon these resources in designing training for its service coordinators. (ALJ Decision at 24).

B. OSHA'S STATUTORY INTERPRETATION THAT WORKPLACE VIOLENCE IS A HAZARD UNDER THE GENERAL DUTY CLAUSE IS PLAINLY CORRECT.

Section 5(a)(1) of the OSH Act requires employers to provide "to each of his employees employment and a place of employment which are free from recognized hazards." 29 U.S.C. §654(a)(1). To establish a violation of this section, OSHA must show that "a condition or activity in the workplace presents a hazard to an employee." OSHA interprets the scope of the general duty clause to include the hazard of workplace violence. OSHA's interpretation of the statute it administers is entitled to deference. *See Chevron U.S.A. v. Natural Resources Defense Council,* 467 U.S. 837 (1984).[11]

Integra and the Chamber of Commerce nevertheless urge the Commission to ignore OSHA's reasonable interpretation of the OSH Act, arguing that violence falls outside the scope of section 5(a)(1) of the OSH Act. (Integra Br. At 12-15; Chamber Br. At 5-6). They argue that direct contact with patients is the nature of Integra's business and, therefore, cannot be defined as

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LICENSED SOCIAL WORKERS EXECUTIVE SUMMARY (2006) *available at* http://workforce.socialworkers.org/studies/nasw_06_execsummary.pdf.

[11] Courts usually apply *Chevron* deference to a statutory interpretation developed in the course of informal agency action such as the process OSHA used to develop the Guidelines. *See generally,* JEFFREY LUBBERS, A GUIDE TO FEDERAL AGENCY RULEMAKING, 505-507 (ABA 2006). But, even in circumstances where *Chevron* deference is not warranted, courts generally give some deference or weight to an agency interpretation of the statute it administers under *Skidmore v. Swift & Co.,* 323 U.S. 134 (1944). *See generally,* Lubbers at 507.

a hazard. It is worth noting that nothing in ALJ Phillips decision bars Integra's service coordinators from continued contact with patients. Indeed, the argument Integra makes about the nature of its business is similar to the argument made by Sea World, and rejected by the Commission and the D.C. Circuit, that direct contact with killer whales was the essential nature of its business. *Sea World of Florida v. Perez,* 748 F.3d 1202, 1210 (D.C. Cir. 2014). In both cases, workers can be protected from recognized hazards, and employers can continue their business, if the method of performing the job is modified to abate risk.

C. OSHA'S GUIDELINES ESTABLISH THAT HEALTH CARE AND SOCIAL SERVICE EMPLOYERS RECOGNIZE WORKPLACE VIOLENCE AS A HAZARD.

The well-settled test for proving a violation of section 5(a)(1), 29 U.S.C. §654(a)(1), requires the Secretary to establish the existence of a hazard that was either actually recognized by the cited employer or by the industry of which it is a part. *National Realty and Constr. Co., v. OSHRC,* 489 F.2d 1257 (D.C. Cir. 1973); *Sea World,* 748 F.3d at 1207. ALJ Phillips found that Integra had actual knowledge of the workplace violence hazards its' service coordinators faced. (ALJ Dec. at 70-75). Given the breadth of federal, state, and professional attention to these risks, it is hard to imagine how any reasonably prudent employer could not have known that social service workers, such as Integra's service coordinators, faced a serious risk of workplace violence.

But, even if Integra did not know actually know of the risk of violence, the health care and social service industries of which it is a part clearly recognized the risk of violence. The Commission and the courts have consistently held that professional standards and NIOSH publications, alerting employers to a serious occupational risk facing workers, can be used to establish industry recognition under the general duty clause. *See Kokosing Constr. Co.,* 17 BNA

OSHC 1869 (Rev. Comm'n 1996); *Cargill, Inc., Nutrene Feed Div.*, 10 BNA OSHC 1398 (Rev. Comm'n 1982); *Bethlehem Steel Corp. v. OSHRC*, 607 F.2d 871 (3rd Cir. 1979); *USPS*, 25 BNA OSHC 1116 (Rev. Comm'n 2014).

Under settled law, each of the professional codes and other materials cited in the Guidelines, standing alone, could be relied upon to show that Integra's industry recognized the threat workplace violence posed to service coordinators.[12] The Guidelines summarize this body of evidence, advise employers that OSHA views this evidence as establishing that workplace violence in the health care and social service industry is a recognized hazard, and that the agency will rely on the general duty clause, 29 U.S.C. §654(a)(1), as enforcement authority when employers fail to take adequate steps to protect employees from this hazard. OSHRC should defer to OSHA's interpretation of the scope of the general duty clause and its application to workplace violence. *See, Skidmore v. Swift & Co.*, 323 U.S. 134 (1944); *Christensen v. Harris County*, 529 U.S. 576 (2000).

D. OSHA HAS DISCRETION TO RELY ON THE GENERAL DUTY CLAUSE TO PROTECT WORKERS FROM THE THREAT OF WORKPLACE VIOLENCE

Guidance documents, such as OSHA's Guidelines, are a widely accepted tool for alerting employers that OSHA views workplace violence as a recognized hazard in the health care and social service industries and describing its enforcement policy towards violence. OSHA

[12] The Guidelines, and many of the publications they reference, speak to the threat of violence facing health care and social service workers. OSHA's expert testified that Integra's service coordinators were doing social work based activities. (ALJ Dec. at 58). Integra attempts to argue that it was not a part of the health care or social service industries were properly rejected by the ALJ. (ALJ Dec. at n.110). Even if Integra was part of a related industry, the Commission can easily infer that professional standards applicable to the health care and social service industries should apply to Integra as well. *Arcadian Corp.*, 20 BNA OSHC 2001 (Rev. Comm'n 2004).

Compliance Directive (Ex. 32) further describes the circumstances under OSHA may cite employers for exposing workers to violence hazards. OSHA should be commended for transparently alerting interested stakeholders of its intent to cite employers who fail to abate violence hazards under the general duty clause.

The decision to rely on enforcement over standard setting as a method to reduce the risk of workplace violence is OSHA's to make. It is generally recognized that administrative agencies may select between rulemaking and adjudication to establish standards of conduct in the regulated community. *See* JEFFREY LUBBERS, A GUIDE TO FEDERAL AGENCY RULEMAKING, 139 (ABA 2006). Nothing requires OSHA to enforce the OSH Act "principally by promulgating standards." (Chamber Br. At 16).

OSHA's choice to rely on standards or enforcement to eliminate hazards has consequences. *See Perez v. Mortg. Bankers Ass'n,* 135 S. Ct. 1199, 1204 (2015). If OSHA issues a standard under section 6(b), 29 U.S.C. §655(b), the standard has the force and effect of law. *Perez,* 135 S. Ct. at 1204. If OSHA cites an employer for violation of a standard, it can establish a violation of the Act by showing that the standard applied and was violated. *See generally, The Duty to Comply with Standards in* OCCUPATIONAL SAFETY & HEALTH LAW 81 (Gregory N. Dale & P. Matthew Shudtz Eds. 3rd ed. 2013). The abatement measures included in a standard are presumed feasible. *United Steelworkers v. Marshall,* 647 F.2d 1189, 1269 (D.C. Cir. 1980). If OSHA had promulgated a workplace violence standard, Integra would have been obligated to comply.

When OSHA issues guidelines, such as those addressing workplace violence, they are not binding and do not have the force of law. *Perez v. Mortg. Bankers,* 135 S. Ct. at 1203-04. They advise employers of what OSHA thinks the general duty clause requires. *Id.* Because the

Guidelines are interpretive they may be issued without notice and comment rulemaking. 5 U.S.C. 553(b)(A). To the extent that they persuasively interpret the literature on industry practices and professional standards on workplace violence risks, OSHRC and the courts should defer to them. *See Christensen v. Harris County,* 529 U.S. at 587; *Skidmore,* 323 U.S. at 140.

Granting deference to OSHA's judgment that violence poses a recognized hazard in Integra's industry does not have the effect of converting advisory guidance into mandatory rules. In any enforcement proceeding, OSHA would still bear the burden of showing that the abatement measures it suggests are feasible. And, since the Guidelines are interpretive, and not legislative, rules and do not have the force of law, Integra is free to argue that the Guidelines are unreasonable, in the sense that they do not accurately describe existing professional standards relating to workplace violence or that the abatement methods they describe are infeasible. *See Perez v. Mortg. Bankers,* 135 S. Ct. at 1209. In other words, OSHA's burden of proving a general duty clause citation remains higher, even if OSHRC defers to the Guidelines, then it would be if OSHA had promulgated a workplace violence standard. Deference does not give OSHA's Guidelines the force of law.

Nor will deference to OSHA's Guidelines circumvent the rulemaking process. OSHA is not required to issue a section 6(b) standard for every hazard covered by the OSH Act. *UAW v. Chao,* 361 F.3d 243 (3rd Cir. 2004) (OSHA has broad authority to allocate its resources and refuse to issue a standard). The OSH Act covers thousands of unregulated hazards. Rulemaking has become ossified and, on average, the standard setting process takes more than seven years to complete. OSHA would be derelict in its duty if it took no action to protect workers from recognized hazards until it could issue a 6(b) standard governing each risk facing workers. Indeed, even if OSHA has adopted a standard, where an employer knows it to be inadequate the

employer has an independent statutory duty to protect workers from harm. *UAW v. General Dynamics,* 815 F.2d 1570 (D.C. Cir. 1987). Thus, even if OSHA were to issue a workplace violence standard, the general duty clause would remain applicable. *Id.*

By notifying employers about how OSHA will exercise its enforcement discretion under section 5(a)(1), and the steps employers can take to avoid citation, OSHA's Guidelines provide constitutionally adequate notice. So long as a "reasonably prudent employer in the industry would have known that the proposed method of abatement was required," courts have rejected employer claims that they lacked notice of the requirements imposed by law. *Sea World,* 748 F.3d at 1216. Here, the Guidelines, and OSHA's Compliance Directive (Ex. 32), make plain OSHA's intent to rely on the general duty clause to cite employers who fail to address workplace violence and describe a variety of feasible abatement measure employers should implement to avoid citation. The Guidelines provided Integra with adequate notice of what the law required.

E. OSHA'S GUIDELINES DESCRIBE FEASIBLE MEASURES TO ABATE THE HAZARD OF WORKPLACE VIOLENCE.

The Guidelines recommend that employers establish workplace violence prevention programs to protect workers from the risk of violence. Among the measures OSHA recommends be included in such a program were increased training, screening of patients to identify those with a history of violence, and assigning more experienced service coordinators to conduct intake with more challenging patients. ALJ Phillips found each of these abatement measures would have been feasible for Integra to implement. (ALJ Dec. at 86-90). In fact, Integra implemented several after its' service coordinator was killed.

Integra and the Chamber nevertheless argue that abatement of the citation is infeasible because Integra does not control its' service coordinators' work environment. Assuming that

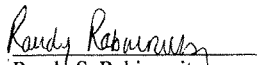
Integra cannot effectively control the homes of the patients its service coordinators visit, it can control the means by which service coordinators accomplish their tasks. OSHA and the Commission have long recognized that even where engineering controls (or fixes to the workplace) are not feasible, an employer must nevertheless try to reduce the hazard through administrative and work practice controls (or fixes to the way the job is accomplished). *United Steelworkers v. Marshall,* 647 F.2d at 1269. Here, the Secretary demonstrated, and the ALJ found, that Integra could have increased the training for service coordinators, assigned an experienced service coordinator to initial assessments of patients with a history of violence, or implemented a mandatory buddy system so a service coordinator would not face a potentially violent situation alone. None of these abatement measures require changes to the physical aspects of the workplace. Integra is feasibly able to implement each of them.

Doing so would not threaten Integra's business model. Just as the remedy for Sea World's general duty clause violations permitted "continued human interactions and performances with killer whales" so long as they "continue with increased safety measures," so too the remedy for Integra's 5(a)(1) violations permit continued patient contact by service coordinators but with increased training, more experience, or accompanied by a co-worker. *See Sea World,* 748 F.3d at 1210. Integra had a duty under the general duty clause to provide its employees with "employment" "free from recognized hazards," 29 U.S.C. §654(a)(1), even when it could not physically alter their place of employment. Clearly, Integra could have organized the work of service coordinators differently to reduce the hazard posed by client violence.

CONCLUSION

For the foregoing reasons, and those advanced by the Secretary of Labor, the ALJs decision affirming the citations issued to Integra Health Management should be upheld.

Respectfully submitted,



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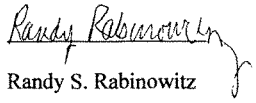
CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of December 2015, I served a copy of the foregoing Brief for Amici Curiae on counsel for the Secretary and Integra electronically.



Randy S. Rabinowitz

Sentinel Event Alert

A complimentary publication of The Joint Commission

Issue 59, April 17, 2018

Physical and verbal violence against health care workers

"I've been bitten, kicked, punched, pushed, pinched, shoved, scratched, and spat upon," says Lisa Tenney, RN, of the Maryland Emergency Nurses Association. "I have been bullied and called very ugly names. I've had my life, the life of my unborn child, and of my other family members threatened, requiring security escort to my car."[1]

Situations such as these describe some of the types of violence directed toward health care workers. Workplace violence is not merely the heinous, violent events that make the news; it is also the everyday occurrences, such as verbal abuse, that are often overlooked. While this *Sentinel Event Alert* focuses on physical and verbal violence, there is a whole spectrum of overlapping behaviors that undermine a culture of safety, addressed in *Sentinel Event Alert* issues 40 and 57;[2,3] those types of behaviors will not be addressed in this alert. The focus of this alert is to help your organization recognize and acknowledge workplace violence directed against health care workers from patients and visitors, better prepare staff to handle violence, and more effectively address the aftermath.

What is workplace violence?

The CDC National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.[4] The U.S. Department of Labor defines workplace violence as an action (verbal, written, or physical aggression) which is intended to control or cause, or is capable of causing, death or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior toward authority, intimidating or harassing behavior, and threats.[5]

Each episode of violence or credible threat to health care workers warrants notification to leadership, to internal security and, as needed, to law enforcement, as well as the creation of an incident report, which can be used to analyze what happened and to inform actions that need to be taken to minimize risk in the future. Under The Joint Commission's Sentinel Event policy, rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a patient, staff member, licensed independent practitioner, visitor, or vendor while on site at an organization is a sentinel event that warrants a comprehensive systematic analysis. While the policy does not include other forms of violence, it is up to every organization to specifically define acceptable and unacceptable behavior and the severity of harm that will trigger an investigation. The Centers for Disease Control and Prevention (CDC) National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.[4] The U.S. Department of Labor defines workplace violence as an action (verbal, written, or physical aggression) which is intended to control or cause, or is capable of causing, death or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior toward authority, intimidating or harassing behavior, and threats.[5]

Published for Joint Commission accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The Joint Commission

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Although most incidents of workplace violence in health care are verbal in nature, other incidents involve assault, battery, domestic violence, stalking, and sexual harassment.[6] The most common type of violence in health care is patient/visitor to worker.[7,8] A 2014 survey on hospital crime attributed 75 percent of aggravated assaults and 93 percent of all assaults against health care workers to patients or customers.[9]

Prevalence of workplace violence in health care

According to the Occupational Safety and Health Administration (OSHA), approximately 75 percent of nearly 25,000 workplace assaults reported annually occurred in health care and social service settings[10] and workers in health care settings are four times more likely to be victimized than workers in private industry.[11] The National Crime Victimization Survey showed health care workers have a 20 percent higher chance of being the victim of workplace violence than other workers.[12] Bureau of Labor Statistics (BLS) data show that violence-related injuries are four times more likely to cause health care workers to take time off from work than other kinds of injuries.[13] The Joint Commission's Sentinel Event data show 68 incidents of homicide, rape, or assault of hospital staff members over an eight-year period.*

Alarmingly, the actual number of violent incidents involving health care workers is likely much higher because reporting is voluntary. Researchers at Michigan State University estimated that the actual number of reportable injuries caused by workplace violence, according to Michigan state databases, was as much as three times the number reported by the BLS,[14] which does not record verbal incidents.[15]

Episodes of workplace violence of all categories are grossly underreported.[10,16] Health care workers are sometimes uncertain what constitutes violence, because they often believe that their assailants are not responsible for their actions due to conditions affecting their mental state.[17] Only 30 percent of nurses report incidents of workplace violence;[18] among emergency department physicians, the reporting rate is 26 percent.[19] Underreporting is due in part to thinking that violence is "part of the job."[20] In addition, worker-to-worker verbal abuse in health care has been accepted too often, leading to thinking that workers must accept verbal abuse from patients, too.

Adding to the problem are the many ways that workplace injuries may be reported at health care organizations. Information about health care workers injured on the job — whether punched by a patient or accidentally stuck by a needle — may be reported into various databases rather than one integrated database. This makes it difficult to recognize the scope of a workplace violence problem, or to track the effectiveness of efforts to mitigate or prevent workplace violence.

To improve tracking efforts, OSHA launched the Injury Tracking Application, a secure website where covered employers must submit their workplace injury and illness information, including acute injuries and illnesses, days away from work, restricted work activity, or job transfer (also known as Days Away, Restrictions and Transfers, or DART).[21,22] In May 2016, OSHA published a rule titled "Improve Tracking of Workplace Injuries and Illnesses," with an original effective date of Jan. 1, 2017 that was extended to Dec. 1, 2017.[21] OSHA is considering whether or not to publish a new standard to prevent workplace violence in health care and social assistance settings. The agency issued a public Request for Information on the extent and nature of workplace violence in the industry and the effectiveness and feasibility of methods used to prevent such violence. The comment period closed on April 6, 2017.[23]

It is important to note that employers are required to provide a place of employment that is "free from recognized hazards that are causing or are likely to cause death or serious harm," under the General Duty Clause, Section 5(a)(1)

* The reporting of most sentinel events to The Joint Commission is voluntary and represents only a small proportion of actual events. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time.

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of the Occupational Safety and Health Act of 1970.[24]

Contributing factors

Violence against health care workers occurs in virtually all settings, with the emergency department (ED) and inpatient psychiatric settings having the most recorded incidents.[11,25] The home care setting presents particular challenges because this environment is less controlled than other health care settings.[25] Sixty-one percent of home care workers report workplace violence each year.[26] Long-term residential care facilities for the aged, cognitively impaired and mentally ill patients present special challenges.[27] There is very little research about other settings.[25]

Virtually all types of health care professionals have been victims. Nurses and nurses' aides, particularly those in emergency settings[11,28] and in nursing homes with dementia units,[29] have been victimized at the highest rate.[11,15,20,30] An American Nurses Association study found that over a three-year period, 25 percent of surveyed registered nurses and nursing students reported being physically assaulted by a patient or a patient's family member, and about half reported being bullied.[31] Physicians, particularly emergency medicine physicians,[11,20,29] and inpatient psychiatric workers[20,32] also are frequently victimized.

The most common characteristic exhibited by perpetrators of workplace violence is altered mental status associated with dementia, delirium, substance intoxication, or decompensated mental illness.[10,33] Also, one study showed that patients in police custody within a health care setting are involved in 29 percent of shootings in emergency departments, with 11 percent occurring during escape attempts.[34] Increasingly, hospitals are providing care for potentially violent individuals.[11]

In addition to caring for patients with these characteristics, other factors associated with violence are:

- Stressful conditions, such as long wait times or crowding in the clinical environment or being given "bad news" related to a diagnosis or prognosis.[10,35]
- Lack of organizational policies and training for security and staff to recognize and deescalate hostile and assaultive behaviors from patients, clients, visitors, or staff.[10]
- Gang activity.[10]
- Domestic disputes among patients or visitors.[36]
- The presence of firearms or other weapons.[10]
- Inadequate security and mental health personnel on site.[10]
- Understaffing, especially during mealtimes and visiting hours.[10]
- Staff working in isolation or in situations in which they can be trapped without an escape route.[10]
- Poor lighting or other factors restricting vision in corridors, rooms, parking lots and other areas.[37]
- No access to emergency communication, such as a cell phone or call bell.[10]
- Unrestricted public access to hospital rooms and clinics.[10]
- Lack of community mental health care.[10]

Workplace violence results in low staff morale, lawsuits, and high worker turnover.[10] High turnover is associated with job burnout – defined as a negative reaction to constant occupational stressors.

There is no conclusive evidence linking workplace violence with demographic groups[38,39] or with urban versus suburban or rural emergency departments;[15] making these assumptions may lead to discrimination against particular types of patients.[25] Although shootings in the health care environment gain much media attention, they are quite rare compared to other kinds of violence, such as assaults not involving a firearm, and verbal abuse.[40]

Recognizing verbal assault as a form of workplace violence cannot be overlooked, since verbal assault is a risk factor for battery.[41] According to the "broken windows" principle,

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apathy toward assaults such as verbal abuse creates an environment conducive to more serious, physical crimes.[20,42]

With leadership commitment and worker participation, customized and evidence-based approaches to reduce workplace violence can be found and will vary from setting to setting. For example, Aria-Jefferson Health implemented Operation Safe Workplace, a multidisciplinary approach to hospital violence. After identifying a baseline of 42 injuries related to workplace violence in fiscal year 2012, the organization gathered and analyzed data before designing interventions to address the problem in five ways: environment, policy and procedure, technology and equipment, communication, and people. By fiscal year 2015, Aria-Jefferson reduced these injuries to 19, a 55 percent decrease.[43] In addition, a cluster randomized trial at Wayne State University reduced incidents of workplace violence on intervention units compared to control units by implementing environmental, administrative and behavioral strategies tailored to the needs of participating units.[44]

Actions suggested by The Joint Commission
Health care workers must be alert and ready to act when they encounter verbal or physical violence — or the potential for violence — from patients or visitors who may be under stress or who may be fragile, yet also volatile. Health care organizations are encouraged to address this growing problem by looking beyond solutions that only increase security.

1. Clearly define workplace violence and put systems into place across the organization that enable staff to report workplace violence instances, including verbal abuse.

- Leadership should establish a goal of zero harm to patients and staff and, to that end, must make clear that the health care organization is responsible for identifying, addressing and reducing instances of workplace violence; that burden must not be placed upon victims of violence.
- Emphasize the importance of reporting all events involving physical and verbal violence toward workers, as well as patients and visitors.
- Encourage conversations about workplace violence during daily unit huddles, including team leaders asking each day if any team members have been victims of physical or verbal abuse or if any patients or family situations may be prone to violence.
- Develop systems or tools to help staff identify the potential for violence, such as a checklist or questionnaire that asks if a patient is irritable, confused or threatening.
- Develop a protocol, guidance and training about the reporting required by the hospital safety team, OSHA, police, and state authorities. For example, Western Connecticut Health Network developed a protocol to be used after incidents of workplace violence against employees.[45]
- Create simple, trusted, and secure reporting systems that result in transparent outcomes, and are fully supported by leadership, management, and labor unions.[46] Protect patient and worker confidentiality in all reporting by presenting only aggregate data or removing personal identifiers.[10]
- Remove all impediments to staff reporting incidents of violence toward workers – such as retribution or disapproval of supervisors or co-workers and a lack of follow-up or positive recognition from leadership.[10,25]

2. Recognizing that data come from several sources, capture, track and trend all reports of workplace violence – including verbal abuse and attempted assaults when no harm occurred.

- Gather this information from all hospital databases, including those used for OSHA, insurance, security, human resources, complaints, employee surveys, legal or risk management purposes, and from change of shift reports or huddles.
- Regularly distribute these workplace violence reports throughout the

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organization, including to the quality committee and up to the executive and governance levels.
- Aggregate and report incidents to external organizations that maintain a centralized database. This can lead to identification of new hazards, trends, and potential strategies for solutions; these solutions can then be shared broadly.[27]

The Centers for Disease and Control and Prevention (CDC) Occupational Health Safety Network is a useful resource to help to analyze and track worker injury and exposure data, including data on workplace violence. See Resources.

3. Provide appropriate follow-up and support to victims, witnesses and others affected by workplace violence, including psychological counseling and trauma-informed care if necessary.[10,11,25]

4. Review each case of workplace violence to determine contributing factors. Analyze data related to workplace violence, and worksite conditions, to determine priority situations for intervention.
- According to OSHA, this process includes a worksite analysis and hazard identification (for example, risk assessment).[10] To determine trends and "hot spots," analyze where, when, why and how violence has occurred and to whom. This process can include a review of workers' compensation, insurance records, OSHA logs and other data relating to workplace violence, as well as an analysis of factors (such as staffing levels) that can contribute to or reduce the likelihood of violence occurring.[10]
- Demonstrate the value and necessity of reporting by communicating to staff the risk assessment findings and the interventions taken to immediately address the situation.

5. Develop quality improvement initiatives to reduce incidents of workplace violence. Support the implementation of cost-effective, evidence-based solutions as they are discovered.[25] After a review of all pertinent data relating to workplace violence, develop evidence-based initiatives and interventions (when possible) to prevent and control workplace violence. Tailor specific interventions to problems identified at the local level. Depending on the data gathered, an initiative for the ED, inpatient psychiatric unit, labor and delivery, or the intensive care unit (ICU) may differ from an initiative in a unit not generally associated with workplace violence. According to OSHA, these initiatives generally focus on eliminating hazards or substituting them with safer work practices.[10] Some examples follow.

- ***Changes to the physical environment:*** Depending on the organization's situation and priorities (identified from the organization's data), physical or technological solutions may include enhanced security or alarms, better exit routes, regular security patrols/rounds, metal detectors, panic buttons (including mobile panic buttons), monitoring or surveillance technology (such as cameras), barrier protection (for example, keypad access doors and fencing), environmental changes to facilitate de-escalation and reduce hazards, and better lighting.[10] As mentioned above, each organization should use its own data to identify the most effective use of these solutions. As just one example, a hospital that has identified a high incidence of confrontations occurring in the parking lot and in waiting areas may want to have more regular security patrols, or a more visible security presence, in those areas.
- ***Changes to work practices or administrative procedures:*** To create a calmer environment less conductive to violence, assign sufficient staff to units to reduce crowding and wait times, both risk factors for workplace violence.[10] Decreasing worker turnover and providing adequate security and mental health personnel on-site also are

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recommended.[10,47] Other administrative or work practice solutions may include developing workplace violence response teams and policies; reviewing entry and identification procedures; and changing work procedures to keep team members, including those providing transportation, secure and not isolated by having the means to call for help.[10]

6. Train all staff, including security, in de-escalation, self-defense and response to emergency codes.[10] When threatening language and agitation are identified, initiate de-escalation techniques quickly.[25] The Crisis Prevention Institute developed these 10 de-escalation tips, for example.[48] Self-defense training may include topics such as violence risk factors, de-escalation techniques, alarms, security support, safe rooms, escape plans, and emergency communication procedures.[10]

- Regarding de-escalation and self-defense, experts suggest that hospitals prohibit firearms from campus, except for firearms used by law enforcement officers.[49] The Centers for Medicare and Medicaid Services (CMS) does not permit the use of weapons by any hospital staff as a means of subduing a patient.[50]
- Conduct practice drills that include response to a full spectrum of violent situations, which could range from a verbally abusive family member to an active shooter. These practice drills can be part of an ongoing safety program, as indicated in The Joint Commission Environment of Care (EC) standards; however, a situation such as an active shooter require more extensive coordination with community responders, and can be addressed in exercises as described in the Emergency Management (EM) standards (see "Related Joint Commission requirements" section).

7. Evaluate workplace violence reduction initiatives by:

- Regularly reviewing reported incidents and leadership's responses to them.
- Analyzing trends in incidents, injuries and fatalities relative to baseline rates and measuring improvement.
- Surveying workers to determine effectiveness of initiatives.
- Tracking if recommendations were completed.
- Keeping abreast of new strategies.
- Partnering with local law enforcement or having a consultant review the worksite.[10] They can provide advice and updates on possible risks that are developing in the community, as well as help with resource planning or security audits. If local law enforcement response time is known to be long due to distance or other factors, consider internal resources or other options to control a situation until law enforcement arrives.

Related Joint Commission requirements

The Joint Commission has several standards that relate directly or indirectly to workplace violence. Leadership (LD) and Rights and Responsibilities of the Individual (RI) standards establish the framework for safety and security of all persons in the organization. Provision of Care, Treatment, and Services (PC) standards provide guidance addressing patient assessment and interventions, Environment of Care (EC) standards address the physical environment and practices that enhance safety. Emergency Management (EM) standards address planning for more extreme risks of workplace violence, such as active shooters, community unrest, and terrorist attack.

The table below lists these standards, along with their program applicability.

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Joint Commission requirements related to workplace violence	Hospital	Critical access hospital	Ambulatory	Office-based surgery	Behavioral health	Home care	Laboratory	Nursing care center
Environment of Care								
EC.01.01.01 EP 4	✔	✔	✔		✔		✔	✔
EC.01.01.01 EP 5	✔	✔	✔		✔		✔	
EC.02.01.01 EP 1	✔	✔	✔	✔	✔	✔	✔	✔
EC.02.01.01 EP 2						✔		
EC.02.01.01 EP 3	✔	✔	✔	✔	✔	✔	✔	✔
EC.02.01.01 EP 6			✔	✔				
EC.02.01.01 EP 7	✔	✔				✔	✔	
EC.02.01.01 EP 8	✔	✔	✔	✔	✔	✔	✔	
EC.04.01.01 EP 1	✔	✔	✔	✔	✔	✔	✔	
EC.04.01.01 EP 2			✔		✔			
EC.04.01.01 EP 3	✔	✔	✔		✔		✔	✔
EC.04.01.01 EP 6	✔	✔					✔	✔
EC.04.01.03 EP 2	✔	✔	✔		✔	✔	✔	✔
EC.04.01.05 EP 1	✔	✔	✔		✔		✔	✔
Emergency Management								
EM.01.01.01 EP 2	✔	✔	✔		✔	✔	✔	✔
EM.01.01.01 EP 3	✔	✔	✔		✔	✔	✔	
EM.01.01.01 EP 4	✔	✔	✔		✔	✔	✔	✔
EM.01.01.01 EP 5	✔	✔	✔		✔	✔	✔	✔
EM.01.01.01 EP 7	✔	✔						✔
EM.02.01.01 EP 2	✔	✔	✔	✔	✔	✔	✔	✔
EM.02.02.01 EP 1	✔	✔	✔		✔	✔	✔	
EM.02.02.01 EP 2	✔	✔						✔
EM.02.02.01 EP 3	✔	✔	✔	✔	✔		✔	
EM.02.02.01 EP 4	✔	✔	✔					✔
EM.02.02.01 EP 6	✔	✔						
EM.02.02.01 EP 12	✔	✔	✔					
EM.02.02.05 EP 1	✔	✔	✔	✔	✔		✔	✔
EM.02.02.05 EP 2	✔	✔						
EM.02.02.05 EP 3	✔	✔						✔
EM.02.02.05 EP 6								✔
EM.02.02.05 EP 7	✔	✔						
EM.02.02.05 EP 8	✔	✔						
EM.02.02.05 EP 9	✔	✔						✔
EM.02.02.05 EP 10	✔	✔	✔	✔	✔		✔	✔
EM.02.02.07 EP 7	✔	✔	✔			✔		
EM.02.02.11 EP 1			✔	✔	✔	✔	✔	
EM.02.02.11 EP 2	✔	✔						✔
EM.02.02.11 EP 3	✔	✔	✔	✔	✔	✔	✔	✔
EM.03.01.03 EP 2	✔	✔	✔	✔				✔
EM.03.01.03 EP 10	✔	✔	✔			✔		

Joint Commission requirements related to workplace violence	Hospital	Critical access hospital	Ambulatory	Office-based surgery	Behavioral health	Home care	Laboratory	Nursing care center
Leadership								
LD.03.01.01	✔	✔	✔	✔	✔	✔	✔	✔
LD.04.01.01 EP2	✔	✔	✔	✔	✔	✔	✔	✔
LD.04.04.05	✔	✔	✔	✔	✔	✔	✔	✔
Provision of Care, Treatment, and Services								
PC.01.02.13 EP 6	✔	✔						
PC.03.05.03 EP 1	✔	✔				✔		
Rights and Responsibilities of the Individual								
RI.01.06.03 EP 1	✔	✔	✔		✔	✔		✔

See the content of these standards on The Joint Commission website, posted with this alert.

Resources

Occupational Safety and Health Administration (OSHA)

- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
- Preventing Workplace Violence in Healthcare

Crisis Prevention Institute

- Top 10 De-Escalation Tips

The Joint Commission

- Workplace Violence Prevention Resources
- Questions & Answers: Hospital Accreditation Standards & Workplace Violence
- Improving Patient and Worker Safety (Pages 95-108)[27]

Centers for Disease Control and Prevention (CDC)

- Occupational Health Safety Network: A free, web-based system to help health care facilities analyze and track data they already collect on workplace violence; sharps injuries; blood and body fluid exposures; slips, trips and falls; and patient-handling injuries.
- Workplace Violence Prevention for Nurses

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- Home Healthcare Workers: How to Prevent Violence on the Job

Centers for Medicare and Medicaid Services (CMS)

- Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers

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CJNR 2006, Vol. 38 N° 4, 96–117

Résumé

Prévention de la violence en soins de santé mentale : le cas de l'État de New York

Jane Lipscomb, Kathleen McPhaul, Jonathan Rosen, Jeanne Geiger Brown, Mona Choi, Karen Soeken, Victor Vignola, Deborah Wagoner, Janet Foley et Peggy Porter

En 1996, le New York State Office of Mental Health adoptait une politique obligeant tous les établissements psychiatriques administrés par l'État à se doter d'un programme proactif de prévention de la violence fondé sur les lignes directrices imposées par la *U.S. Occupation Safety and Health Administration*. Cette décision a fourni une occasion d'évaluer l'effet de ce type de lignes directrices sur la santé et la sécurité au travail. Les auteurs rapportent ici les résultats d'une étude à plusieurs volets dont le but était d'évaluer la faisabilité et les répercussions d'une intervention participative destinée à prévenir la violence au travail. Ils décrivent la mise en œuvre d'un programme de prévention dans trois établissements hospitaliers, en se fondant sur : une analyse approfondie du milieu de travail; des groupes de discussion réunissant des employés; des sondages menés avant et après l'instauration du programme dans le but d'évaluer les changements de perception à l'égard des agressions physiques et de la qualité des différents volets du projet. Les résultats attestent de la faisabilité de ce type de programme et de ses répercussions favorables au sein des établissements de santé mentale. On a constaté chez les employés de tous les milieux de travail concernés une amélioration notable des perceptions concernant l'engagement de la direction et la participation du personnel en matière de prévention de la violence.

Mots clés : prévention de la violence, violence au travail, établissements psychiatriques.

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Violence Prevention in the Mental Health Setting: The New York State Experience

Jane Lipscomb, Kathleen McPhaul, Jonathan Rosen, Jeanne Geiger Brown, Mona Choi, Karen Soeken, Victor Vignola, Deborah Wagoner, Janet Foley, and Peggy Porter

In 1996 the New York State Office of Mental Health issued a policy requiring all State-operated psychiatric facilities to develop and implement a proactive violence-prevention program based on guidelines issued by the US Occupational Safety and Health Administration. This presented an opportunity to evaluate the impact of the guidelines on worker health and safety. The authors report the findings of a mixed-method study to evaluate the feasibility and impact of a participatory intervention to prevent workplace violence. They describe the implementation of the intervention in 3 in-patient facilities, including an extensive worksite analysis, staff focus groups, and a baseline and post-intervention survey of changes in staff perception of the quality of the program's elements and physical assault following implementation of the program. The authors provide evidence for the feasibility and positive impact of a comprehensive violence-prevention program in the in-patient mental health workplace. Staff perception of the quality of management commitment and employee involvement in violence-prevention was significantly improved in all worksites post-implementation.

Keywords: Violence prevention, occupational health, worksite analysis, staff assaults, workplace violence, psychiatric hospitals

Introduction

In 1996 the US Occupational Safety and Health Administration published *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (US Department of Labor & OSHA, 1996). These federal guidelines include the basic elements of any proactive health and safety program: Management Commitment and Employee Involvement; Worksite Analysis; Hazard Prevention and Control; and Training and Education. The OSHA guidelines provide an outline for developing a violence-prevention program, but they are "performance-based," so the challenge of developing a specific, effective process for implementation is left to each individual workplace. It should be noted that a number of international professional and governmental agencies have issued policies

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and guidance on violence prevention in the health-care setting (American Association of Colleges of Nursing, 2004; American Nurses Association, 1994; Canadian Federation of Nurses Unions, 1994; Canadian Nurses Association, 2002; International Council of Nurses, 2000; International Labour Organization, 1998; World Health Organization, 2005). For example, the Canadian Federation of Nurses Unions and the Canadian Nurses Association have issued strongly worded position statements recognizing the prevalence of workplace violence in health care and advocating for its prevention. The authors of these statements believe that recognition of workplace violence in the form of prevention policy must be part of a comprehensive program such as the one described in this paper.

This paper describes a participatory intervention to prevent workplace violence, based on the OSHA guidelines, that was implemented in three New York State in-patient mental health facilities between 2000 and 2004. The purpose of the study was to evaluate the feasibility of the participatory intervention process as well as to evaluate the impact of the program on threats of assault and staff perception of the quality of their facility's violence-prevention program. Finally, the paper describes best practices as identified by joint labour-management advisory groups that were responsible for developing and implementing the violence-prevention programs at the study facilities.

Literature Review

Workplace violence is recognized as a significant occupational hazard in the health and social service sectors, particularly in mental health facilities (Bensley, Nelson, Kaufman, Silverstein, & Kalat, 1993; Bensley et al., 1997; CDC/NIOSH, 2001; Duhart, 2001; Duncan et al., 2001; Flannery, Hanson, & Penk, 1994; Gerberich et al., 2004; Hesketh et al., 2003; Lipscomb & Love, 1992; Love & Hunter, 1996; McPhaul & Lipscomb, 2004; Rippon, 2000; Toscano & Weber, 1995; UIIPRC, 2001). According to the Department of Justice National Crime Victim Survey (Duhart), an average of 1.7 million assaults occur at work annually in the United States. The assault rate for mental health professionals and custodial workers is 68.2 per 1,000, compared to 12.6 per 1,000 workers across all occupations. The rate for nurses across all settings is 21.9% (Duhart). Six percent of the workplace crimes result in injury requiring medical treatment, yet only about half (46%) of all incidents are reported to the police. The health sector leads all industries in non-fatal assaults, with 45% of all non-fatal assaults against workers in the United States resulting in lost workdays (Bureau of Labor Statistics, 2006). The rate of nonfatal assaults to workers in "nursing and personal care facilities" is 31.1 per 10,000, versus only 2.8 per 10,000 in the private sector as a whole

(Bureau of Labor Statistics). In a Washington State psychiatric facility, 73% of staff surveyed reported at least a minor injury related to an assault by a patient during the previous year; only 43% of those reporting moderate, severe, or disabling injuries related to such assaults had filed for workers' compensation. The survey found an assault incidence rate of 437 per 100 employees per year, compared to hospital incidence rates of only 35 per 100 (Bensley et al., 1997).

Very few published studies include an evaluation of violence-prevention efforts. Runyan, Zakocs, and Zwerling (2000), in a comprehensive review of the literature on violence-prevention interventions, found five studies evaluating training interventions (Carmel & Hunter, 1990; Goodridge, Johnston, & Thomson, 1997; Infantino & Musingo, 1985; Lehmann, Padilla, Clark, & Loucks, 1983; Parkes, 1996), two examining post-incident psychological debriefing programs (Flannery, Rosen, & Turner, 1998; Matthews, 1998), and three evaluating administrative controls to prevent violence (Drummond, Sparr, & Gordon, 1989; Hunter & Love, 1996). All studies focused on the health-care sector and all involved registered nurses as well as other direct-care staff. Findings from these nine studies were equivocal, with six reporting a positive impact and three reporting no impact or a negative impact. All were quasi-experimental and did not use a formal control group. Runyan et al. criticize the design of violence-prevention interventions published to date because of the lack of systematic rigour in the evaluation.

Since publication of the Runyan et al. (2000) review, Arnetz and Arnetz (2000) have reported on a randomized controlled trial of 47 health-care workplaces that examined an intervention of "continuous registration" of violent events for 1 year with "structured feedback" from supervisors. Hospitals that received the intervention reported significantly more incidents of violence than the control hospitals. The authors attribute this finding to increased awareness and reporting of the violence following the intervention, as well as improved supervisory support at these facilities. None of the aforementioned intervention studies documented the organizational process for implementing a violence-prevention program or for evaluating the impact of a program.

Methods

Setting

The New York State Office of Mental Health (OMH) was selected as the setting for this study, as a result of pilot work that demonstrated both feasibility and strong labour-management cooperation (Rosen, 1997) and monitoring by an active labour-management health and safety committee, the OMH Multi-Union Health and Safety Committee. In

1998, the OMH, working through this committee, instituted a Safe and Therapeutic Environment Program (STEP) policy requiring all 26 inpatient OMH facilities to develop and implement a proactive violence-prevention program based on the OSHA guidelines and pilot projects. The 1998 STEP policy integrated existing agency policies and requirements of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The system-wide implementation of STEP, along with the strong support of the Health and Safety Committee and the collaboration of academic researchers, presented a "natural experiment" whereby the feasibility and impact of a participatory workplace violence-prevention intervention could be evaluated.

Sample

Early in this 4-year project, a Request for Applications was sent to all inpatient mental health facilities in New York State inviting them to serve as intervention sites (n = 26). Criteria for selection as a study site included management commitment, as measured by willingness to commit the resources necessary to develop and implement a program and labour/management cooperation demonstrated by the presence of an active health and safety committee. Seven applications were received and three psychiatric facilities (two for adults and one for children) were selected to receive the interventions. Later, three facilities similar to the intervention sites in terms of the type of facility (i.e., for adults or for children) and location (i.e., upstate, downstate), as well as having established labour and management cooperation, were selected for comparison. The selected psychiatric facilities ranged in size from 54 beds (children) to 369 beds (adults). The children's facilities serve a larger geographic area than the adult facilities. All intervention and comparison facilities serve a civil population. A large percentage of patients in all OMH facilities have dual diagnoses of mental illness and chemical addiction and, often, a history of criminal activity. Despite these similarities, there are substantial differences between individual facilities, due in part to a high degree of operational autonomy and a high degree of variability in the implementation of the STEP policy amongst the 26 OMH facilities.

Participation by comparison facilities was voluntary and, at baseline, these facilities had lower rates of assaults on staff. Furthermore, staff in comparison facilities perceived the quality of their facilities' violence-prevention program as higher than did staff in intervention facilities. Management and union leaders have ascribed this finding to the high level of cooperation between labour and management at the comparison facilities. In this paper, we refer to the non-intervention sites as "comparison" sites; however, they might more accurately be described as "usual

practice" sites, as they were responsible for implementing the OMH STEP policy but did not benefit from the support of the team resources of the worksite-violence study (i.e., consultation with the team and with the project's New York State-based violence-prevention coordinator). Within each intervention and comparison facility, three wards were selected as the focus of the intervention and evaluation so that the study team could concentrate our efforts and resources on a feasible number of study units.

Description of the Intervention

The OSHA *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (www.osha.gov) served as a framework for the study. The study used a participatory action research approach, with management, labour, and direct-care staff representatives working closely with researchers in the design and implementation of the project (Israel, Eng, Schulz, Parker, & Satcher, 2005; Robson, Shannon, Goldenhar, & Hale, 2001). A Project Advisory Group (PAG) made up of labour, OMH, and academic partners provided guidance and oversight for the overall project. The intervention had three main components: (1) developing and supporting a facility-level PAG to design and implement a facility-specific program, (2) conducting a comprehensive risk assessment, and (3) designing and implementing feasible recommendations evolving from the risk assessment.

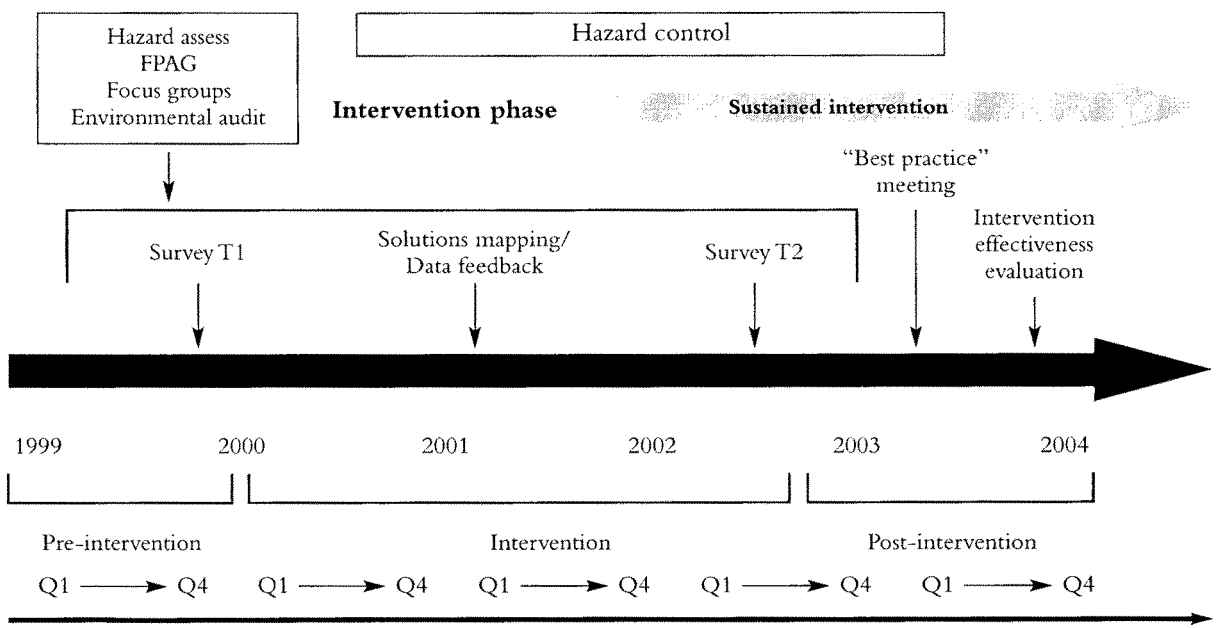
The 4-year project included a number of specific activities as depicted in the study timeline (Figure 1). The timeline was driven in part by the availability of federal funds; however, efforts to sustain the project continue with labour/management cooperation in several OMH facilities.

The OSHA elements of management commitment and employee involvement, worksite analysis, hazard control and prevention, and training were operationalized within the project as described below.

Management Commitment and Employee Involvement: Joint Labour-Management PAGs

The greatest challenge in designing and implementing a comprehensive violence-prevention program is securing strong management and labour (and/or worker) support. The central mechanism for assuring this first and most critical element of the OSHA guidelines was joint hospital-level labour-management PAGs. These local groups of 10 to 15 individuals were responsible for shaping and implementing the violence-prevention program in each intervention workplace. They reviewed draft focus group and survey questions and participated in walk-through environmental surveys. They developed action plans for responding to each specific recommendation in the worksite analysis. This included evaluating recom-

Figure 1 *Workplace Violence Prevention Intervention Study Timeline*



mended changes to clinical and work practices and, where necessary, updating policies and implementing suggested environmental controls. The groups also guided the development of site-specific training and ongoing evaluation of the project.

Worksite Analysis

A primary function of the study team was to conduct a comprehensive worksite analysis based on strong input from the PAG and direct-care providers. The analysis had four components: (1) review of facility injury data, (2) environmental survey of the study wards in each intervention facility, (3) staff focus groups, and (4) staff survey. The first two of these components are described below.

Review of injury data. The collection and evaluation of injury data is critical to the success of any violence-prevention program. The OMH maintains an electronic injury and illness database, the Occupational Injury Reporting System (OIRS), which tracks staff injuries from all causes. Quarterly reports are provided to all the facilities. This system allowed for the analysis of injury trends by job title, time of day, severity, and other factors. The OIRS injury data were tracked over the course of the study (including a retrospective review of data from the preceding 2 years) to evaluate the impact of the intervention on patient-related assaults.

Environmental survey. An architect specializing in the design and renovation of secure state buildings conducted extensive walk-through evaluations of each intervention ward across all work shifts. The survey had six components: (1) review of background data such as floor plans, typical patient characteristics, incident reports, and staffing levels; (2) an initial tour to examine the worksite layout; (3) a discussion with direct-care staff to learn about how the ward operated, typical schedules, and problems or concerns; (4) observation of staff and patient interaction and discussion with staff during both day and evening shifts; (5) follow-up discussion with the PAG to review observations and initial impressions; and (6) preparation of a written report documenting observations, including photographs of the wards, making comparisons with similar environments, and providing short- and long-term recommendations for environmental modification.

Hazard Prevention and Control

The intervention consisted of a number of distinct, ongoing hazard-control activities. Early in the project, the PAGs developed hazard-control action plans to address risks identified in the injury data review, environmental survey, focus groups, and staff survey. The Statewide Project

Advisory Group tracked each facility's progress in implementing these plans.

Environmental controls. Short-term and long-term environmental recommendations were addressed as part of the hazard-control portion of the project. Each intervention facility attempted to implement the feasible short-term recommendations within 6 months of receiving its individual environmental survey report. Long-term recommendations were considered for future capital-improvement projects. In a number of cases, the environmental audit was used to support requests for funding. Examples of specific recommended controls are shown in Figure 2.

Administrative and work-practice controls. A major focus of the intervention was improved communication and teamwork — for example, including direct-care staff in developing and implementing treatment plans and sharing information between shifts regarding individual patient aggressiveness. In one facility a peer "coach" was assigned to help direct-care staff to improve their skills in preventing and managing crisis situations.

Figure 2 ***Recommendations from Environmental Survey***

Design	Replace solid panel doors with lexan (transparent) panels to allow for line of sight in and out of staff offices (ST). Reorganize patient sleeping areas to reduce staff need to monitor at any given time (LT).
Structure	Secure bedroom wardrobes to floor/wall to avoid use as weapon or as door blockade (ST). Replace solid wall in day room with a lexan (transparent) window to allow for line of sight and more light into this highly used space (LT).
Hardware/Mechanical	Replace open hinges with continuous hinges on doors leading in and out of patient-care areas to reduce pinching hazards (ST). Instal a personal alarm system (LT).
Acoustics	Provide carpet and absorptive wall panels in day room to address poor acoustics and to reduce stress and anxiety (ST).
Functional	Modify medication administration policy to avoid long patient lines and the potential for client-on-client altercations (ST). Implement a smoke-free workplace to reduce workplace violence associated with smoking (LT).

Note: ST = short-term recommendation; LT = long-term recommendation.

Staff Training and Education

Training and education is a distinct element of the OSHA guidelines. The OMH's Preventing and Managing Crisis Situations (PMCS) is a comprehensive, mandatory two-and-a-half-day course given annually at all OMH facilities by staff certified as PMCS trainers. The curriculum covers assessment of potential violence, non-verbal and verbal de-escalation techniques, approved physical defensive intervention techniques, and application of seclusion/restraint procedures.

Rather than provide redundant training, the project's training element was designed to increase management commitment and employee involvement in the violence-prevention process and to identify additional interventions. Staff learned how to use risk-assessment data (e.g., focus group and staff survey results) to develop a specific hazard-control plan, identify barriers, reach consensus, and keep the process moving. This was accomplished in a participatory, multidisciplinary day-long workshop. It also served as a forum for the PAG and researchers to communicate directly with direct-care staff and managers on the progress of the project. Project-related training began with a presentation and discussion of focus group results, environmental surveys, and the staff survey findings. Next, joint management and labour teams facilitated small group discussions of specific problems identified during the risk-assessment process and spent several hours generating concrete, feasible solutions acceptable to staff and management alike. Over the subsequent 6 months, the PAG developed action plans for each proposed solution and communicated its progress to staff during follow-up meetings.

Evaluation of Intervention Effectiveness

Focus Group Methods

Purposive sampling of direct-care workers at each of the three intervention facilities was conducted in such a way that non-supervisory direct-care workers were recruited to participate in focus groups on work time prior to the commencement of the intervention. Two focus groups at each intervention facility were conducted, allowing for participation across shifts and non-supervisory job titles. The pre-intervention focus groups launched the intervention in the sense that, by discussing the issue, the workers became sensitized and engaged in violence-prevention efforts. The post-intervention focus group was conducted with members of the Facility Project Advisory Groups (FPAGs) from each of the three intervention facilities and observed by the PAG members. Instead of being a confidential forum for staff to discuss violence, the post-intervention group represented an opportunity to share best practices and what worked for each facility.

Focus groups were conducted with direct-care staff to inform survey development and to provide qualitative data on staff perceptions of risk factors for violence on their wards and proposed solutions. Sixty staff members participated in one of six focus groups (two per intervention facility) conducted across all shifts at the three sites. Each 90-minute discussion was led by a trained facilitator, external to the OMH, and was centred on four questions: (1) In your opinion, what are the three leading causes of violence on your unit and/or in your facility? (2) If you were the director in charge of a safe and therapeutic environment, what practical steps would you take to reduce violence, provide safety to the direct care staff, and improve therapeutic treatment of patients? (3) In your opinion, what are the greatest barriers to implementing these practical steps? (4) Are you satisfied with the current violence-prevention core curriculum/training in your facility?

Focus Group Findings

Findings related to common themes emerging from the focus group discussions were presented to the FPAGs for discussion and action. They were also presented to direct-care staff during the project-related training sessions that generated additional ideas for intervention. These themes included the changing patient populations, inadequate staffing and deployment of staff, hierarchical management style, and low management commitment to staff safety. Additional, specific risk factors that emerged from the focus group discussions included ineffective patient programming and problems such as long wait times in food lines.

In the final year of the project, representatives of the three intervention PAGs met with the research staff to discuss lessons learned and the project's successes. This discussion was conducted as a focus group, with one member of the project staff serving as facilitator. Individuals representing the three facilities were asked to discuss what worked and did not work throughout the project. The discussion was recorded on flip charts, summarized in a report, and shared with participants for review, validation, and revision. This report was ultimately shared with the directors of all 26 facilities.

Project successes included a violence-prevention training coach at one study site and the adoption of one facility's written violence-prevention program in the facility's overall strategic plan. A summary of the meeting resulted in the following list of violence-prevention best practices addressing each of the five elements of the OSHA guidelines:

Management commitment to the violence-prevention program

- management communication of its intentions to reduce violence on the wards

- regular participation of senior leadership in violence-prevention meetings
- senior staff presence at all PMCS training sessions and a requirement for management to comply with annual PMCS training
- participation of upper-level administrators in ward rounds and morning report
- ongoing data collection, data sharing, and discussion of injury data with staff
- use of the courts for medication over-resistance and pressing assault charges
- management responsiveness to staff solutions for reducing violence
- allocation of resources for staff training and overtime related to violence prevention
- strong program for post-assault response staff

Employee involvement in the violence-prevention program

- regular communication via the committee process: rounds, shift-to-shift communication
- multidisciplinary STEP committee membership
- team approach to identifying needs and solutions and consensus decision-making on implementation of project recommendations

Hazard-assessment activities

- use of staff focus groups and staff surveys
- periodic environmental audit/assessment and mapping of high-risk areas with staff input
- encouragement of accurate and timely reporting of injuries
- data collection and analysis and review of reporting practices

Hazard-control activities

Infrastructural/organizational

- creation of violence-prevention infrastructure (STEP/PAG committee)
- documentation of the hazard controls implemented or a timetable for implementation
- assessment of hazard-control effectiveness via the committee infrastructure using ongoing data collection and review

Environmental

- assessment of ward movement to avoid prolonged standing in line
- installation of locks wherever necessary
- installation of staff personal alarm system and alarms in all nursing stations and medicine and treatment rooms
- removal of wire glass

Administrative

- ongoing assessment of data collection and data use
- ongoing assessment of PMCS training and management of psychiatric emergencies

Behavioural

- improvement of the shift-to-shift reporting process
- senior staff rounds of treatment units
- clinical/treatment rounds across disciplines, including treatment aides

Staff Survey Methods

A representative staff survey was conducted prior to full implementation of the participatory intervention and 1 year post-intervention. In each of the six facilities (three intervention and three comparison), all staff, including supervisors and administrators, were invited to participate in the survey. Staff were provided release time to complete the survey during work hours. The study coordinator visited the facilities and administered the survey on all three shifts.

Identical direct-care staff surveys were conducted in 2001 and 2003. The survey was adapted from a Washington State survey developed for assessing assaults in state mental hospitals (Bensley et al., 1997). It included sections on risk factors for violence, violence-prevention measures, threats and assaults, and staff perceptions of the quality of the OSHA elements on their ward. The self-administered survey took approximately 20 minutes to complete and was completed on work time.

The survey analysis consisted of the change in staff perceptions of the quality of the OSHA elements on their ward, as well as their change in frequency of assault experience over the preceding 12 months. Staff were asked to evaluate the quality of (1) management commitment to violence prevention, (2) employee involvement in violence-prevention efforts, (3) environmental design of ward (environmental controls), and (4) staff teamwork and cooperation (administrative and work practice controls) on their ward over the preceding 12 months (1 = *poor*, 2 = *fair*, 3 = *good*, 4 = *excellent*). Staff were also asked if they had participated in PMCS training during the previous year (yes/no).

The aforementioned staff assaults were assessed by asking the number of times in the preceding 12 months the worker experienced patient aggression while assigned to duties on their current ward. There were six levels of violence: (1) threat but no physical contact, (2) physical assault but no physical injury, (3) physical assault resulting in mild injury, (4) physical assault resulting in moderate injury, (5) physical assaults resulting in major injuries, and (6) physical assault resulting in permanent/partial physical disability.

Frequencies were examined by facility and also by intervention and comparison group. Analysis of variance was used to test the change in scores, using an alpha of .05 to evaluate level of significance. All analyses were conducted using SPSS Version 11.0.

Staff Survey Findings

Between May 2001 and January 2002 the pre-intervention survey was completed by 406 direct-care staff (90% response rate) from three intervention and three comparison facilities. The post-intervention survey was conducted in the spring of 2003 and was completed by 319 direct-care staff (70% response rate). The number of respondents from individual facilities ranged from 43 to 117 for the pre-intervention survey and 36 to 69 for the post-intervention survey. Because surveys were anonymous and no identifiers were used, it was not possible to match data from pre- and post-surveys. Among respondents, approximately 65% were female; > 70% were 40 years of age or older; 60% were non-white; 50% were mental health therapy aides, 24% were registered nurses, and 26% had various clinical job titles.

Table 1 compares staff ratings, for intervention and comparison facilities (mean value on a scale of 1–4), of the quality of the OSHA elements. The item "percentage trained in the past year" was reported as yes/no. Staff in both intervention and comparison facilities reported statistically significant (or borderline) improvements in the first four elements, while the intervention facilities also reported significant improvement in the fifth element.

Table 2 compares the frequency of reported threats and physical assaults among intervention and comparison facility staff pre- and post-intervention. Overall, nearly 90% of staff reported threats of assault in the preceding 12 months (data not shown), with the mean number ranging from 35 to 70 threats for the two time periods and two groups. By comparison, less than 40% of staff reported a physical assault with moderate injury, with the mean number ranging from 0.8 to 1.76 per staff member. When the difference (or change) in reported threats and physical assaults during the preceding 12 months was calculated for the pre- and post-intervention periods, a slight reduction in the mean change in physical assaults with any level of injury among intervention facility staff and among severe and permanent injury among comparison facility staff was noted. An increase was observed in threats of assault among the staff of both intervention and comparison facilities. Possible interpretations for this finding include: a greater tendency to report these less severe events; a shift of some physical assaults to threats of assault (an averted physical assault); or a real increase in threats of assault.

Table 1 *Change in OSHA Element Mean Item Scores for Staff Working in Six New York State Inpatient Psychiatric Facilities (Pre-survey in 2001, Post-survey in 2003)*

OSHA Elements	Intervention (*N*=468)					Comparison (*N*=257)				
		Mean	(*SD*)	*F*	*P* Value		Mean	(*SD*)	*F*	*P* Value
Management commitment[a]	Pre	2.16	(0.88)	19.56	< .001	Pre	2.38	(1.00)	5.52	0.020
	Post	2.53	(0.84)			Post	2.65	(0.82)		
Employee involvement[a]	Pre	2.41	(0.85)	13.39	< .001	Pre	2.43	(0.90)	15.41	< .001
	Post	2.71	(0.81)			Post	2.84	(0.74)		
Environmental design of ward[a]	Pre	2.01	(0.83)	6.01	.015	Pre	2.18	(0.89)	4.56	0.034
	Post	2.21	(0.81)			Post	2.41	(0.82)		
Staff teamwork and cooperation[a]	Pre	2.79	(0.83)	4.74	.030	Pre	2.69	(0.90)	2.96	0.087
	Post	2.97	(0.87)			Post	2.89	(0.83)		
% Training in past year[b]	Pre	62.4	(48.5)	30.29	< .001	Pre	60.7	(49.0)	0.95	0.201
	Post	85.6	(35.2)			Post	66.7	(47.4)		

[a] Response options: 1 = *poor*, 4 = *excellent*.
[b] Percentage of staff receiving PMCS training in the preceding year.

Table 2 *Change in Frequencies of Threats and Assaults for Psychiatric Hospital Staff Working in Six NYS Inpatient Facilities (Pre-survey in 2001, Post-survey in 2003)*

Threats/Assaults	Intervention (*N*=468)					Comparison (*N*=257)				
		Mean Number of Assaults	(*SD*)	Mean Change %	*P* Value		Mean Number of Assaults	(*SD*)	Mean Change %	*P* Value
Threat of assault by a patient but no physical injury	Pre	35.30	(70.31)	98.3	< .001	Pre	36.24	(72.03)	46.8	0.08
	Post	70.00	(90.32)			Post	53.21	(76.02)		
Physical assault by a patient but no injury	Pre	10.26	(38.85)	21.2	0.59	Pre	7.21	(31.78)	18.9	0.75
	Post	12.43	(43.45)			Post	8.57	(34.07)		
Physical assault by a patient – mild injury	Pre	6.53	(29.50)	-2.9	0.95	Pre	3.28	(18.02)	51.8	0.54
	Post	6.34	(27.07)			Post	4.98	(24.67)		
Physical assault by a patient – moderate injury	Pre	1.76	(7.29)	-17.6	0.65	Pre	0.85	(1.93)	52.9	0.47
	Post	1.45	(6.49)			Post	1.30	(6.81)		
Physical assault by a patient – severe injury	Pre	0.23	(0.95)	-43.5	0.23	Pre	0.17	(0.60)	-17.6	0.77
	Post	0.13	(0.54)			Post	0.14	(0.75)		
Physical assault by a patient – permanent injury	Pre	0.09	(0.42)	-11.1	0.69	Pre	0.06	(0.27)	-16.5	0.60
	Post	0.08	(0.30)			Post	0.05	(0.28)		

[a] Number of threats/assaults during the preceding 12 months. Unit = Number of times/preceding 12 months.

Trends in facility-level occupational injury data (OIRS) prior to and during the course of this study yielded equivocal results (not shown) and suggest either that facility-level data are not sensitive to the impact of the intervention at the ward level or that the intervention had no detectable impact on incident reports over the study period.

Discussion

This paper has described a process for implementing the OSHA guidelines in the in-patient mental health setting. The process, although examined within the in-patient mental health setting, can serve as a model for all health and social service workplaces regardless of the risk of workplace violence in the setting. The process of worksite analysis, hazard control, education, and evaluation is a traditional approach to workplace safety and, as such, should be incorporated into risk-management activities. In settings with a patient population at lower risk of violence than the mental health setting, such as acute care and outpatient settings, a more limited environmental audit than the one conducted here may be sufficient — for example, a walk-through survey conducted by direct-care and building maintenance staff. It should be pointed out that most health-care workplaces are at risk of workplace violence. The benefit of averting an incident of serious workplace violence far outweighs the cost of a proactive program.

The OSHA guidelines serve as an effective performance-based model for a comprehensive program. Their emphasis on management commitment and employee involvement was critical to the successful implementation of the program at each of the three facilities. The model of ongoing hazard analysis, control, and evaluation has facilitated the continuing growth of each program. The discussion among PAGs from the three intervention facilities in the final year of the project was highly effective for synthesizing and sharing project success stories and will facilitate the dissemination of the project beyond the three study sites. Moreover, future communication will help to sustain and improve programs across all facilities.

Program impact was evaluated through a combination of quantitative and qualitative assessments. Specifically, qualitative (i.e., focus group) data informed quantitative (staff survey) tool development. Both types of data were used by PAGs to define the nature and magnitude of the hazard and to craft control strategies. A comparison of pre- and post-intervention survey data indicates an improvement in staff perception of the quality of the facility's violence-prevention program (i.e., OSHA elements) in both intervention and comparison facilities. Objective data that might validate

staff perception data were not sought since, in general, we were most interested in staff perceptions relative to violence-prevention efforts. Staff in both intervention and comparison facilities reported improvements in management commitment, employee involvement, environmental design of ward, and staff teamwork and cooperation. The intervention facilities also reported improvements in the percentage of staff receiving PMCS training in the preceding year, which may reflect heightened awareness of the importance of training in the context of a comprehensive program.

It should be noted that because this intervention project was conducted within a highly dynamic mental health-care system, the OMH continued to implement a number of statewide initiatives to address workplace violence prior to and during the study. These initiatives included: the Safe and Therapeutic Environment Program (STEP) policy, a statewide Trauma Response policy, a comprehensive employee training initiative, and a related clinical program for trauma and mentally ill substance abusers. It was in this dynamic environment that we measured improvements at both intervention and comparison facilities. Comparison of the change in staff-reported physical assaults did not indicate a statistically significant reduction in staff assaults at the facility level in either intervention or control facilities.

The project has a number of limitations. Many factors, individually and in combination, contribute to physical assaults in the in-patient mental health setting. We did not measure and therefore were unable to control for any of the individual patient or staff characteristics that undoubtedly contribute to the occurrence of assaults. For example, it is recognized that a small percentage of the patient population, less than 10%, is responsible for up to 50% of violence towards staff (Lion, Snyder, & Merrill, 1981). This project did not attempt to develop a specific strategy for preventing the violence perpetrated by this patient subset. We did not control for the movement of these patients throughout the system, which may have contributed to our difficulty in demonstrating a reduction in physical assault over time. The need to address the problem of patients who are frequent assaulters was identified in this project.

The OSHA guidelines focus on controlling workplace violence via environmental modification, review of policy and procedure, and training. Likewise, this project focused on these types of prevention activities. In addition, an intervention designed to promote change at the organizational level is likely to require a longer follow-up period than 1 year between the project-related training and the post-intervention survey. In addition, because of the relative intensity of the intervention, the number of participating facilities was limited (i.e., study units and

staff). Lastly, we were unable to randomly assign facilities to either the intervention or the comparison group, and therefore were unable to control for many unmeasured differences between and among intervention and comparison facilities.

Among the project's many strengths was the participatory research framework, which maximized the expertise and collaborative work of academic researchers, management, labour unions, and direct-care staff. A second important strength was the commitment of the OMH Multi-Union Health and Safety Committee to the transparent and ongoing evaluation of its violence-prevention activities, allowing for the description and evaluation of this unique endeavour. In an effort to communicate the results to other OMH facilities and beyond, the project findings were presented at a meeting of the 26 facility directors upon completion of the funded research project.

In conclusion, this paper provides evidence of the feasibility and positive impact of a comprehensive violence-prevention program, based on the OSHA guidelines, within the in-patient mental health workplace. In addition, the paper has described the challenges entailed in evaluating a program's impact in mental health settings as well as the importance of using both quantitative and qualitative measures to assess impact. Evaluation of the project's sustainability will include conducting future focus groups in the intervention facilities and continuous evaluation of the OIRS data on injuries related to patient behaviour.

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VIOLENCE in the Workplace

Current Intelligence Bulletin 57

Risk Factors and Prevention Strategies

Risk Factors

A number of factors may increase a worker's risk for workplace assault, and they have been described in previous research [Collins and Cox 1987; Davis 1987; Davis et al. 1987; Kraus 1987; Lynch 1987; NIOSH 1993; Castillo and Jenkins 1994]. These factors include the following:

- Contact with the public
- Exchange of money
- Delivery of passengers, goods, or services
- Having a mobile workplace such as a taxicab or police cruiser
- Working with unstable or volatile persons in health care, social service, or criminal justice settings
- Working alone or in small numbers
- Working late at night or during early morning hours
- Working in high-crime areas
- Guarding valuable property or possessions
- Working in community-based settings

Prevention Strategies

Environmental Designs

Commonly implemented cash-handling policies in retail settings include procedures such as using locked drop safes, carrying small amounts of cash, and posting signs and printing notices that limited cash is available. It may also be useful to explore the feasibility of cashless transactions in taxicabs and retail settings through the use of machines that accommodate automatic teller account cards or debit cards. These approaches could be used in any setting where cash is currently exchanged between workers and customers.

Physical separation of workers from customers, clients, and the general public through the use of bullet-resistant barriers or enclosures has been proposed for retail settings such as gas stations and convenience stores, hospital emergency departments, and social service agency claims areas. The height and depth of counters (with or without bullet-resistant barriers) are also important considerations in protecting workers, since they introduce physical distance between workers and potential attackers. Consideration must nonetheless be given to the continued ease of conducting business; a safety device that increases frustration for workers or for customers, clients, or patients may be self-defeating.

Visibility and lighting are also important environmental design considerations. Making high-risk areas visible to more people and installing good external lighting should decrease the risk of workplace assaults [NIOSH 1993].

Access to and egress from the workplace are also important areas to assess. The number of entrances and exits, the ease with which nonemployees can gain access to work areas because doors are unlocked, and the number of areas where potential attackers can hide are issues that should be addressed. This issue has implications for the design of buildings and parking areas, landscaping, and the placement of garbage areas, outdoor refrigeration areas, and other storage facilities that workers must use during a work shift.

Numerous security devices may reduce the risk for assaults against workers and facilitate the identification and apprehension of perpetrators. These include closed-circuit cameras, alarms, two-way mirrors, card-key access systems, panic-bar doors locked from the outside only, and trouble lights or geographic locating devices in taxicabs and other mobile workplaces.

Personal protective equipment such as body armor has been used effectively by public safety personnel to mitigate the effects of workplace violence. For example, the lives of more than 1,800 police officers have been saved by Kevlar® vests [Brierley 1996].

Administrative Controls

Staffing plans and work practices (such as escorting patients and prohibiting unsupervised movement within and between clinic areas) are included in the California Occupational Safety and Health Administration *Guidelines for the Security and Safety of Health Care and Community Service Workers* [State of California 1993]. Increasing the number of staff on duty may also be appropriate in any number of service and retail settings. The use of security guards or receptionists to screen persons entering the workplace and controlling access to actual work areas has also been suggested by security experts.

Work practices and staffing patterns during the opening and closing of establishments and during money drops and pickups should be carefully reviewed for the increased risk of assault they pose to workers. These practices include having workers take out garbage, dispose of grease, store food or other items in external storage areas, and transport or store money.

Policies and procedures for assessing and reporting threats allow employers to track and assess threats and violent incidents in the workplace. Such policies clearly indicate a zero tolerance of workplace violence and provide mechanisms by which incidents can be reported and handled. In addition, such information allows employers to assess whether prevention strategies are appropriate and effective. These policies should also include guidance on recognizing the potential for violence, methods for defusing or de-escalating potentially violent situations, and instruction about the use of security devices and protective equipment. Procedures for obtaining medical care and psychological support following violent incidents should also be addressed. Training and education efforts are clearly needed to accompany such policies.

Behavioral Strategies

Training employees in nonviolent response and conflict resolution has been suggested to reduce the risk that volatile situations will escalate to physical violence. Also critical is training that addresses hazards associated with specific tasks or worksites and relevant prevention strategies. Training should not be regarded as the sole prevention strategy but as a component in a comprehensive approach to reducing workplace violence. To increase vigilance and compliance with stated violence prevention policies, training should emphasize the appropriate use and maintenance of protective equipment, adherence to administrative controls, and increased knowledge and awareness of the risk of workplace violence.

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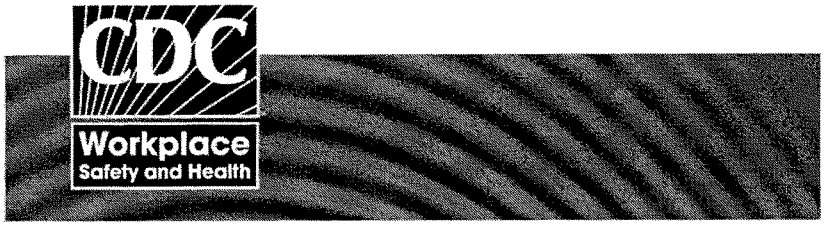

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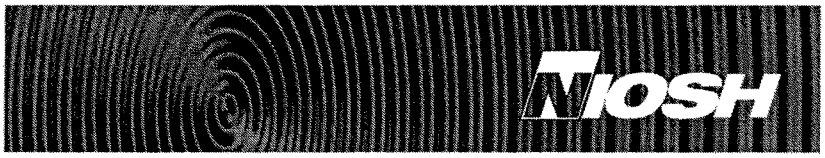

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About NIOSH

As part of the Centers for Disease Control and Prevention (CDC), the National Institute for Occupational Safety and Health (NIOSH) conducts research and makes recommendations to prevent work-related illness and injury. NIOSH works with industries, labor organizations, and universities to understand and improve worker safety and health.

NIOSH is often confused with OSHA (the Occupational Safety and Health Administration). However, NIOSH and OSHA are separate agencies with different functions. NIOSH is a CDC research agency in the U.S. Department of Health and Human Services. OSHA is a regulatory agency in the U.S. Department of Labor.

Introduction

Today more than 5 million U.S. hospital workers from many occupations perform a wide variety of duties. They are exposed to many safety and health hazards, including violence. Recent data indicate that hospital workers are at high risk for experiencing violence in the workplace. According to estimates of the Bureau of Labor Statistics (BLS), 2,637 nonfatal assaults on hospital workers occurred in 1999—a rate of 8.3 assaults per 10,000 workers. This rate is much higher than the rate of nonfatal assaults for all private-sector industries, which is 2 per 10,000 workers.

Several studies indicate that violence often takes place during times of high activity and interaction with patients, such as at meal times and during visiting hours and patient transportation. Assaults may occur when service is denied, when a patient is involuntarily admitted, or when a health care worker attempts to set limits on eating, drinking, or tobacco or alcohol use.

The purpose of this brochure is to increase worker and employer awareness of the risk factors for violence in hospitals and to provide strategies for reducing exposure to these factors.

What is workplace violence?

Workplace violence ranges from offensive or threatening language to homicide. NIOSH defines workplace violence as *violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty.*

Examples of violence include the following:

Threats: Expressions of intent to cause harm, including verbal threats, threatening body language, and written threats.

Physical assaults: Attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives.

Muggings: Aggravated assaults, usually conducted by surprise and with intent to rob.

Case Reports

An elderly patient verbally abused a nurse and pulled her hair when she prevented him from leaving the hospital to go home in the middle of the night.

• • • • •

An agitated psychotic patient attacked a nurse, broke her arm, and scratched and bruised her.

• • • • •

A disturbed family member whose father had died in surgery at the community hospital walked into the emergency department and fired a small-caliber handgun, killing a nurse and an emergency medical technician and wounding the emergency physician.

These circumstances of hospital violence differ from the circumstances of workplace violence in general. In other workplaces such as convenience stores and taxicabs, violence most often relates to robbery. Violence in hospitals usually results from patients and occasionally from their family members who feel frustrated, vulner able, and out of control.

Who is at risk?

Although anyone working in a hospital may become a victim of violence, nurses and aides who have the most direct contact with patients are at higher risk. Other hospital personnel at increased risk of violence include emergency response personnel, hospital safety officers, and all health care providers.

Where may violence occur?

Violence may occur anywhere in the hospital, but it is most frequent in the following areas:

- Psychiatric wards
- Emergency rooms
- Waiting rooms
- Geriatric units

What are the effects of violence?

The effects of violence can range in intensity and include the following:

- Minor physical injuries
- Serious physical injuries
- Temporary and permanent physical disability
- Psychological trauma
- Death

Violence may also have negative organizational outcomes such as low worker morale, increased job stress, increased worker turnover, reduced trust of management and coworkers, and a hostile working environment.

What are the risk factors for violence?

The risk factors for violence vary from hospital to hospital depending on location, size, and type of care. Common risk factors for hospital violence include the following:

- Working directly with volatile people, especially if they are under the influence of drugs or alcohol or have a history of violence or certain psychotic diagnoses
- Working when understaffed—especially during meal times and visiting hours
- Transporting patients
- Long waits for service
- Overcrowded, uncomfortable waiting rooms
- Working alone
- Poor environmental design
- Inadequate security
- Lack of staff training and policies for preventing and managing crises with potentially volatile patients
- Drug and alcohol abuse
- Access to firearms
- Unrestricted movement of the public
- Poorly lit corridors, rooms, parking lots, and other areas

Prevention Strategies for Employers

To prevent violence in hospitals, employers should develop a safety and health program that includes management commitment, employee participation, hazard identification, safety and health training, and hazard prevention, control, and reporting. Employers should evaluate this program periodically.

Although risk factors for violence are specific for each hospital and its work scenarios, employers can follow general prevention strategies.

Environmental Designs

- Develop emergency signaling, alarms, and monitoring systems.
- Install security devices such as metal detectors to prevent armed persons from entering the hospital.
- Install other security devices such as cameras and good lighting in hallways.
- Provide security escorts to the parking lots at night.
- Design waiting areas to accommodate and assist visitors and patients who may have a delay in service.
- Design the triage area and other public areas to minimize the risk of assault:
  - Provide staff restrooms and emergency exits.

— Install enclosed nurses' stations.

— Install deep service counters or bullet-resistant and shatterproof glass enclosures in reception areas.

— Arrange furniture and other objects to minimize their use as weapons.

Administrative Controls

- Design staffing patterns to prevent personnel from working alone and to minimize patient waiting time.
- Restrict the movement of the public in hospitals by card-controlled access.
- Develop a system for alerting security personnel when violence is threatened.

Behavior Modifications

- Provide all workers with training in recognizing and managing assaults, resolving conflicts, and maintaining hazard awareness.

Dealing With the Consequences of Violence

Violence may occur in the workplace in spite of preventive measures. Employers should be prepared to deal with the consequences of this violence by providing an environment that promotes open communication and by developing written procedures for reporting and responding to violence. Employers should offer and encourage counseling whenever a worker is threatened or assaulted.

Safety Tips for Hospital Workers

Watch for signals that may be associated with impending violence:

- Verbally expressed anger and frustration
- Body language such as threatening gestures
- Signs of drug or alcohol use
- Presence of a weapon

Maintain behavior that helps diffuse anger:

- Present a calm, caring attitude.
- Don't match the threats.
- Don't give orders.
- Acknowledge the person's feelings (for example, "I know you are frustrated").
- Avoid any behavior that may be interpreted as aggressive (for example, moving rapidly, getting too close, touching, or speaking loudly).

Be alert:

- Evaluate each situation for potential violence when you enter a room or begin to relate to a patient or visitor.
- Be vigilant throughout the encounter.
- Don't isolate yourself with a potentially violent person.
- Always keep an open path for exiting—don't let the potentially violent person stand between you and the door.

Take these steps if you can't defuse the situation quickly:

- Remove yourself from the situation.
- Call security for help.
- Report any violent incidents to your management.

Case Reports: Prevention Strategies That Have Worked

A security screening system in a Detroit hospital included stationary metal detectors supplemented by hand-held units. The system prevented the entry of 33 handguns, 1,324 knives, and 97 mace-type sprays during a 6-month period.

• • • • •

A violence reporting program in the Portland, Oregon, VA Medical Center identified patients with a history of violence in a computerized database.* The program helped reduce the number of all violent attacks by 91.6% by alerting staff to take additional safety measures when serving these patients.

• • • • •

A system restricting movement of visitors in a New York City hospital used identification badges and color-coded passes to limit each visitor to a spe cific floor. The hospital also enforced the limit of two visitors at a time per patient. Over 18 months, these actions reduced the number of reported violent crimes by 65%.

*Health information and the electronic recording of this information must comply with appliscable Federal standards on privacy under Titles 42 and 45 of the U.S. Code.

Summary

All hospitals should develop a comprehensive violence prevention program. No universal strategy exists to prevent violence. The risk factors vary from hospital to hospital and from unit to unit. Hospitals should form multidisciplinary committees that include direct-care staff as well as union representatives (if available) to identify risk factors in specific work scenarios and to develop strategies for reducing them.

All hospital workers should be alert and cautious when interacting with patients and visitors. They should actively participate in safety training programs and be familiar with their employers' policies, procedures, and materials on violence prevention.

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Testimony of National Nurses United
Before the House Education and Labor Committee
Subcommittee on Workforce Protections
February 27, 2019

National Nurses United ("NNU") submits this testimony in support of legislation mandating that the Occupational Safety and Health Administration's ("OSHA") of U.S. Department of Labor issue a comprehensive occupational safety and health standard on workplace violence prevention in health care and social service settings. NNU, representing over 155,000 members across the country, is the largest union and professional association representing registered nurses ("RNs") in the United States. With members who work as bedside professionals in every state in the nation, NNU understands that workplace violence has become endemic for RNs and other workers in healthcare and social service settings.

The risk of workplace violence is a serious occupational hazard for RNs and other healthcare workers. Countless acts of assault, battery, and aggression that routinely take place in healthcare settings demonstrate a frightening trend of increasing violence faced by healthcare workers throughout the country. In addition to innumerable anecdotal and media accounts, several national surveys document the prevalence of violence committed against healthcare workers. We have included data on the incidence of violence, rates of injuries, and data and descriptions of the impact on nurses and other healthcare workers in Attachments 1 and 2.

As a persistent and endemic workplace hazard for our members, NNU has advocated for occupational health and safety standards to prevent violence in healthcare settings. Our efforts have resulted in the establishment of some of the best state-level standards on preventing and reducing violence in the workplace for our members. Where state-level standards have not been established, we have won strong protections for our members through collective bargaining. But despite these strides, protections for RNs and other healthcare workers across the country will remain piecemeal in light of federal OSHA's exclusive jurisdiction in 24 states. A federal OSHA standard on preventing workplace violence in healthcare is necessary to protect healthcare workers. We describe these reasons in more detail in Attachment 3.

Congress tasked OSHA with assuring "so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources..." including by passing mandatory standards. (29 U.S.C. § 651) From the available data and from our members' experiences, it is clear that OSHA is not upholding its duty, assigned by Congress, to protect healthcare workers from workplace violence. OSHA needs to pass a formal workplace violence prevention standard and implement a strong enforcement campaign to effectively protect healthcare workers from workplace violence. Despite

granting NNU's petition for a workplace violence prevention standard in January of 2017, OSHA's work on such a standard has stalled.[1]

A bill introduced last week and referred to this Committee, The Workplace Violence Prevention for Health Care and Social Service Workers Act (H.R. 1309), would mandate that OSHA promulgate an interim final standard on workplace violence prevention for healthcare employers within one year and a final standard within 42 months. Importantly, this bill would also set the minimum requirements for the OSHA standard, based on proven standards that have been implemented in California and on the published literature. We have described the contents of the bill and why they are important, including a description of the supporting published literature, in Attachment 4.

HEALTHCARE WORKERS REPORT A WIDE RANGE OF EXPERIENCES AND IMPACTS OF WORKPLACE VIOLENCE.

PHYSICAL FORCE AND INJURIES: The effects of workplace violence span a wide range of types and severity for RNs and other healthcare workers. Many incidents involving the use of physical force against an employee result in physical injuries, ranging from minor bruising and abrasions to death. Many of these injuries meet the criteria for recording in OSHA 300 Logs. These injuries may result in days away from work. A 2004 study found that, about 20% of respondents who experienced physical violence responded that they self-treated injuries.[2]

THREATS OF VIOLENCE: Threats of physical force and threats of the use of a dangerous weapon—although they may be solely verbal—can result in severe psychological trauma and stress for workers, especially those who are repeatedly exposed to these threats. In these situations, a physical injury is not sustained, but RNs and other healthcare workers report serious and lasting effects, including stress, anxiety, difficulty working, post-traumatic stress symptoms and disorders. These non-physical injuries harm RNs' health and may lead RNs to leave their jobs, implicating workplace violence in the high rates of turnover.[3]

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[1] OSHA moved the workplace violence standard to the long-term action list in the Spring 2017 Unified Agenda of Regulatory and Deregulatory Actions. Although it has since been moved to the action list, OSHA takes an average of seven years to complete new standards according to the Government Accountability Office's 2012 report.

Government Accountability Office. "Multiple Challenges Lengthen OSHA's Standard Setting." April 2, 2012, *available at* https://www.gao.gov/products/GAO-12-330 (Accessed February 24, 2019).

[2] Gerberich, S.G., Church T.R., McGovern P.M., et al. An epidemiological study of the magnitude and consequences of work related violence: the Minnesota Nurses' Study. *Occup. Environ. Med.* Vol. 61, 2004, pp. 495-503.

[3] Nurses who experience workplace violence are more likely to leave their jobs. Mazurenko et al. Analyzing U.S. nurse turnover: Are nurses leaving their jobs or the profession itself? *J. Hospital Admin*, Vol. 4 (4), 2015.

TRAUMA AND STRESS: One study of trauma and stress symptoms in emergency nurses was published in 2011.[4] Using the Impact of Event Scale-Revised, researchers found that 94% indicated the presence of at least one stress symptom after a violent event, 25% indicated symptoms that posed clinical concern, and 15% indicated symptoms high enough to suppress the immune system. The researchers also found that 37% of respondent nurses had negative total productivity scores, which demonstrated decreased work performance after experiencing a violent event, and found that there were significant indirect relationships between stress symptoms and work productivity.

NNU SURVEY OF REGISTERED NURSES: In surveys on nurses' experiences of workplace violence conducted by NNU during health and safety classes, the sample of 286 RNs provided responses to questions on the impact of workplace violence they experienced within the past year. These NNU survey results on the impact of workplace violence on RNs are included below in Table 1. Fifty-four percent of respondents reported that they experienced anxiety, fear, or increased vigilance due to a workplace violence incident in the previous year. Nearly 20% of the respondents reported taking time off from work to recover from workplace violence, and nearly 10% reported changing jobs or leaving their job due to workplace violence.

TABLE 1: NNU Survey on Workplace Violence – Impact of Workplace Violence on Nurses.

How has workplace violence impacted you and your work?	Percent of respondents who experienced these effects from workplace violence in the past year
Physical injury or other physical symptoms (e.g., headache, stomach aches, etc.)	16.8%
Took time off work	18.2%
Anxiety, fear, or increased vigilance	54.2%
Difficulty working in environment that reminds me of past incident	18.2%
Applied for workers' compensation	4.9%
Changed or left job	9.1%
Physical injury prevents me from working	3.5%
Psychological effects prevent me from working	9.8%
No injury/no effect or did not experience violence	30.8%

STORIES OF WORKPLACE VIOLENCE FROM DIRECT CARE REGISTERED NURSES.

Congress should consider descriptive information about worker's experiences with workplace violence in evaluation of how to effectively protect health care and social service workers from workplace violence. Descriptive information played an important role in the development of the landmark California Division of Occupational Safety and Health Standard on Workplace Violence Prevention in Health Care that went into full effect just

[4] Gates, D. et al. Violence Against Nurses and its Impact on Stress and Productivity. *Nursing Economic$*. Vol. 29:2, 2011, pp. 59-67.

last April.[5] In particular, descriptive information can inform the Committee on the quotidian experiences of nurses' and other healthcare workers' with workplace violence.

During NNU health and safety classes held between February and March 2017, we captured this type of descriptive information on workplace violence as part of a classroom activity called "hazard mapping." In hazard mapping activities, worker participants reflect on their experiences of a hazard, identify the location in the workplace, and then visualize or "map" those hazards with others in the discussion group to facilitate a conversation about hazards, prevention of those hazards, and any attendant occupational health and safety rights. The full list of descriptive examples of workplace violence that NNU collected during hazard mapping activities is included in Attachment 1.

Included here are brief descriptions of workplace violence incidents experienced by NNU members.

- Cynthia Palomata, RN in Northern California: Palomata was an RN in a jail facility where she was killed in a workplace violence incident in 2010. She and her colleagues had alerted management that the dim lighting in their work area was a risk factor for workplace violence, especially given the risk factors associated with the specific population that they work with. Her employer delayed and refused to respond, eventually providing a heavy-bottomed table lamp to improve lighting. When Palomata was providing care to a patient, he picked up the lamp and hit her on the head with it. She was in the hospital for three days and never woke up before she died. Palomata's murder was preventable, if her employer had responded to nurses' reports of risk factors for workplace violence and the necessary prevention measures.

- Allysha Shin, RN in Southern California: Shin is a nurse on a neuroscience unit in a large acute care hospital. She was carefully monitoring a patient who had had a hemorrhagic stroke. This patient had a history of violence and had been verbally abusive to Shin the previous night. She started her shift with a sitter, who was assigned to help closely monitor this patient. After two hours, the sitter was called away to attend to another patient. Later, the patient grew agitated, kicked Shin in the face, and broke free of her restraints. Shin yelled for help. It required six other staff members to assist Shin in getting the patient back to bed and in her restraints, during which the patient kicked Shin several more times. Shin had to take the next two shifts off work to recover. She reports that she still suffers from anxiety.[6]

- Elizabeth Dehaemers, Kansas City, Missouri- Dehaemers is an RN in a progressive unit at an acute care hospital. She has experienced several workplace violence incidents over the course of her career as a nurse. She has been hit by patients who are

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[5] See Title 8 Calif. Code of Reg. §3342, available at https://www.dir.ca.gov/title8/3342.html (Accessed February 23, 2019).

[6] Allysha Shin's experience was reported on by Modern Healthcare on March 13, 2017. That article is available at https://www.modernhealthcare.com/article/20170311/MAGAZINE/303119990.

disoriented. When she reports such incidents to management, she is often told that it is "just part of the job." In one particular experience, Dehaemers was punched in the face by a patient in front of four other nurses. Nothing was done; there was no follow up. A few weeks after the incident, she was reassigned to care for the same patient with no additional safety measures or supports, despite having been previously assaulted by the patient. Dehaemers reports fear and anxiety upon returning to work.

Thank you to members of the Subcommittee for holding a hearing on this serious occupational hazard. We will remain diligent in our efforts to obtain the most protective health and safety standard for our members, and we look forward to our continued work with Congress to pass H.R. 1309 and to win the most protective occupational safety and health standard for NNU's members as well as all direct care registered nurses, health care workers, and social service workers in the country.

ATTACHMENTS

1. NNU Fact Sheet: NNU "Hazard Mapping" Descriptive Data (By Hospital Unit)
2. NNU Fact Sheet: Alarmingly High Rates of Violence Among Healthcare Workers.
3. NNU Issue Brief: Why Congress Should Mandate OSHA Action on Workplace Violence Prevention.
4. NNU Issue Brief: H.R. 1309 & Necessary Elements of an OSHA Workplace Violence Prevention Standard.
5. Timeline of State & Federal Efforts On Workplace Violence.

ATTACHMENT 1: NNU "Hazard Mapping" Descriptive Data (By Hospital Unit).

NNU surveyed 286 members in Sacramento, San Francisco, and Chicago during health and safety trainings that focused on workplace violence and safe patient handling and were led by an NNU staff industrial hygienist. Focus group-style discussions and "hazard mapping" on workplace violence were also conducted at these trainings. Trainings were held between February and March 2017. Findings and results from the NNU survey and discussions have been compiled by the NNU staff industrial hygienist.

Through hazard mapping with our members, NNU captured brief descriptions of violent incidents that nurses experienced or witnessed at work. Listed below are some descriptions of workplace violence incidents collected through NNU's hazard mapping, as well as the hospital unit in which the incident occurred.

Emergency Departments (Including Entrances):

- Patient punched my chest and spit on my face while trying to sedate him in the ER.
- A nurse was punched in the jaw by a patient while the nurse was inserting an IV into his arm.
- An alcoholic patient experiencing withdrawal became combative and attempted to attack staff.
- Parent became verbally combative when told of need to perform lumbar tap and check temperature rectally of the child.
- Patient became verbally combative and hit the counter when became impatient waiting for a room and to be examined by staff.
- Patient grabbed an ink pen and tried to stab staff.
- Husband threatened staff when he was not allowed to see his wife. The husband brought his gun to the ER and threatened staff.
- Staff member attacked by patient and was cut with the staff member's scissors.
- Staff member was struck from behind by patient. Staff member suffered closed head trauma.
- Patient admitted via EMS in the ER for over 12 hours with a firearm.
- Patient angry about the wait times and threatened me that she was going to come back and hurt me in triage.
- We were in the ER by ourselves and the ER was isolated with no code buttons at the time and with no other way to get help quickly. Another pregnant nurse had to run to get help while I held the patient from behind.
- Family threatened the nurse after the patient had to be intubated and sent to the Operating Room.
- Suicidal psychiatric patient found a pair of large scissors for splint cutting. She held staff at bay until the deputies arrived, threatening to harm the staff and other patients.
- Patient had psychotic episode, grabbing a nurse and digging her nails into the nurse's arm.
- Patient pulled a knife on a nurse upon arrival.
- A patient grabbed my hair, swung me around, and broke my nose.

Medical/Surgical Units (In-Patient):

- Patient threw a metal pill crusher at staff and through the hospital window, which broke.
- A nurse was kicked in the back of the neck by an elderly patient with dementia, resulting in a vertebral fix.
- Nurse was hit by a patient in her ear that caused her ear to bleed. The nurse quit her job and did not return to work. Psychiatric patient on the med/surg floor without specialty training for staff.
- Patient choked nurse with her stethoscope. Nurse was severely injured.
- Patient with dementia dislocated my finger.
- Husband wanted staff to give his wife a shower. But the unit was short staffed that day so the staff promised a shower the next day. The husband got upset and threatened to go get his gun.
- Patient refused his medication, stating if you ask one more time I will hit you.
- Patient hit staff.
- Confused patient recovering from overdose spat, yelled at, and scolded the nurses.
- I was taking care of a combative patient who had wrist restraints on. I turned my back and was kicked hard in the back. I made sure from then on I was far away before I turned around.
- A patient pushed me and said I stole his money.
- Patient hit staff and injured them. Patient needed specialized psychiatric care but was placed by hospital in general medical/surgical unit without specialized training for staff.
- Patient threatened to strangle a nurse.
- Nurse struck in head with telemetry box.
- Patient's husband grabbed nurse's neck and flung her during a code.
- Patient headbutted me when we were transferring him back to bed.
- Confused patient tried to kick us when we were cleaning and turning him.
- Patient pulled a knife on a nurse.
- Patient bit nurse who was trying to hold the patient in bed.
- Patient going through alcohol withdrawal became combative and tried to enter another patient's room. Nurse tried to stop him and was elbowed in the face, fracturing her mandible.
- Patient threw food at nurse's feet.
- Patient threw a can of soup at me, resulting in a black eye.
- Patient threw phone, IV pole, and chairs at staff from inside the room.
- Confused patient spitting at and punching nurses.
- Patient's wife grabbed a nurse by her face.
- A patient threw hot coffee at a nurse's chest. The nurse suffered first and second degree burns and left work.
- Confused elderly patient pinched me and pulled my hair while I was trying to take her vital signs and do the patient assessment.
- A patient had filled a few urinals and wanted to throw at staff if he didn't receive the care that he wanted.
- A patient threatened to get his gun and shoot all the staff on the floor.
- A patient bit the nurse while the nurse was feeding the patient.

Intensive or Critical Care Units (In-Patient):

- Patient was going through alcohol withdrawal, punched nurse when she was placing restraints.
- Newly intubated patient struggled with the nurse while the patient attempted to extubate himself. The nurse tried to keep the patient from falling out of bed and extubating himself. In the struggle, the nurse injured her right shoulder. The unit was short-staffed.

- A nurse was hit by a patient going through withdrawal. The nurse's finger was broken and she was out of work on workers' compensation for several months.
- A patient's family member physically bumped into me on purpose.
- I was kicked by a patient who was coming out of anesthesia.
- A patient was dying from a gunshot wound. The patient's family member would not leave the room and kept insisting that the staff save the patient or he wouldn't leave.
- Family member of a patient threatened to attack a nurse after work.
- Family member of a patient threatened to physically attack a nurse and lunged at the nurse.
- Nurse struck on the nose by a patient. She required surgery to recover.
- Confused patient punched me.
- Nurse was bit by a patient.
- Patient tried to kick me when I attempted to stop him from falling.
- Nurse was trying to insert an IV into a confused patient. The patient grabbed the nurse's hair. It took several nurses to pry the patient's hand off her hair.
- Patient on a ventilator attempted to kick me in the head.
- Patient admitted for alcohol withdrawal and drug use. Unprovoked, got out of bed after pulling out IV and catheter, left the unit, entered the elevator, and threatened to hit staff when approached.
- Alcoholic patient actively withdrawing and having DTs was very combative despite being in four point restraints. He broke out of his restraints and kicked an RN in the head.
- Patient punched me in the face.
- Patient became agitated while sitting on a chair. He grabbed a plastic knife from his dinner tray and was going to attack a nurse with the plastic knife.
- Patient's husband threatened to burn down the hospital if the patient died.
- Confused patient tried to kick me in the head when I was emptying the catheter. Patient had wrist restraints on but legs had not been an issue prior to this.

Psychiatric Units (In-Patient):

- Patient throwing objects at nurses.
- Staff was bitten on the arm by a patient, requiring ER treatment.
- Staff was punched in the head.
- A psych nurse had her nose broken.
- A patient punched a tech in the nose until he broke it.
- A patient threatened to hit me.
- A patient hit staff in the jaw while the nurse encouraged the patient to take medication.
- Detainee sprayed a nurse with a concoction of feces and other bodily waste.
- Patient punched nurse very hard in the chest. The nurse had a history of cardiac problems. The nurse was bruised.
- Patient used a chair to break the window.
- A detainee pushed a nurse down from behind. The nurse sustained a fracture of wrist and injury to the knee.
- Nurse was administering medication in the hallway. The nurse was struck twice by a patient. Nurse was bleeding profusely from wounds to her face.
- Acute breakdown schizophrenic patient hit one nurse in the face and kicked her, kicked another nurse and spit in her face, and spit in the face and kicked a nurses' aide. Delay in code because no one was available to help respond.
- Nurse was hit and assaulted.

- Patient requested a banana and then threw it at the nurse.
- Patient scratched staff.
- Patient punched a nurse in the face, fracturing the facial bone.

Telemetry Units:

- Patient hit nurse.
- Dementia patient scratched the nurse providing care.
- Combative patient hit nurse when providing care to him.
- Older patient got confused, combative. He got out of bed and was going to leave the room. I put myself between the patient and the door. The patient put both hands on my shoulders and pushed me backwards.
- Patient threw dirty, wet towel in nurse's face.
- Nurse was punched in the throat by a patient with dementia. The patient went into other patients' rooms. Security was called to the floor and was kicked twice in the groin prior to restraining the patient.
- Patient withdrawing from alcohol kicked nurse in the chest and grabbed the nurse's arm while she was trying to keep the patient from falling out of bed.
- End-of-life patient had an upset son who said he was going to come back with either a lawsuit or a gun.
- Nurse's arm was pulled by a patient. The patient punched the nurse in the face. Before the nurse could move away, the patient threw the call light at her face.
- Patient waited for a nurse to turn around and then hit her really hard on her head with a steel handle bar from a portable lift equipment.
- Nurse was taking vitals and doing assessment when patient hit the nurse's hand.
- Patient was not responsive. Apparently, he was ignoring us when trying to wake him to give him his medication. Nurse was concerned that the patient was non-responsive and didn't know the patient was just ignoring us. After one person did a sterna rub, the patient swung at me, narrowly missing my face, and then jumped out of bed and chased us out of the room.
- Transplant patient confused, kicking, scratching, spitting. Threw TV remote control.
- Patient's wife came to visit unexpectedly. She started fighting with the patient's girlfriend.
- Patient was withdrawing from drugs, and became very combative. Security was called and a knife was found.
- Psych patient was throwing feces at nurses.

Operating Rooms (OR) and Post-Anesthesia Care Units (PACU):

- While talking to patient, patient tried to hit a nurse and refused vital signs check. Patient stated that he was not here for that, just for a medication refill.
- Patient was mad and tried to hit an employee. He was tired of waiting in the ER to be seen.
- Doctor was handed the wrong instrument during surgery. The doctor threw the scalpel at a nurse who was impaled in the shoulder.
- Gang members entered the OR, attempting to "finish off" the patient.
- Patient woke up after anesthesia combative.
- Patient in soft wrist restraints with sitter. Patient broke out of restraints and strangled the doctor.
- Patient screamed at and threatened a nurse because he asked for his medication too soon.
- Patient threw things at the nurse.

- Patient was in pain and threatened to punch us in the face. The patient was given medication and appeared to be in less pain. The patient requested to get up to urinate.
- During a leg assessment, the patient slammed the nurse's hand with his foot.
- Patient combative and aggressive after surgery. The patient had a history of being combative after surgery if the wife was not present. The nurse's wrist was grabbed and bruised.
- Pediatric patient was agitated after emerging from anesthesia. The patient calmed down to her baseline per her mom and wanted her IV out. The mother helped hold her arm down while I removed her IV. The patient tried to bite me as I was removing the tape.

Labor and Delivery Units:

- Infant admitted with heart condition. Father was aggressive and pushed staff.
- Parents were yelling in the room with the door closed. The mother, patient, handed me the newborn and told me to take the baby since she was worried about what the father would do. Security and the police department came and removed him, but we don't have a locked unit.
- Father of a baby threatened to "shoot up the place" if anyone took their baby. Child
- Protective Services was involved with the family due to a history of abuse and drugs.
- Security escorted him out.
- I have been kicked multiple times.
- Boyfriend and father-in-law were fighting. Boyfriend pulled out a knife and had a gun in his pocket.
- Nurse transporting patient from Labor and Delivery Unit to the Post-Partum Unit was assaulted by patient en route.
- Angry dad came on the unit, drunk and angry because the baby was listed under the mother's maiden name.
- I had a patient who was physically combative, fighting against my care of her. I was hurt while doing a vaginal exam. My arm was outstretched and she clamped her legs against my right arm, tearing tendons. My workers' compensation claim was denied.
- Family members threatened to harm nurses involved in a Child Protective Services case that resulted in their baby being taken away.
- Patient bit a nurse and broke skin, causing the nurse to go to the ER.
- The husband of a woman in labor had a gun. He gave three versions of why and said he had a permit.
- A family threatened a nurse after a medical error. They threatened to catch her in the parking lot.
- A patient's boyfriend and the father of her baby was intoxicated and on meth and threatened the nurse when asked to leave the post-partum unit. The nurse was fearful for weeks and had security escort her to her car after each shift.
- Patient's husband yelled at a nurse when talking about pain management because he didn't want his wife to get any medications.

Pediatric Units:

- A father was angry that his baby wasn't going home. He took a threatening posture, yelling, saying that he was going to take the baby against medical advice.
- A parent said they would call the police on us.
- A child slapped me.
- A nurse was kicked by a psychotic pediatric patient.

- Parent threatened a nurse because their baby wasn't doing well.

Outpatient Clinics:

- In group therapy, two patients pulled knives out.
- Patient punched a dentist because he pulled the wrong tooth. Dentist was knocked out and had to go to the ER.
- Patient threw a chair at a nurse.
- Disgruntled patient shot a physician and technician. The physician required emergency surgery. Technician required treatment in the ER.
- Patient hit a nurse with his cane.
- A homeless patient was denied a bus pass after wound care. A bus pass was usually given at another clinic. The patient became aggressive and verbally abusive.
- Patient threatening to leave against medical advice after a procedure. The patient had initially reported that they had a means of transportation before the procedure that necessitated sedation. The patient threatened the RN, "You had better not stand in my way." The patient left against medical advice after eventually signing the release form.

Parking Areas:

- A person committed suicide by shooting themselves in their car directly outside the hospital's Emergency Department entrance.
- A patient died a year ago but the mother had still not accepted it. The mother waited in the parking lot, asking if each worker was a nurse. If the worker said yes, the mother said,
- "You killed my family, I will kill you."

Other Units, Settings, or Locations in the Hospital:

- Parents of patient slapped nurses' hands.
- Parents of patient punched the wall.
- Baby's father slapped a nurse in the face.
- Patients spit on, throw urine and feces, curse out the nurses.
- I was hit by a tele box, thrown by a confused patient.
- A patient was verbally abusive because the patient was seen fifteen minutes after their scheduled appointment time.
- Family member broke glass in multiple windows along the hallway with their fist after viewing an expired family member.
- Patient was combative, swiping at aides and nurses who were around him. He swung his catheter bag around to hit people.
- Patient attempted to go to the bathroom, pooping himself, and was upset when I tried to help him to the bathroom. He started swinging his catheter bag, full of urine, at me, and tried to hurt me. Urine got in my hair.
- Nurse was almost run down by a person stealing her car.
- Patient blocked a nurse in a small room, got on top of her and held a knife to her throat.

ATTACHMENT 2: Alarmingly High Rates of Violence Among Healthcare Workers.

AVAILABLE DATA ON WORKPLACE VIOLENCE RATES IN HEALTHCARE

As published in recent literature, the incidence of workplace violence and threats of workplace violence for healthcare workers is alarmingly high.

- A 2004 article reporting on a survey of almost 5,000 nurses licensed in Minnesota found that 12% of RNs reported experiencing physical assault at work annually and that 38.5% of RNs experienced non-physical assault—including threats, sexual harassment, and verbal abuse—at work annually.[7] The vast majority of physical violence was from patients or clients—96.8% of physical violence related to a specific event and 90.7% of physical violence related to an ongoing event.

- A 2011 article reporting on a survey of over 900 nurses working in nursing homes found that 48% of respondents reported being physically assaulted at least once in the prior three months by a resident or resident's visitor.[8] Twenty-six percent of respondents reported being assaulted one or two times while 22% reported having experienced three or more assaults.

- Another 2011 article reported on a study that recorded workplace violence incidents at six different hospitals that were implementing or continuing surveillance systems on workplace violence incidents.[9] The authors reported a rate of 18.87 workplace violence incidents per 100 full-time employees for nursing staff.

- A 2015 article on survey hospital workers on workplace violence reporting found that 62% of respondents had been the target of violence in the past year but that 88% of respondents had experienced a violent incident <u>that they had not reported</u> to their employer in the previous year.[10]

- A 2016 article reported on a survey of healthcare workers about their experiences of workplace violence and reporting practices.[11] The authors reported that 39% of respondents reported having experienced an incident of workplace violence from a patient or a person accompanying a patient ("Type II" workplace violence).

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[7] Gerberich (2004) at pp. 495-503. The annual incidence rate of physical assaults was 12.0 per 100 persons, 95% confidence interval (CI) 12.2 to 14.3. The annual incidence of non-physical assaults was 38.5 per 100 persons, 95% CI 36.7 to 40.3.

[8] Miranda H., Punnett L., Gore R., and Boyer J. Violence at the workplace increases the risk of musculoskeletal pain among nursing home workers. *Occup. Environ. Med.* Vol. 68, 2011, pp. 52-57.

[9] Arnetz, J. et al. Development and Application of a Population-Based System for Workplace Violence Surveillance in Hospitals. *Am. J. of Industrial Medic.* Vol. 51, 2011, pp. 925-34.

[10] Arnetz, J. et al. Underreporting of Workplace Violence: Comparison of Self-Report and Actual Documentation of Hospital Incidents. *Workplace Health and Safety*. Vol. 63, 2015, pp. 200-10.

[11] Pompeii et al. Hospital Workers Bypass Traditional Occupational Injury Reporting Systems When Reporting Patient and Visitor Perpetrated (Type II) Violence. *Amer. J. of Indus. Med.*, 2016, 59: pp. 853-65.

- A 2018 article studied occupational injuries and related factors among newly licensed registered nurses (nurses who were licensed between 1 year and 2.5 years prior to the survey date) working in hospitals in Florida.[12] The authors report that 25% of newly licensed registered nurses reported having experienced physical violence at least once.

NNU SURVEY OF REGISTERED NURSES ON WORKPLACE VIOLENCE

NNU conducted a survey on nurses' experiences of workplace violence during health and safety classes held between February and March 2017. The sample of 286 RNs from three cities—Chicago, IL, Sacramento, CA, and San Francisco, CA—reported the types of violence that they experienced within the past year at work. Results from the questions on RN experience with workplace violence are included below in Table 2.

TABLE 2: NNU Survey on Workplace Violence – Experience Rates by RNs in the Past Year.

What types of workplace violence have you experienced in the past year?	Percent of respondents who experienced this type of violence in the past year at work.
Objects thrown at you	24.5%
Pinched or scratched	34.6%
Slapped, punched, or kicked	26.2%
Spat on or exposed to other bodily fluids	18.9%
Verbally threatened	62.9%
Physically threatened	21.0%
Groped or touched inappropriately	11.9%
Verbally harassed based on your sex or appearance	30.1%
I have not experienced workplace violence	17.1%

AVAILABLE DATA ON WORKPLACE VIOLENCE-RELATED INJURY RATES IN HEALTHCARE

The U.S. Bureau of Labor Statistics ("BLS") conducts annually the Survey of Occupational Injuries and Illnesses and reports data on non-fatal work-related injuries on their website.[13] According to the BLS, in 2017, RNs in private industry in the U.S. experienced a rate of 13.6 violence-related injuries per 10,000 full-time employees. The injury rate for RNs is more than three times higher than the violence-related injuries for workers overall in the same year.[14]

The rate of violence-related injuries for private hospitals in the U.S. was 17.2 per 10,000 full-time employees. This is more than four times higher than the violence-related injury

[12] Unruh, L. and Asi, Y. "Determinants of Workplace Injuries and Violence Among Newly Licensed RNs." *Workplace Health & Safety*, Vol. 66(10), 2018.

[13] U.S. Bureau of Labor Statistics, U.S. Department of Labor. "Occupational Injuries and Illnesses and Fatal Injuries Profiles," available at https://data.bls.gov/cgi-bin/dsrv?cs.

[14] The violence-related injury rate for workers overall in the U.S. in 2017 was 4.0 per 10,000 full-time employees.

rate for workers overall in the same year. State-run, public hospitals and nursing and residential care facilities have astonishingly higher rates of 145.9 and 222.4 per 10,000 full-time employees, respectively.

Data from the U.S. Department of Health and Human Services National Electronic Injury Surveillance System—Work Supplement (NEISS-Work) estimates that the rate in 2011 of nonfatal injuries from workplace violence for healthcare workers was statistically greater than all workers combined.[15]

Between January 1, 2012 and September 30, 2014, a total of 112 U.S. healthcare facilities reported 10,680 OSHA-recordable injuries from workplace violence.[16] Registered nurses and nurse assistants had the highest injury rates of all occupations examined.[17] In the time period of the study, between 2012 and 2014, injury rates due to workplace violence increased for all job classifications and nearly doubled for both nurses and nurse assistants. Only 49% of all reports examined in this study specified the type of assault that led to the injury. Of these, 99% were physical assaults. The workplace violence injuries recorded were clustered in locations where direct patient care is provided in healthcare facilities.[18]

While the most recently available data indicates that rates of workplace violence are high for healthcare workers, it is also important to recognize that the problem is increasing. The healthcare industry has grown rapidly over the past ten years and, according to the BLS projections, will continue to grow over the next ten years.[19] Not only are there more affected workers, rates of workplace violence injuries have also increased in recent years. Between 2011 and 2013, rates increased about 12%.[20] With these rapidly increasing rates and employment, more and more workers will be harmed and killed unless protections are created.

UNDERREPORTING OF WORKPLACE VIOLENCE

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[15] U.S. Government Accountability Office. *Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence* (GAO-16-11), 2016, at p. 10, available at http://www.gao.gov/products/GAO-16-11 (Accessed February 21, 2019).

[16] OSHA-recordable injuries are defined as work-related injuries and illnesses that result in at least one of the following: death, loss of consciousness, days away from work, restricted work activity or job transfer, medical treatment beyond first aid, or a diagnosis by a physician or other licensed health care professional. *See* 29 C.F.R. §1904, et seq.; *see also* Occupational Safety & Health Administration. U.S. Department of Labor. "OSHA Recordkeeping and Reporting Requirements," available at https://www.osha.gov/recordkeeping/ (Accessed February 21, 2019).

[17] U.S. Centers for Disease Control and Prevention. "Occupational Traumatic Injuries Among Workers in Health Care Facilities—United States, 2012-2014," available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6415a2.htm (Accessed February 21, 2019).

[18] *Id.*

[19] U.S. Bureau of Labor Statistics, U.S. Department of Labor. Industry employment and output projections to 2024, 2015, available at https://www.bls.gov/opub/mlr/2015/article/occupational-employment-projections-to-2024.htm (Accessed February 21, 2019).

[20] GAO Report (2016) at pp. 18-19.

All incidents of violence must be reported for the prevention plan to be fully effective, but employees need training on why reporting is important and how to report without fear of reprisal for themselves or their patients. Many sources of data on workplace violence and related injuries underreport its prevalence. This is, in part, due to the mistaken understanding in healthcare that workplace violence is part of the job. Oftentimes, hospital supervisors and managers perpetuate this dangerous view of workplace violence, reifying the idea that reporting incidents is futile.

In focus group-style discussions, NNU members have reported that supervisors and managers respond to reports of workplace violence with comments or actions that communicate to workers that it is just "part of the job."[21] Also reflected in NNU members' experience with workplace violence, it is common for supervisors and managers to discourage employees from making reports of violence from patients. RNs also describe in discussions on workplace violence that they are hesitant to report violence from patients with dementia or other conditions that cause disorientation and combativeness, because they fear their patients, for whom they serve as advocates, will be criminally punished, otherwise blamed, or denied care as a result. These reasons for underreporting underline the importance of clear communication procedures to effective workplace violence prevention plans and of protections, like non-retaliation policies, for reporting incidents and concerns about risks of violence.

Some researchers have attempted to measure the level and scope of underreporting. A study of one hospital system in the United States led by Judith Arnetz, the results of which were published in 2015 in Workplace Health and Safety, examined the difference between self-reported workplace violence incidents and those reported in the hospital system's electronic reporting database.[22] Researchers sent surveys to employees working in 42 units of the hospital system on their experience with violence at work and whether they reported it. They found that 88% of respondents had not documented in their employer's electronic system an incident of violence they had experienced in the previous year.

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[21] See Attachment 1 (summarizing observations from NNU focus-group style discussions on workplace violence).

[22] Arnetz et al. (2015).

ATTACHMENT 3: Why Congress Should Mandate OSHA Action on Workplace Violence Prevention.

THE IMPORTANCE OF AN OSHA STANDARD

Despite recognition of workplace violence as a hazard in healthcare and a significant amount of attention to the issue, OSHA continues to delay development of a workplace violence prevention standard.

Through the Occupational Safety and Health Act ("OSH Act"), Congress mandated prioritization of the safety of workers and the prevention of occupational injury and created an obligation by employers to provide a workplace free from recognized hazards, including workplace violence in healthcare settings. To fulfill this legislative mandate, OSHA was tasked and is required by the OSH Act to promulgate mandatory health and safety standards to protect workers across the country from workplace hazards.

Congress envisioned in the passage of the OSH Act that all workplace safety standards promulgated by OSHA be highly protective.[23] It recognized that OSHA's leadership would be necessary in creating uniform standards across the nation, requiring, where conflicts existed among occupational standards, that "the Secretary [of Labor] promulgate the standard which assures the greatest protection of the safety or health of the affected employees."[24] Thus, where serious occupational hazards persist despite voluntary measures, OSHA is required by law to act and to establish a mandatory workplace health and safety standard.

A formal OSHA standard on workplace violence in healthcare would fulfill the Agency's statutory obligations. As documented by a Government Accountability Office ("GAO") report from March 2016 recommending that OSHA provide additional information to assist inspectors in developing citations and recommending that OSHA develop a policy for following up on hazard alert letters concerning workplace violence hazards in healthcare facilities, OSHA inspectors would be able to utilize the specific requirements of a formal standard to assess the effectiveness of employers' plans, ensuring that these plans are comprehensive, focused on prevention, and created with the input and insight from affected employees.[25] Through the creation of specific requirements for employers' workplace violence prevention plans, a formal standard would fortify OSHA's ability to

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[23] Control of Hazardous Energy Sources (Lockout/Tagout), 58 Fed. Reg. 16612-02, 16614-15, at fn. 109 (Final Rule, supplementation statement of reasons, Mar. 30, 1993) (codified at 29 C.F.R. §1910) ("In setting safety standards, OSHA must act consistently with the Act's overriding purposes, which is to provide a high degree of employee protection.").

[24] 29 U.S.C. §655(a).

[25] *See* GAO Report (2016).

enforce this obligation to protect healthcare employees from workplace violence through improved measures in evaluating and citing violations.

OSHA'S CURRENT EFFORTS ARE INADEQUATE

Forty-five years of ineffective voluntary measures requires the immediate attention of Congress to pass legislation requiring OSHA to establish a federal workplace violence prevention standard. Strong enforcement programs are necessary to encourage employer compliance with OSHA standards. OSHA already has established that workplace violence qualifies under the General Duty Clause[26] and has taken some action to see that it is enforced. Accordingly, the agency has performed inspections and issued citations under the General Duty Clause. In April 2015, OSHA also released an enforcement directive and a three-year National Emphasis Program - Nursing Home and Residential Care facilities to increase enforcement efforts around workplace violence in healthcare settings.[27]

However, the 2016 GAO report on workplace violence in healthcare examined OSHA's enforcement record on workplace violence under the General Duty Clause and found it wanting. The GAO analysis found that approximately 65% of the inspections of healthcare facilities for workplace violence that OSHA conducted between 1991 and April 2015 took place between 2012 and 2014. The analysis also found that OSHA citations are region-dependent and inconsistent across the United States. Three of the ten OSHA regions conducted 60% of all the inspections performed. Moreover, only 5% of the inspections conducted in healthcare facilities between 1991 and early 2015 resulted in a General Duty Clause citation.[28]

It is clear that enforcement efforts have not been coordinated or effective. OSHA inspectors interviewed during the GAO analysis agree:

> Some inspectors and other regional officials from 5 OSHA regional offices said it is difficult to collect sufficient evidence to meet all four criteria [for a General Duty Clause citation] during an inspection.... Another inspector noted that an employer may have a minimal workplace violence prevention program and that it is sometimes difficult to prove that the employer has not done enough to address the hazard.[29]

On June 25, 2015, following the release of the GAO report, OSHA issued a memorandum to establish guidance for inspections conducted in inpatient healthcare settings, North

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[26] *See* Occupational Safety and Health Administration, U.S. Department of Labor. OSHA Workplace Violence Fact Sheet (2002), available at http://www.osha.gov/OshDoc/data_General_Facts/factsheet-workplace-violence.pdf (Accessed February 23, 2019).

[27] Occupational Safety & Health Administration. U.S. Department of Labor. Enforcement Directive on National Emphasis Program—Nursing and Residential Care Facilities (NAICS 623110, 623210 and 623311) (Enforcement Directive CPL 03-00-016 (April 2015), *available at* https://www.osha.gov/enforcement/directives/cpl-03-00-016 (Accessed February 21, 2019).

[28] GAO report (2016), pp. 21, 22.

[29] GAO report (2016), pp. 28.

American Industry Classification System ("NAICS") Major Groups 622 (hospitals) and 623 (nursing and residential care facilities).[30] The memorandum requires that all inspections, both programmed and unprogrammed, cover the focus hazards from the expired National Emphasis Program- Nursing and Residential Care Facilities which includes workplace violence among a list of four other focus hazards. While admirable, the memorandum does not establish a clear and enforceable standard to protect healthcare workers from violence in the workplace.

OSHA'S CURRENT VOLUNTARY GUIDELINES ARE INSUFFICIENT

In the area of workplace violence in healthcare settings, OSHA first issued voluntary guidelines in 1996, which were updated in 2004 and again last year. These guidelines provide recommendations for employers on how to assess and evaluate workplace violence hazards and on control measures that may be implemented to reduce or eliminate these hazards, but fall short of creating any mandatory requirements or enforceable provisions to protect workers. NNU's experience tells us that coordinated worker enforcement campaigns are necessary to ensure that healthcare employers comply even with mandated standards and laws.

Employers have not followed OSHA's non-mandatory suggestions or guidelines where there are no associated penalties or consequences. One study found that more than 80% of U.S. employers report no change in their workplace violence prevention programming after a significant violent event, even though 35% cite negative effects such as increased absenteeism and reduced productivity.[31] OSHA should recognize that voluntary guidelines have not and will not ensure that healthcare workers are protected from workplace violence.

The failure of voluntary guidelines and the recognition of the necessity for developing standards are evident in the American National Standard, which was approved by the American National Standards Institute, Inc. ("ANSI"). ANSI, a recognized source of national consensus standards in federal regulation,[32] developed its workplace violence standard based on "a majority consensus among professionals from disparate disciplines (including security, human resources, mental health, law enforcement and legal arenas) regarding practices viewed as effective, recommended, and—in some cases—essential through work in this field."[33] Glaringly missing from ANSI's process of creating national standards are any workers directly affected by workplace violence in the healthcare industry and their

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[30] Assistant Secretary for Occupational Safety and Health, U.S. Department of Labor. Memorandum. "Inspection Guidance for Inpatient Healthcare Settings," June 25, 2015, available at https://www.osha.gov/dep/enforcement/inpatient_insp_06252015.html (Accessed February 21, 2019).

[31] Bureau of Labor Statistics, U.S. Department of Labor. "Survey of Workplace Violence Prevention," 2006, available at http://www.bls.gov/iif/oshwc/osnr0026.pdf (Accessed July 9, 2016).

[32] *See* 29 C.F.R. § 1910.2(g).

[33] Engineering 360, "Standards Detail" for ASIS/SHRM, Workplace Violence Prevention and Intervention American National Standard, 2011, available at http://standards.globalspec.com/std/1401097/asis-wvpi-1 (Accessed July 10, 2016).

unions. The lack of worker representation and participation in ANSI is juxtaposed to the unabashed presence of representatives of healthcare employers, universities, insurance providers as well as a variety of corporate interests.

ANSI's orientation towards industry representation highlights the scope of the problem in establishing occupational safety and health standards that can effectively address hazards that employees face in the workplace. Not surprisingly, the "voluntary standards" set by the guardians of healthcare management and corporate interests have failed to stem the tide of workplace violence. This is an overwhelming testament to the futility of "voluntary" guidelines in reducing death and disability in the workplace and especially in the healthcare setting.

NNU members report that current employer-initiated efforts to prevent workplace violence are lacking. Reporting of all violent incidents is a crucial element for an effective workplace violence prevention plan, but only 37% of the RN respondents to NNU's survey on workplace violence, which is described in more detail above, reported that their employer has a clear way to report workplace violence incidents. And while the majority of RN respondents reported that their employers provide some level of training on workplace violence, many respondents also noted on the paper surveys that their employer's training is brief, online, or not effective. Without a clear mechanism to report incidents of workplace violence and without training on how and why it is important to report, workers will not report all incidents of violence. With limited information on the circumstances that result in or have a high likelihood of escalating to violence, lack of reporting severely limits the effectives of any hazard assessment, prevention, or control procedures and measures. NNU survey results are included below in Table 3.

TABLE 3: NNU Survey on Workplace Violence Results – Employers' Prevention Measures.

What does your employer currently do to prevent workplace violence?(Select all that apply.)	Percent of respondents reporting that their employer has implemented this prevention measure
Provides training on workplace violence	57.7%
Uses a chart or room flagging system to indicate patients with increased risk for violence	22.4%
Provides a clear way to report incidents	36.7%
Has security guards available at all times to respond to violent incidents	43.4%
Uses metal detectors	2.1%
Uses security cameras	24.1%
Limits visiting hours	13.6%
Includes nurses and other employees in violence risk assessments	19.9%
I'm not sure	14.0%

Also, lacking from many current employer-driven workplace violence prevention and control measures is the active involvement of direct patient care employees in the

development of those measures. RN involvement in the development of hazard prevention measures is essential to an effective prevention program. But only 20% of respondents to NNU's survey on workplace violence reported that their employer includes RNs and other healthcare employees in violence risk assessments.

Moreover, NNU's survey data demonstrates that current training provided by employers has been ineffective. When workplace violence incidents do occur, employers should follow up promptly to provide medical care to injured employees, to investigate what happened, and to install prevention measures as needed to prevent future similar incidents from occurring. In the NNU survey, data results on this account were striking—a large percentage of respondents replied "I don't know" when asked about what measures their employer's take to investigate or follow up on incidents of workplace violence even though almost 60% reported receiving training on workplace violence. These RNs did not know whether their employer provides access to counseling, trains or retrains employees, or changes practices to reduce risk of violence. If training does not effectively convey basic information about the employer's prevention plan, that training is ineffective. NNU's survey results on questions about incident investigation measures are included in Table 4.

TABLE 4: NNU Survey on Workplace Violence – Incident Investigation Measures.

After a workplace violence incident, my employer generally ____.		Percent of Respondents
Investigates what happened	Yes	63.0%
	I don't know	18.1%
	No	18.9%
Provides access to counseling	Yes	31.3%
	I don't know	50.4%
	No	18.3%
Trains or retrains employees	Yes	39.8%
	I don't know	41.7%
	No	18.5%
Changes practices to reduce risk of violence	Yes	30.0%
	I don't know	51.6%
	No	18.3%
Discourages employees from reporting incidents	Yes	13.3%
	I don't know	68.1%
	No	18.6%
Reprimands or blames employees	Yes	26.0%
	I don't know	57.2%
	No	16.7%
Ignores it	Yes	28.3%
	I don't know	48.1%
	No	23.5%

INDIVIDUAL STATES HAVE MOVED AHEAD OF OSHA ON PREVENTING WORKPLACE VIOLENCE.

Through the stewardship of NNU and our affiliate, the California Nurses Association ("CNA"), healthcare workers in California are now covered under a comprehensive workplace violence prevention standard promulgated by the California Division of Occupational Safety and Health ("Cal/OSHA") that we believe will be the best in the nation. California recently enacted CNA-sponsored legislation requiring the creation of a statewide standard on workplace violence prevention plans based on the long-standing recognition that violence in healthcare settings is a serious occupational hazard for healthcare workers in California and throughout the nation.[34] Rulemaking was completed in October of 2016. The Workplace Violence Prevention in Health Care Standard has been fully in effect since April 1, 2018. The final standard reflects Cal/OSHA's collaborative process with CNA members, employer representatives, content matter experts, and members of other unions.

CNA's experience in California serves as an apt model on the national scale. On February 20, 2014, CNA submitted a petition to California's Occupational Safety and Health Standards Board ("OSHSB") calling for a workplace violence prevention standard to protect California RNs and other healthcare workers from violence in their workplaces. The petition was granted by OSHSB, which noted that "violence directed against healthcare workers is a serious and on-going problem' and that "no federal OSHA standard or national consensus standard directly addresses workplace violence protection."[35] The OSHSB authorized an advisory committee, the Workplace Violence Prevention in Healthcare Committee, composed of unions, healthcare employers, and other stakeholders, to begin developing the standards. The committee held its first meeting on September 10, 2014.

During that same year and in recognition of the serious threat of workplace violence against RNs and other healthcare workers, Senator Alex Padilla, now California's Secretary of State, authored legislation, S.B. 1299, directing Cal/OSHA to issue a standard with specific, prescribed elements requiring healthcare employers to establish, implement, and maintain workplace violence prevention plans. We are proud to have sponsored this important legislation on behalf of our California members. This legislation is now law.

The state's Senate Committee on Labor and Industrial Relations noted in the legislative record that healthcare workers had a high risk of work-related assault with RNs in particular having the highest risk.[36] Relying on the 2007 National Institute of Occupational and Environmental Health report, the Senate committee recognized that industry

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[34] *See* Cal. Lab. Code § 6401.8.

[35] California Occupational Safety and Health Standards Board. "Revised Proposed Petition Decision of the California Occupational Safety and Health Standards Board (Petitions 538 and 539)," pp. 1-2 (Jun. 19, 2014), *available at* http://www.dir.ca.gov/oshsb/documents/petition_539_propdecision_revised.pdf (last visited Jul. 10, 2016).

[36] Hearing on S.B. 1299 Before the California Senate Committee on Labor and Industrial Relations, , 2013-2014 Regular Session, pp. 3-4 (April 24, 2014) (Committee analysis and report).

prevention efforts were inadequate, stating that the report "found some consistent areas which suggested potential for improved protection and/or improved efficiency."[37] In its analysis, the state Senate committee highlighted the following problem areas as in clear need of improvement:

1. Surveillance of workplace violence events is uncoordinated and inefficient;
2. Nursing staff within emergency departments were often unsatisfied with their interactions with security personnel;
3. Although all hospitals trained the majority of personnel in emergency and psychiatric units, no hospitals trained all employees regularly stationed in the unit;
4. Employee training programs rarely included review of violence trends within their specific hospital;
5. OSHA logs and employers' reports did not provide detailed information about the circumstances of a violent event, which could limit prevention efforts; and
6. Few hospitals had effective systems to communicate about the presence of violent patients, hospital security equipment systems were uncoordinated and insufficient to protect the unit, and security programs and training were often less complete in psychiatric units than in emergency departments.[38]

And California is in good company. Connecticut, Illinois, Maine, Maryland, New Jersey, New York, Oregon, and Washington all recognize and regulate workplace violence in healthcare, social services, or both. All nine states' requirements are similar to OSHA's guidelines on effective comprehensive workplace violence prevention plans.[39] In addition to these states recognized in the GAO report, NNU-affiliate Minnesota Nurses Association recently worked with state legislators to pass a law that requires hospitals to develop and implement comprehensive workplace violence prevention plans. This law took effect January 1, 2016. Several additional states seek to educate employers about the hazard of workplace violence through published guidance. North Carolina, for example, published guidelines explaining that healthcare, long-term care, and social service workers all face an increased risk of work-related assaults.[40]

A state-by-state effort, however, is insufficient to protect all healthcare workers. Twenty-four states are under federal OSHA jurisdiction in addition to the private industry in five additional states.[41] Federal OSHA should act now to promulgate a workplace violence prevention standard so that all US healthcare workers are protected from workplace violence.

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[37] *Id.* at p. 4.

[38] *Id.*

[39] GAO Report (2016) at pp. 39-41.

[40] North Carolina Department of Labor. Workplace Violence Prevention Guidelines and Program for Healthcare, Long Term Care and Social Services Workers (Dec. 2013), available at http://www.nclabor.com/osha/etta/indguide/ig51.pdf (Accessed July 2016).

[41] Occupational Safety and Health Administration, U.S. Department of Labor. *Table of OSHA-Approved State Plans: Basic Facts and Information,* available at https://www.osha.gov/dcsp/osp/approved_state_plans.html#ftn (Accessed June 13, 2016).

ATTACHMENT 4: H.R. 1309 & Necessary Elements of an OSHA Workplace Violence Prevention Standard.

H.R. 1309 (Courtney) would require OSHA to promulgate a standard on workplace violence prevention for healthcare and social service employers, setting timelines on promulgation and minimum content requirements for the standard. NNU strongly encourages the Subcommittee to take action on this bill, with one significant amendment.

Timeline for Promulgation

This bill sets timelines for promulgation of an interim final standard and a final standard. Given OSHA's delay in work on a workplace violence prevention standard, it is necessary for Congress to set such timelines.[42] Importantly, H.R. 1309 allows the text of the Act to be enforced as an OSHA standard should OSHA miss the one year timeline to pass an interim final standard. The bill also requires OSHA to issue a proposed final standard within two years of enactment and to promulgate a final standard within 42 months of enactment. Additionally, employers would be required to implement workplace violence prevention plans within six months of promulgation of an interim final standard.[43] Quick action is needed to protect registered nurses and other healthcare workers from the growing epidemic of workplace violence.

Scope

The scope of H.R. 1309 is expansive, including many healthcare and social service employers where workplace violence is a significant hazard. Importantly, hospitals, clinics, nursing homes, home health care, and other healthcare employers would be covered. The bill specifies requirements for an OSHA standard, including, importantly, the minimum necessary components for employers' workplace violence prevention plans. Some provisions in the H.R. 1309 are outlined here.

H.R. 1309, Sec. 103 (1)(A)(i)

That employers obtain the active involvement of employees in creating, implementing, and maintaining the workplace violence prevention plans.

Active worker involvement in every step of creating, implementing, and reviewing a workplace violence prevention plan is a vital element ensuring their effectiveness. Direct care registered nurses and other healthcare workers have nuanced knowledge and expertise in how workplace violence happens and what prevention measures will be effective. Their involvement is necessary to effectively identifying workplace violence risk factors and hazards as well as to selecting the most effective prevention measures and

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[42] *See* H.R. 1309, Sec. 101.
[43] *See* H.R. 1309, Sec. 103 (1).

crafting effective policies and procedures for reporting, communication, and other elements. However, the responsibility to create the workplace violence prevention plan must lie with the employer, which always has the responsibility to provide a workplace free from recognized hazards under the OSH Act.

The published literature supports the importance of direct care employee involvement in crafting workplace violence prevention plans.

- A 2014 study found a 50% decrease in assaults after implementation of a plan created with employees, managers, and administration.[44] The authors noted "This result emphasizes that the effectiveness of workplace violence prevention programs is predicated not only on strategies examining risk factors related to patients, employees, and the employer but on programs with employee involvement and management commitment and endorsement."
- A 2017 study of compared hospital units where unit supervisors worked with direct patient care staff to develop workplace violence action plans based on unit-specific data and worksite walkthroughs to others that did not have any interventions.[45] Intervention units reported less than half the violent incident rate of control units at six months.
- A 2011 study examined the impact of a workplace violence prevention plan implemented in a psychiatric rehabilitation unit in Italy over a period of 10 years.[46] The author highlighted that engaging the expertise of direct care healthcare workers was vital to identifying and understanding the sources, patterns, and opportunities for prevention of workplace violence. The plan involved continual assessments of environmental and patient-specific risk factors, implementing environmental and architectural changes, policies and procedures, and staff education. The author reported a statistically significant reduction in workplace violence incidents post-implementation ($p<0.001$) and a significant decrease in use of restraints and seclusion measures for patients who became aggressive or violent.

H.R. 1309, Sec. 103 (1)(A)(ii)
That employer workplace violence prevention plans must be unit-specific.

Workplace violence prevention plans must be tailored to each patient care unit or other work area to be effective. Each patient care unit or other work area within a hospital or other healthcare facility has different risk factors for workplace violence. Such risk factors depend on a multitude of factors that are often specific to the unit at that particular hospital. For example, an intensive care unit at hospital A may have different risk factors than an intensive care unit at hospital B based on physical infrastructure differences, patient population differences, policy and procedure differences, staffing differences, and other factors. Each covered employer's workplace violence prevention plan must be specific to each unit or work area.

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[44] Gillespie, G.L., et al., "Implementation of a Comprehensive Intervention to Reduce Physical Assaults and Threats in the Emergency Department." *Journal of Emergency Nursing*, Vol. 40, 2014, pp. 586-91.

[45] Arnetz, J.E., et al., "Preventing Patient-to-Worker Violence in Hospitals: Outcome of a Randomized Controlled Intervention." *Journal of Occupational and Environmental Medicine*, Vol. 59 (1), 2017, p. 18.

[46] Magnavita, N., Violence Prevention in a Small-Scale Psychiatric Unit: Program Planning and Evaluation. International Journal of Occupational and Environmental Health, Vol. 17, 2011, pp. 336-44.

The published literature supports the importance of the unit- or work area-specific requirement for workplace violence prevention plans.

- A 2017 study randomized 42 inpatient hospital units into intervention and control groups.[47] The authors found that intervention units—which including worksite walkthroughs, environmental risk assessment, unit-specific data analysis, and input of direct care staff to develop unit-specific action plans—reported less than half the violent incident rate of control units at 6 months post-implementation and that intervention units reported nearly a third the violence-related injuries of control units at 24- months post-implementation.
- A similar 2014 repeated-measures study randomized six emergency departments into intervention and control groups.[48] Researchers partnered with direct care employees, managers, and hospital administrators to develop workplace violence prevention plans including environmental changes, policies and procedures, and education and training. While not all intervention units fully implemented the plans, the authors observed a 50% decrease in assaults in the unit that most thoroughly implemented a unit-specific workplace violence prevention plan.

H.R. 1309, Sec. 103(1)(B)(ii)
That employers must conduct risk assessments, including assessments of environmental risk factors and patient-specific risk factors, for each unit or work area, with direct care employee involvement.

Risk assessments are important elements of workplace violence prevention plans. Employers must identify all risk factors for workplace violence and workplace violence hazards to effectively implement control and prevention measures. Such risk assessments must evaluate both environmental risk factors and patient-specific risk factors. Environmental risk factors include when employees are working in isolated or remote locations, where assailants could prevent entry into the work area by responders or other employees, poor illumination or blocked visibility, lack of physical barriers, lack of effective escape routes, obstacles and impediments to accessing alarm systems, locations where alarm systems are not operational, entryways where unauthorized access may occur, presence of furnishings or any objects than can be used as weapons, and storage of high-value items, currency, or pharmaceuticals.

Once again, the published literature affirms that many of these factors indicate an increased risk for workplace violence.

- One 2011 study examined bed occupancy and staff reports of workplace violence.[49] The researchers found that workplace violence incidents were statistically significantly more likely to happen on overcrowded units. This relationship was found to be dose-dependent, which is an important element for establishing causality in research studies.

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[47] Arnetz et al. (2017).
[48] Gillespie (2014).
[49] Virtanen, M., et al., Overcrowding in psychiatric wards and physical assaults on staff: data-linked longitudinal study. *The British Journal of Psychiatry*, Vol. 98, 2011, pp. 149-55.

- One 2005 study surveyed over 6,000 nurses in Minnesota about their experiences of workplace violence and employers' prevention measures.[50] The researchers found that certain environmental interventions were significantly associated with lower rates of workplace violence. The odds for workplace violence were about twice as high when the workplace was less bright than daylight as compared to when the units were lit "as bright as daylight." Having physical barriers blocking vision was associated with increased workplace violence. Having security personnel was associated with decreased workplace violence rates. Staffing can be important to reducing workplace violence.

H.R. 1309, Sec. 103(1)(B)(iii)
That employers must implement prevention measures, engineering controls, and work practice controls to correct workplace violence hazards; however, this language must be strengthened.

Under the OSH Act, employers are responsible for providing a workplace free from recognized hazards. This includes the significant hazards posed by workplace violence in healthcare facilities. While H.R. 1309 sets forth a requirement that workplace violence prevention plans effectively prevent and control hazards in each work area and unit in healthcare and social service settings, the language included in Sec. 103(1)(B)(iii) potentially undermines this intent. Specifically, the requirement that employers implement "hazard prevention, engineering controls, or work practice controls to correct, in a timely manner, *hazards that the employer creates or controls* applying industrial hygiene principles of the hierarchy of controls..." (emphasis added). Hospitals and other healthcare facilities employ nurses and other healthcare workers to provide hands on care to patients. There are effective measures that healthcare employers can implement that reduce the risk of or mitigate the frequency and impact of workplace violence. This potentially limiting language should be deleted from the bill to provide the necessary protection to nurses and other healthcare workers at risk of injury from workplace violence.

It is an important requirement in this section that employers implement prevention measures according to the hierarchy of controls. In our members' experience, employers often rely exclusively on training and worker behavior when responding to workplace violence. When these are the only measures an employer implements, it effectively shifts the burden of prevention onto employees. While training is an important element of workplace violence prevention, engineering and work practice or administrative controls should be prioritized according to the hierarchy of controls.

The published literature, as described above, has a wealth of evidence supporting the myriad measures that employers can implement to prevent or control workplace violence. Additionally, a 2002 study of workplace fatalities from workplace violence over a period of years in North Carolina found that certain environmental interventions were statistically

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[50] Gerberich, S. G., et al. Risk Factors for Work-Related Assaults on Nurses. *Epidemiology*, Vol. 16 (5), 2005, pp. 704-9.

significantly associated with a lower risk of worker homicide.[51] Workplaces with bright exterior lighting had half the odds for worker homicide than without bright exterior lighting; workplaces with staffing that prevented workers from being alone at night had less than half the odds for worker homicide than without these staffing levels; workplaces with alarms had half the odds for worker homicide than without alarms; and workplaces with combinations of five or more administrative controls very significantly reduced the odds for worker homicide, to 0.1 the odds without administrative controls.

H.R. 1309, Sec. 103(1)(B)(iv)
That employers must implement incident response and post-incident investigation procedures.

Clear response and post-incident follow-up plans are also an important part of an effective workplace violence prevention plan. H.R. 1309 includes many of the important elements of effective response and post-incident investigation, including the requirement to investigate workplace violent incidents and to seek involved employees' opinions on what could have prevented the incident from occurring. However, there are a few missing elements. First, post-incident response should provide immediate medical care for employees who have been injured, including making trauma counseling accessible to all employees affected. OSHA recognizes that injury from workplace violence may manifest in nonphysical manners and including trauma counseling is an important tool in mitigating the psychological impact of violence. This requirement should be added to H.R. 1309.

Second, a post-incident debriefing should be conducted as soon as possible after an incident and must include the input from employees involved on their opinions on the cause of the incident and what measures could have been taken to prevent the injury. Finally, the post-incident response includes a review of the risk factors identified and corrective measures taken under the workplace violence prevention plan. Such requirements serve to recognize that the employees directly involved in incidents of workplace violence can provide valuable insight on how to prevent or mitigate similar incidents of violence in the future. NNU urges Congress to include this language in H.R. 1309.

Inclusion of a requirement for employers to develop preparedness plans for workplace violence emergencies, including active shooter events, is increasing important. One study examined media reports of hospital-based shootings between 2000 and 2015.[52] The authors found that the number of hospital-based shootings per year has been increasing for approximately the past decade. H.R. 1309 importantly includes such a requirement.[53]

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[51] Loomis, D. et al., Effectiveness of Safety Measures Recommended for Prevention of Workplace Homicide. *Journal of the American Medical Association*, Vol. 287 (8), 2002, pp. 1011-17.

[52] Gao and Adashi. "An Analysis of Active Shooters in the Hospital Setting, 2000-2015." Available at https://repository.library.brown.edu/studio/item/bdr%3A581443/PDF/ (Accessed February 23, 2019).

[53] *See* H.R. 1309, Sec. 103(1)(B)(v).

H.R. 1309, Sec. 103(1)(B)(v)
That employers develop communication and reporting procedures.

Communicating information regarding increased risks for workplace violence between employees and between shifts and units is critical in hazard identification and assessment. It is important that H.R. 1309 includes a requirement that employers establish effective communication procedures in their workplace violence prevention plans. These communications procedures are vital to the effectiveness of a workplace violence prevention plan. NNU members have raised concerns in the health and safety classes that they find out about an ongoing incident with the potential to affect the entire facility only long after the fact informally from their co-workers. Communication procedures enable nurses and other healthcare workers to be aware of increased risk for violence, contribute to the ongoing assessment of workplace violence risks, and to implement the employer's preventive measures and other parts of the workplace violence prevention plan.

H.R. 1309, Sec. 103(1)(B)(v)
That employers must provide training.

Training is a necessary element of an effective workplace violence prevention plan but training by itself is not enough to provide the highest level of protection for employees against workplace violence. Under a federal standard on workplace violence prevention, OSHA should require that employees receive in-person and hands-on training so that they are educated regarding the workplace violence hazards that they face in the course of doing their jobs, the prevention measures implemented by their employer, and the policies, procedures, and communication methods established by their employer on workplace violence.

Because training is an important aspect of safety and health programs, it should always be provided to employees on paid time. Additionally, healthcare employers often assign online training modules to RNs to complete during a shift while they are also have full patient assignments. During NNU's focus group-style discussions, RNs reported that online formats are not effective at conveying information about workplace violence plans and risks of workplace violence. In order for training to be effective, an OSHA should opt for frequent, in-person training with hands-on practice where appropriate.

The published literature underlines the importance of hands on, interactive training.

- A 2002 described the effectiveness of staff training intervention in the emergency department at a large academic, urban hospital.[54] Results showed that interactive, hands-on training can be effective in reducing violence rates but that refresher training is needed to maintain those

[54] Fernandes, C. et al. The Effect of an Education Program on Violence in the Emergency Department. *Annals of Emerg. Med.* Vol. 39:1, 2002, pp. 47-55.

effects. Researchers measured violent incident rates using a survey filled out by staff at the end of each shift on alternate days for two weeks before implementation, at three months, and at six months post-implementation of the staff training intervention. Data results showed a statistically significant decrease in the rates of violence at three months post-implementation, which then increased slightly at six months post-implementation.

- A 2009 study reported on the effectiveness of a workplace violence intervention implemented in a psychiatric inpatient unit at a Veterans' Affairs hospital that included real-time incident recording tools and regular meetings on workplace violence with all staff and patients.[55] To implement the intervention, the hospital gave unit staff members hand-held event recorders to easily record violent incidents in real-time during their shifts and began holding "The Violence Prevention Community Meeting" twice weekly on day shift but not the night shift. The meetings were attended by all patients and all day shift staff on the psychiatric inpatient unit. Rates of violence were significantly reduced on the day shift—by 89% during treatment and 57% from pre-treatment to post-treatment—but the night shift did not show significant changes in violent incident rates.

H.R. 1309, Sec. 103(4)
That employers must create and maintain violent incident logs, making these logs available to employees and their representatives on request, and report related information electronically to OSHA.

H.R. 1309 importantly includes provisions that would require covered employers to create violent incident logs and to record information about every workplace violence incident that occurs in the facility. Such a requirement is important to capture information necessary for effective hazard assessment and plan evaluation. Existing forms and recordkeeping—like workers' compensation forms, OSHA 301 forms, and 300 Logs—are insufficient to capture the information necessary. An effective workplace violence prevention program or plan is dependent upon accurate reporting of incidents.

Accurate recordkeeping of all incidents in the Violent Incident Log is critical to the development of a comprehensive workplace violence prevention plan. There are several components to these recordkeeping requirements. First, the Violent Incident Log must capture information solicited from employees involved in the incident. Second, because blame is not attached to a patient, recordkeeping provides the data and opportunity to evaluate unintentional acts in the aggregate and can help in identifying ways to reduce the frequency of these incidents. Additionally, information about patient specific risk factors is collected in Violent Incident Logs, which is to adopt safety measures and to address any medical conditions or disease process that may increase patient confusion, disorientation, aggression, or other patient behavior that may lead to acts of violence.

H.R. 1309 would also require that OSHA create an online reporting system for employers to report certain information about workplace violence rates and severity in their facilities.

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[55] Lanza, M. et al. Reducing Violence Against Nurses: The Violence Prevention Community Meeting. *Issues in Mental Health Nursing*, Vol. 30, 2009, pp. 745-50.

This would be useful information for OSHA to have that could drive more effective enforcement activities.

H.R. 1309, Sec. 103(6)
That employers must at least annually review the workplace violence prevention plan.

H.R. 1309 includes a provision that would require employers to review the effectiveness of their workplace violence prevention plans with the active participation of employees and their representatives. Such a review is important to maintaining an effective workplace violence prevention plan and provides a consistent and regular point of input for employees and their representatives to provide feedback on the workplace violence prevention plan. However, the annual evaluation should be unit-specific.

H.R. 1309, Sec. 103(7)
That employers are prohibited from retaliating against an employee for making a report, concern, or seeking assistance for a workplace violence incident.

Anti-retaliation provisions are important to ensuring that employees can report workplace violence incidents and concerns about workplace violence effectively to their employers. It is also important that employees' right to report workplace violence incidents to local law enforcement or to seek assistance from local law enforcement during a workplace violence incident is protected. H.R. 1309 current contains this important language.

ATTACHMENT 5: TIMELINE OF STATE & FEDERAL EFFORTS ON WORKPLACE VIOLENCE.

1995 Cal/OSHA, releases "Cal/OSHA Guidelines for Workplace Security."[56]

1996 Federal OSHA issues voluntary guidelines, "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers."

2004 Federal OSHA updates their voluntary guidelines.

2013 California Nurses Association sponsors SB 718 (Senator Yee) to require Cal/OSHA to develop a workplace violence prevention standard for hospitals and other healthcare employers.[57]

U.S. Representatives George Miller and Robert Scott submit a letter to the Government Accountability Office to request an investigation into federal OSHA's activities on workplace violence in healthcare and social service settings.[58]

2014 California Nurses Association sponsors SB 1299 (Padilla) in the California legislature, which required Cal/OSHA to develop a workplace violence prevention standard for hospitals and other healthcare employers and set minimum requirements for such a standard. It passes and is signed by the Governor.

California Nurses Association petitions the California Occupational Safety and Health Standards Board to promulgate a standard on workplace violence prevention in hospitals and other healthcare facilities. The petition is granted.[59]

2015 Federal OSHA updates their "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" for a second time.[60]

2016 The U.S. Government Accountability Office releases their report on federal OSHA's enforcement activities on workplace violence, "Workplace Health and Safety: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence."[61]

National Nurses United submits a petition to federal OSHA to promulgate a workplace violence prevention standard for hospitals and other healthcare employers, based upon the comprehensive Cal/OSHA standard.[62]

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[56] California Division of Occupational Safety and Health. "Cal/OSHA Guidelines for Workplace Security." March 30, 1995, available at https://www.dir.ca.gov/dosh/dosh_publications/worksecurity.html (Accessed February 23, 2019).

[57] For the original text of SB 718 (Yee), see http://www.leginfo.ca.gov/pub/13-14/bill/sen/sb_0701-0750/sb_718_bill_20130222_introduced.html (Accessed February 23, 2019).

[58] See https://edlabor.house.gov/media/blog/miller-and-courtney-ask-gao-to-investigate-workplace-violence-for-health-care-and-social-workers (Accessed February 23, 2019).

[59] For the text of the petition and the Occupational Safety and Health Standards Board's analysis and decisions see https://www.dir.ca.gov/oshsb/petition_539.html (Accessed February 23, 2019).

[60] OSHA's "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" was updated twice, in 2004 and 2015. The updated version is available at https://www.osha.gov/Publications/osha3148.pdf (Accessed February 23, 2019).

[61] GAO Report (2016).

The California Occupational Safety and Health Standards Board unanimously approves the proposed Cal/OSHA Workplace Violence Prevention in Health Care Standard.[63]

2017 Assistant Secretary of Labor David Michaels grants NNU's petition for a federal OSHA standard on workplace violence prevention in healthcare.[64]

2018 Representative Ro Khanna introduced the Health Care Workplace Violence Prevention Act, H.R. 5223.[65]

Cal/OSHA's Workplace Violence Prevention in Health Care Standard goes fully into effect.[66]

Representative Joe Courtney introduced the Workplace Violence Prevention for Health Care and Social Service Workers Act, H.R. 7141.[67]

2019 Representative Joe Courtney introduced H.R. 1309 on February 19, 2019.

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[62] Press release on the petition available at https://www.nationalnursesunited.org/blog/national-nurses-united-petitions-federal-osha-workplace-violence-prevention-standard (Accessed February 23, 2019).

[63] For minutes of the meeting where the California Occupational Safety and Health Standards Board unanimously approved the Workplace Violence Prevention in Health Care Standard see https://www.dir.ca.gov/OSHSB/documents/minutesOct2016.pdf (Accessed February 23, 2019).

[64] Press release on granting of the petition available at https://www.nationalnursesunited.org/press/nnu-nurses-petition-granted-national-standard-prevent-workplace-violence-healthcare (Accessed February 23, 2019).

[65] For the text of the bill, see https://www.congress.gov/bill/115th-congress/house-bill/5223 (Accessed February 23, 2019).

[66] For the full text of this standard, 8 CCR §3342, see https://www.dir.ca.gov/title8/3342.html (Accessed February 23, 2019).

[67] For the text of the bill, see https://www.congress.gov/bill/115th-congress/house-bill/7141/text (Accessed February 23, 2019).

latimes.com/news/local/la-me-hospital-violence-20110731,0,158771.story

latimes.com

Surveys find widespread violence against nurses and other hospital caregivers

Nearly 40% of employees in California emergency rooms said they had been physically assaulted on the job in the previous year

By Jessica Garrison and Molly Hennessy-Fiske, Los Angeles Times

July 31, 2011

The patient was drunk, naked and covered in blood when he burst out of his emergency room cubicle around 2 a.m., brandishing scissors. He lunged at two nurses and began chasing them.

It took two police officers and three zaps from a Taser to subdue him.

Rattled by this attempted stabbing in 2009 and other attacks at Ventura County Medical Center, emergency room nurse Lorraine Sandoval began keeping count of every time a colleague was assaulted or threatened by patients. On average, she found, it was once or twice a day.

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"We should not have to wait until a nurse, doctor or EMT or patient is seriously injured or killed before something is done," Sandoval recalled telling her bosses, who later installed an armed officer in the emergency room.

Although nearly invisible to the public except in extreme cases, violence against nurses and other hospital caregivers is commonplace in California and around the nation, according to surveys, state records and interviews with hospital employees and industry experts.

Some workers, especially in emergency rooms, say they experience some level of assault — biting, hitting, kicking and chasing — so often they consider it an unavoidable part of the job. Most attacks don't result in serious injury, but hundreds have resulted in workers' compensation claims in California alone in recent years, according to a Times review.

Nearly 40% of employees in California emergency rooms said they had been assaulted on the job in the previous year, according to a survey by UC San Francisco and other researchers in 2007. More than one in 10 emergency room nurses surveyed in 2010 said they had been attacked in the previous week, according the Emergency Nurses Assn., which represents 40,000 emergency room nurses nationally.

Many industry experts and hospital staffers say they believe violence by patients and visitors is rising

but can't say for sure because it hasn't been rigorously tracked over time. The issue has recently gained attention, however, as hospital employee unions, including the California Nurses Assn., have begun pushing for broader protections and more reporting by hospitals.

The violence flares most often in emergency rooms and psychiatric wards, say staffers, researchers and security officials. In emergency rooms, waiting times have grown as increasing numbers of unemployed and uninsured patients seek basic care they can't afford to pay for in doctors' offices.

"We have a lot of men who have lost their jobs, lost their homes, 50-year-old men who have worked their whole lives," said Colleen Sichley, a 17-year nurse at Antelope Valley Hospital in Lancaster and a union representative. "They're angry. Just between the cursing and the bad language, and the physical stuff, and it's anybody" who can lash out, she said.

Staffers are obligated by law to evaluate anyone who goes for treatment, said Michael B. Jackson, an emergency room nurse at UC San Diego Medical Center. He said that whether they be gang members, drug users, psychotic patients or just "people that get frustrated with wait times," they might act out.

Acutely ill mental patients are landing in general hospitals because many lack consistent outpatient care that might keep them from deteriorating.

Hospitals sometimes blame employees for mishandling violence rather than reporting and investigating it, said Kathleen McPhaul, an assistant professor at the University of Maryland School of Nursing who has written about hospital violence and believes it is rising. "Even if the staff did something wrong," she said, "the employer needs to take responsibility and get to the bottom of it and train the staff."

Jan Emerson-Shea, vice president for external affairs for the California Hospital Assn., said that hospitals "generally are very safe places," and that most have specific protocols to follow if trouble arises.

Every so often, a high-profile tragedy prompts hospitals to rethink their security plans. In 1993, a mentally disturbed gunman opened fire in the emergency room at Los Angeles County/USC Medical Center, wounding three doctors. Since then, County-USC and other major urban hospitals have installed metal detectors and posted armed police officers in emergency rooms.

But smaller hospitals have not always gone to the same lengths. Even facilities with armed guards don't tend to station them in private treatment areas. Assaults can be difficult to predict, and guards sometimes arrive too late.

Jackson, a former Marine, said some people give an indication that they may turn violent, such as pacing, yelling or making threats; "other times it just happens."

Jackson said he was checking in a patient once who said he was "frustrated with the system." Suddenly, the patient said, " 'Let me show you how serious I am' and then he pulled out a knife and started waving it around.... It was just me and a couple of secretaries standing behind me, and I started wrestling with this guy. I grabbed the arm that had the knife and it fell on the ground."

Nurse DeAnne Dansby said a patient tackled and tried to rape her in February 2010 in the emergency room at Mercy General Hospital in Sacramento. The patient, identified by paramedics as homeless, had been taken to the hospital earlier that morning with hypothermia, she said. As he warmed up, he became agitated. Dansby stepped in to prevent him from harming a student nurse, and the man went at her and she fell so hard to the floor that her head "ricocheted," she said.

"By the time they could get to me this guy already had my scrub pants down almost to my knees," she said. "It took 13 people to get this idiot off of me."

Weeks after the attack, Dansby said, she was diagnosed with displaced herniated discs and severed nerves. She lost the use of her left arm and can no longer move her neck enough to "look up at the sky," she said.

"That guy could have killed me," said Dansby, who received workers' compensation payments — uncontested by the hospital — before going back to Georgia and finding a less strenuous job.

Under California regulations, among the strictest in the country, all significant injuries must be reported to the state and law enforcement. But the law does not spell out what "significant" means.

Dansby said her supervisor told her: "If you are going to work for this hospital, you are not going to press charges," so she did not.

Two months after she was assaulted but before the full extent of her injuries became clear, Dansby said, she was dismissed. Because she was a probationary employee, hospital officials did not need to cite a cause.

Later, she said, the nurses union representative accused her of exaggerating her injuries to avenge her firing.

Officials at Mercy hospital issued a statement saying that "the hospital's actions were in compliance with its policies and procedures, and with California law."

Bonnie Castillo, head of the California Nurses Assn., said hospital officials discourage nurses from reporting assaults because "it interferes with their image of being a safe haven."

A 2009 study published in the Annals of Epidemiology found that more than half of hospital workers in California and New Jersey had not told their supervisors after being assaulted, in part because "workers often accept these events as part of their job."

Nine assaults involving significant injury or death were reported to California's Department of Public Health from fiscal year 2007 to fiscal 2009, according to records released to The Times. During the same period, 370 hospital workers filed compensation claims alleging that they were injured in assaults involving criminal acts, although the significance of those injuries was not clear.

Those workers' compensation numbers do not include many more people who were injured in assaults not deemed crimes, which could include attacks by someone with dementia or psychosis, said Susan Gard, head of policy for California's Division of Workers' Compensation.

The Times also reviewed crime reports taken by the Los Angeles Police Department at all hospitals in Los Angeles over a recent 10-month period, finding that not a single assault was reported at nearly a third of the 40 hospitals in the city. At California Hospital Medical Center in downtown Los Angeles, however, nine were reported, most of which clearly involved attacks on employees.

Katreena Salgado, the hospital's director of public affairs, said it's not because there's more violence at her hospital but because the administration takes the staff's safety seriously and encourages employees to report assaults by patients or visitors capable of understanding their actions.

Even low-level violence can bring great stress, staffers at many hospitals said.

Amelia Mendoza, 53, a nurse's assistant at Huntington Hospital in Pasadena for six years, was struck by a patient on her arm in April 2009, according to allegations by her family in a workers' compensation case. The assault was relatively minor, according to her family's lawyer, but her blood pressure shot up so high she required treatment.

A few days later, Mendoza was assaulted again by the same patient, her family alleged. After unsuccessfully seeking treatment at the hospital again for her blood pressure, she had a massive stroke and died last October.

This spring, a workers' compensation judge found that the death "arose out of and in the course of" her employment and that the attacks may have played a role.

In a written statement, Huntington officials said: "We strongly disagree with the decision and are proceeding with a formal appeal."

Some violence may be unavoidable, but staffers complain that they haven't been trained in the best way to contain it.

In 2008, a 338-pound patient was admitted for chest pain at a Kaiser Permanente hospital in Oakland and was observed by staffers to be angry and anxious, according to state documents. The next morning he got out of bed, took off his clothes and began punching his 68-year-old roommate in the face.

Hearing screams, a nurse ran to the room. The patient then began chasing her. "I ran," the nurse later told state investigators. "I didn't know what to do.... No one knew what to do."

The patient cornered a group of nurses by the elevators and struck four staffers before picking up a fifth employee and "swinging" him around, according to the state's investigative report.

Even after security officers handcuffed the patient and placed him in a chair, he ran away again before being wrestled to the ground.

He experienced "some degree of head trauma," according to the state report, and died a week later "after another episode of increased agitation" that was not described.

Later, the California Department of Public Health found that the hospital had failed to provide proper supervision to an acutely ill mental patient.

Kaiser officials called the case "extremely unusual" and said they had since provided training to staffers and "strengthened the hospital's security plan."

Even though extreme violence is rare, many employees and union leaders say, it often occurs after a trail of unheeded warnings.

At Danbury Hospital in Connecticut, nurses had been lodging complaints for months about violence against staff members, including a nurse who was punched in the jaw, then fell and broke her hip in 2009, said Mary Consoli, a nurse and president of the local nurses union.

Their pleas were ignored, she said, until last spring, when an 85-year-old patient with dementia took a

gun out of his pocket. A nurse tried to intervene and was shot three times, sustaining long-term damage to his hand, according to Consoli.

Occupational safety investigators issued $6,000 in fines, noting a long list of previous fractures, bites and bruises to staffers.

"You don't want to be grateful for this shooting," Consoli said. "But if it wasn't for this shooting," she said, nothing would have been done.

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12 NYCRR PART 800.6

PUBLIC EMPLOYER
WORKPLACE VIOLENCE PREVENTION PROGRAMS

800. 6

(a) **Title and Citation:** Within and for the purposes of the Department of Labor, this part may be known as Code Rule 800.6, Public Employer Workplace Violence Prevention Programs, relating to requirements of public employers to develop and implement programs to prevent and minimize the hazards of workplace violence to public employees; allowing any employee or authorized employee representative of employees who believes that a serious violation of this safety or health standard exists, or an imminent danger exists, to request an inspection by the department of labor; and providing for the enforcement of such requirement by the Commissioner of Labor. It may be cited as Code Rule 800.6"Public Employer Workplace Violence Prevention Programs" as an alternative and without prejudice to its designation and citation established by the Secretary of State.

(b) **Purpose and Intent:** It is the purpose of this part to ensure that the risk of workplace assaults and homicides is evaluated by affected public employers and their employees and that such public employers design and implement protection programs to minimize the hazard of workplace violence to employees.

(c) **Application:** This part shall apply throughout the State of New York to the State, any political subdivision of the state, any public authority, public benefit corporation or any other governmental agency or instrumentality thereof. This part shall not apply to any employer as defined in Section twenty-eight hundred one-a of the Education Law.

(d) **Terms:** As used in or in connection with this part, the following terms mean:

(1) Authorized Employee Representative. An employee authorized by the employees or the designated representative of an employee organization recognized or certified to represent the employees pursuant to Article 14 of the Civil Service Law.

(2) Commissioner. The Commissioner of Labor of the State of New York or his or her duly authorized representative for the purposes of implementing this Part.

(3) Employee. A public employee working for an employer.

(4) Employer. The State, any political subdivision of the State, any public authority public benefit corporation, and any other governmental agency or instrumentality thereof, except that an employer shall not include, for purposes of this part, any employer defined as such in Section twenty-eight hundred one-a (2801a) of the Education Law.

(5) Imminent Danger. Any conditions or practices in any place of employment which are such that a danger exists which could reasonably be expected to cause death or serious physical harm immediately or before the imminence of such danger can be eliminated through the enforcement procedures otherwise provided for by this Part.

(6) Retaliatory Action. The discharge, suspension, demotion, penalization or discrimination against any employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

(7) Serious physical harm. Physical injury which creates a substantial risk of death, or which causes death or serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of any bodily organ or a sexual offense as defined in Article 130 of the Penal Law.

(8) Serious Violation: A serious violation of the public employer workplace violence prevention program (WVPP) is the failure to:

(a) Develop and implement a program.

(b) Address situations which could result in serious physical harm.

(9) Supervisor. Any person within the employer's organization who has the authority to direct and control the work performance of an employee, or who has the authority to take corrective action regarding the violation of a law, rule or regulation to which an employee submits written notice.

(10) Workplace. Any location away from an employee's domicile, permanent or temporary, where an employee performs any work-related duty in the course of his or her employment by an employer.

(11) Workplace Violence. Any physical assault or acts of aggressive behavior occurring where a public employee performs any work-related duty in the course of his or her employment including but not limited to:

(i) An attempt or threat, whether verbal or physical, to inflict physical injury upon an employee;

(ii) Any intentional display of force which would give an employee reason to fear or expect bodily harm;

(iii) Intentional and wrongful physical contact with a person without his or her consent that entails some injury;

(iv) Stalking an employee with the intent of causing fear of material harm to the physical safety and health of such employee when such stalking has arisen through and in the course of employment.

(12) Workplace Violence Prevention Program. An employer program designed to prevent, minimize and respond to any workplace violence, the development and implementation of which is required by Article 2, Section 27-b of the New York State Labor Law.

(e) **Management Commitment and Employee Involvement**

(1) Workplace Violence Policy Statement: The employer shall develop and implement a written policy statement on the employer's workplace violence prevention program goals and objectives and provide for full employee participation through an authorized employee representative.

(i) The workplace violence policy statement shall be posted where notices to employees are normally posted.

(ii) The policy statement shall briefly indicate the employer's workplace violence prevention policy and incident alert and notification policies for employees to follow in the event of a workplace violence incident.

(2) The responsibility and authority for preparing, determining the content of and implementing the requirements of this part remains with the employer. Local governments and all other public employers may elect to share resources in the development and implementation of their workplace violence prevention programs.

(f) **Risk Evaluation and Determination**

(1) Record Examination:
The employer shall examine any records relevant to the purposes of this Part in its possession, including records compiled in the previous year under Labor Law Section 27a, that concern workplace violence incidents to identify patterns in the type and cause of injuries. The examination shall look to identify patterns of injuries in particular areas of the workplace or incidents which involve specific operations or specific individuals.

(2) Administrative Risk Factors
The employer shall assess relevant policies, work practices, and work procedures that may impact the risk of workplace violence.

(3) Evaluation of Physical Environment
The employer, with the participation of the authorized employee representatives, shall evaluate the workplace to determine the presence of factors which may place employees at risk of workplace violence. The Department of Labor has tools to aid employers in performing this evaluation which will be posted on the Department's web-site. Factors which might place an employee at risk include but are not limited to:

(i) Working in public settings (e.g. Social Service Workers, Police Officers, Firefighters, Teachers, Public Transportation Drivers, Health Care Workers, other Governmental Workers or Service Workers);

(ii) Working late night or early morning hours;

(iii) Exchanging money with the public;

(iv) Working alone or in small numbers;

(v) Working in a location with uncontrolled public access to the workplace; or

(vi) Areas of previous security problems.

(g) **The Workplace Violence Prevention Program**

(1) Employers with 20 or more full time permanent employees, with the participation of the authorized employee representative, shall develop a written workplace violence prevention program. Such participation shall include soliciting input from the authorized employee representative as to those situations in the workplace that pose a threat of workplace violence, and on the workplace violence prevention program the employer intends to implement under these regulations. Safety and health programs developed and implemented to meet other federal, state or local regulations, laws or ordinances are considered acceptable in meeting this requirement if those programs cover or are modified to cover the topics required in this paragraph. An additional or separate safety and health program is not required by this paragraph.

(2) The workplace violence prevention program shall include the following:

(i) A list of the risk factors identified in the workplace examination;

(ii) The methods the employer will use to prevent the incidence of workplace violence incidents;

(iii) A hierarchy of controls to which the program shall adhere as follows: engineering controls, work practice controls, and finally personal protective equipment;

(iv) The methods and means by which the employer shall address each specific hazard identified in the workplace evaluation;

(v) A system designed and implemented by the employer to report any workplace violence incidents that occur in the workplace. The reports must be in writing and maintained for the annual program review;

(vi) A written outline or lesson plan for employee program training;

(vii) A plan for program review and update on at least an annual basis. Such review and update shall set forth any mitigating steps taken in response to any incident of workplace violence.

(viii) Nothing in this part shall require the disclosure of information otherwise kept confidential for security reasons. Such information may include information which, if disclosed:

(a) Would interfere with law enforcement investigations or judicial proceedings;

(b) Would deprive a person of a right to a fair trial or impartial adjudication;

(c) Would identify a confidential source or disclose confidential information relating to a criminal investigation;

(d) Would reveal criminal investigative techniques or procedures, except routine techniques and procedures; or

(e) Would endanger the life or safety of any person.

(h) **Employee Information and Training**

(1) Upon completion of the workplace violence prevention program, every employer shall provide each employee with information and training on the risks of workplace violence in their workplace or workplaces at the time of the employee's initial assignment and at least annually thereafter. Such information as necessary shall be provided to affected employees whenever significant changes are made to the workplace violence program. At a minimum training shall address the following:

(i) Employers shall inform employees of the requirements of this Part and the risk factors in their workplace that were identified in the risk evaluation and determination, except that nothing in this part shall require the disclosure of the information otherwise kept confidential for security reasons as identified in paragraph (g)(2)(viii).

(ii) Employers shall inform employees of the measures that employees can take to protect themselves from the identified risks including specific procedures that the employer has implemented to protect employees such as incident alert and notification procedures, appropriate work practices, emergency procedures, and use of security alarms and other devices;

(iii) Employers with 20 or more full-time permanent employees shall inform employees of the location of the written workplace violence program and how to obtain a copy, and shall make it available for reference to employees, authorized employee representatives and the Commissioner in the work area during the regularly scheduled shift.

(i) **Recordkeeping and Recording Of Workplace Violence Incidents**

(1) Employers shall establish and implement reporting systems for incidents of workplace violence. Reporting systems developed and implemented to meet other federal state or local regulations, laws or ordinances are considered acceptable in meeting this requirement if they cover or are modified to cover the information required in this paragraph. An additional or separate reporting system is not required by this paragraph.

(2) Employers at sites where there is a developing pattern of workplace violence incidents which may involve criminal conduct or a serious injury shall attempt to develop a protocol with the District Attorney or Police to insure that violent crimes committed against employees in the workplace are promptly investigated and appropriately prosecuted. The employer shall provide information on such protocols and contact information to employees who wish to file a criminal complaint after a workplace violence incident.

(3) Systems for reporting instances of workplace violence.

(i) The employer shall develop and maintain a Workplace Violence Incident Report that can be in any format but, at a minimum, shall contain the following relating to the incident being reported:

(a) Workplace location where incident occurred;

(b) Time of day/ shift when incident occurred;

(c) A detailed description of the incident, including events leading up to the incident and how the incident ended;

(d) Names and job titles of involved employees;

(e) Name or other identifier of other individual(s) involved;

(f) Nature and extent of injuries arising from the incident; and

(g) Names of witnesses.

(ii)

(a) If the case is a "privacy concern case" as defined below, the employer shall still be liable for developing a Workplace Violence

Incident Report as set forth above. However, before sharing a copy of such Report with any party other than the Commissioner, the employer shall remove the name of the employee who was the victim of the workplace violence and shall instead enter "PRIVACY CONCERN CASE" in the space normally used for the employee's name.

(b) The employer shall treat incidents involving the following injuries or illnesses as privacy concern cases:

(1) An injury or illness to an intimate body part or the reproductive system;

(2) An injury or illness resulting from a sexual assault;

(3) Mental illness;

(4) HIV infection;

(5) Needle stick injuries and cuts from sharp objects that are or may be contaminated with another person's blood or other potentially infectious material; and

(6) Other injuries or illnesses, if the employee independently and voluntarily requests that his or her name not be entered on the Report.

(4) The Workplace Violence Incident Report must be maintained for use in annual program review and updates. This requirement does not relieve an employer of the recordkeeping requirements of 12NYCRR Part 801.

(5) The employer, with the participation of the authorized employee representative, shall conduct a review of the Workplace Violence Incident Reports at least annually to identify trends in the types of incidents in the workplace and review of the effectiveness of the mitigating actions taken.

(j) **Employee Reporting Of Workplace Violence Prevention Concerns or Incidents**

(1) Any employee or his or her authorized employee representative who believes that a serious violation of the employer's workplace violence

protection program exists, or that a workplace violence imminent danger exists, shall bring such matter to the attention of a supervisor in the form of a written notice and shall afford the employer a reasonable opportunity to correct such activity, policy or practice.

(2) Written notice to an employer shall not be required where workplace violence imminent danger exists to the safety of a specific employee or to the general health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

(3) If, following a referral of such matter to the employee's supervisor and after a reasonable opportunity to correct such activity, policy or practice, the matter has not been resolved and the employee or the authorized employee representative still believes that a serious violation of a workplace violence prevention program remains or that an imminent danger exists, such employee may request an inspection by notifying the Commissioner of Labor of the alleged violation. Such notice and request shall be in writing, shall set forth with reasonable particularity the ground(s) for the notice and shall be signed by such employee or their authorized employee representative. A copy of the written notice shall be provided by the Commissioner to the employer or the person in charge no later than the time of inspection, except that at the request of the person giving such notice, such person's name and the names of individual employees or authorized employee representatives of employees shall be withheld. Such inspection shall be made forthwith by the Commissioner.

(4) The authority of the Commissioner to inspect premises pursuant to such employee complaint shall not be limited to the alleged violation contained in such complaint. The Commissioner may inspect any other area of the premises in which he or she has reason to believe that a serious violation of this section exists.

(5) The Commissioner may, upon his or her own initiative, conduct an inspection of any premises occupied by an employer if he or she has reason to believe that a violation of this section has occurred. The current PESH administrative plan will be used for the enforcement of this section, including a general schedule of inspections, which provides a rational administrative basis for such inspection.

(6) No employer shall take retaliatory action against any employee because the employee exercises any right accorded him or her by this Part.

(k) **Effective Dates**

(1) The Employer's Policy Statement required by section (e) of this Part shall be completed within 30 days after the effective date of this Part.

(2) The workplace risk evaluation and determination required by section (f) of this Part shall be completed within 60 days of the effective date of this Part.

(3) The workplace violence prevention program required by section (g) of this Part shall be complete within 75 days of the effective date of this Part.

(4) Employers shall be in compliance with the entire Part within 120 days of the effective date of this Part.

Preventing Workplace Violence: A Road Map for Healthcare Facilities

December 2015

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OSHA
Occupational Safety and Health Administration
www.osha.gov • (800) 321-OSHA (6742)
OSHA 3827

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This document is advisory in nature and informational in content. It is not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by OSHA standards or the *Occupational Safety and Health Act of 1970*.

1. Introduction

Workplace Violence Prevention: A Pervasive Challenge

Workers in hospitals, nursing homes, and other healthcare settings face significant risks of workplace violence, which can refer to any physical or verbal assault toward a person in a work environment. Violence in healthcare facilities takes many forms and has different origins, such as verbal threats or physical attacks by patients, gang violence in an emergency department (ED), a distraught family member who may be abusive or even becomes an active shooter, a domestic dispute that spills over into the workplace, coworker bullying, and much more. The healthcare industry has many unique factors that increase the risk of violence, such as working directly with people who have a history of violence or who may be delirious or under the influence of drugs. In some cases, employees or patients might perceive that violence is tolerated as "part of the job," which can perpetuate the problem.

Statistics collected by the Bureau of Labor Statistics show the magnitude of the problem:

- From 2011 to 2013, U.S. healthcare workers suffered 15,000 to 20,000 workplace-violence-related injuries every year that required time away from work for treatment and recovery (i.e., serious injuries). Healthcare accounts for nearly as many injuries as all other industries combined.[1]
- Violence is a more common source of injury in healthcare than in other industries. From 2011 to 2013, assaults constituted 10–11 percent of serious workplace injuries in healthcare, compared with 3 percent among the private sector as a whole.[2]
- Healthcare and social assistance workers experienced 7.8 cases of serious workplace violence injuries per 10,000 full-time equivalents (FTEs) in 2013. Other large sectors such as construction, manufacturing, and retail all had fewer than two cases per 10,000 FTEs.[3]

These statistics do not include the many additional assaults and threats that do not lead to time away from work. Studies also show that violence in healthcare workplaces is underreported; thus, the problem is considerably larger than the official statistics suggest.

Defining Workplace Violence

Organizations have defined workplace violence in various ways. The National Institute for Occupational Safety and Health defines workplace violence as "violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty." Enforcement activities typically focus on physical assaults or threats that result or can result in serious physical harm. However, many people who study this issue and the workplace prevention programs highlighted here include verbal violence—threats, verbal abuse, hostility, harassment, and the like—which can cause significant psychological trauma and stress, even if no physical injury takes place. Verbal assaults can also escalate to physical violence.

Workplace violence comes with a high cost. First and foremost, it harms workers—often both physically and emotionally—and makes it more difficult for them to do their jobs. Employers also bear several costs. A single serious injury can lead to workers' compensation losses of thousands of dollars, along with thousands of dollars in additional costs for overtime, temporary staffing, or recruiting and training a replacement. Even if a worker does not have to miss work, violence can still lead to "hidden costs" such as higher turnover and deterioration of productivity and morale.

Despite the complex nature of the problem, many proven solutions exist. These solutions work best when coordinated through a comprehensive workplace violence prevention program.

About This Road Map

OSHA has developed this resource to assist healthcare employers and employees interested in establishing a workplace violence prevention program or strengthening an existing program. This road map is related to another

[1] Source: Bureau of Labor Statistics data for 2011–2013, covering injuries that required days away from work. These statistics are restricted to private industry to allow for proper comparison. "Healthcare" data cover three large industry segments: NAICS 621, "Ambulatory Health Care Services"; 622, "Hospitals"; and 623, "Nursing and Residential Care Facilities."

[2] Ibid.

[3] Source: Bureau of Labor Statistics data for 2013, covering injuries that required days away from work. These statistics are restricted to private industry to allow for proper comparison. They are also restricted to intentional injuries caused by humans, excluding self-inflicted injuries. These data cover the large industry group known as NAICS 62, "Health Care and Social Assistance."

OSHA publication called *Guidelines for Prevention of Violence in Healthcare*—available at www.osha.gov/SLTC/workplaceviolence—which introduces the five building blocks and offers recommendations on developing effective policies and procedures. Like the guidelines, this road map describes the five core components of a workplace violence prevention program. In addition, this road map is intended to complement OSHA's guidelines by providing real-world examples of how healthcare facilities have put workplace violence policies and procedures into practice.

Examples have been drawn from about a dozen healthcare organizations nationwide, representing a range of facility types, sizes, geographic settings, and approaches to addressing workplace violence. Facilities profiled here include several privately run acute care hospitals, private and state-run behavioral health facilities, and a group of nursing homes. These facilities have agreed to share their successful models, tools, and "lessons learned" to help inform and inspire others.

OSHA obtained some of the examples in this road map from published sources, but obtained most of the information from the facilities themselves through site visits, meetings, and interviews. OSHA appreciates the time and knowledge the facilities shared. In deciding what information to use, OSHA highlighted selected components of each facility's program. All facilities acknowledged that their violence prevention programs were "in progress" and that "continuous improvement" is an important goal.

2. Comprehensive Workplace Violence Prevention Programs: An Overview

Although OSHA has no standard specific to the prevention of workplace violence, employers have a general duty to "*furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.*" This requirement comes from Section 5(a)(1) of the *Occupational Safety and Health (OSH) Act of 1970* and is known as the General Duty Clause.

OSHA has determined that the best way to reduce violence in the workplace is through a comprehensive workplace violence prevention program that covers five core elements or "building blocks":

- **Management commitment and employee participation.** Managers demonstrate their commitment to workplace violence prevention, communicate this commitment, and document performance. They make workplace violence prevention a priority, establish goals and objectives, provide adequate resources and support, appoint leaders with the authority and knowledge to facilitate change, and set a good example. Employees, with their distinct knowledge of the workplace, ideally are involved in all aspects of the program. They are encouraged to communicate openly with management and report their concerns without fear of reprisal.
- **Worksite analysis and hazard identification.** Processes and procedures are in place to continually identify workplace hazards and evaluate risks. There is an initial assessment of hazards and controls, regular reassessments, and formal re-evaluations after incidents, through accident review boards or after-action reviews.
- **Hazard prevention and control.** Processes, procedures, and programs are implemented to eliminate or control workplace hazards and achieve workplace violence prevention goals and objectives. Progress in implementing controls is tracked.
- **Safety and health training.** All employees have education or training on hazard recognition and control, and on their responsibilities under the program, including what to do in an emergency.
- **Recordkeeping and program evaluation.** Accurate records of injuries, illnesses, incidents, assaults, hazards, corrective actions, patient histories, and training can help employers determine the severity of the problem, identify trends or patterns, evaluate methods of hazard control, identify training needs, and develop solutions for an effective program. Programs are evaluated regularly to identify deficiencies and opportunities for improvement.

The core elements are all interrelated, and each is necessary to the success of the overall system. When integrated into a comprehensive workplace violence prevention program, particularly a written program, these elements offer a systematic approach—used by employers and employees, working together—to find and correct workplace hazards before injuries occur and on an ongoing basis. These components also align with the core elements of a safety and health management system (also known as an injury and illness prevention program, or I2P2), which can provide an overarching framework for planning, implementing, evaluating, and improving all workplace safety and health management efforts—for example, programs addressing violence prevention, bloodborne pathogens, and patient handling.

To learn more about connections and synergies between workplace violence prevention, safety and health management systems, and patient safety, see *Workplace Violence Prevention and Related Goals: The Big Picture* at www.osha.gov/Publications/OSHA3828.pdf.

3. Getting Started

Some healthcare organizations have begun to take serious action on workplace violence after an "eye-opening" incident—e.g., a shooting or a hostage situation—or after caring for a particularly challenging patient. Others have taken action after learning about incidents elsewhere in the news, or perhaps simply as a result of gaining a greater awareness of the problem. Whether an organization's decision to create or strengthen its workplace violence prevention program is more reactive or proactive, it can be difficult to know where to start in crafting a strategy that affects so many aspects of an organization, from the physical environment to policies, procedures, and management priorities.

Developing a workplace violence prevention program typically begins by convening a planning group or task force to tackle the issue. Alternatively, an organization may charge an existing safety and health committee with addressing workplace violence. No matter the starting point, management needs to ensure that whoever is leading the initiative has the authority and knowledge to convene the group and require participation, facilitate the necessary changes to policies and procedures, and ensure that adequate resources are available and committed for building and sustaining an effective program.

The composition and commitment of the committee or task force are key factors in its success or failure. Management must be committed to creating an effective program. Staff from all affected areas should be included to bring important knowledge and perspectives to the planning process. In addition, involving them from the outset can ensure buy-in when the plan is enacted. If the workforce is unionized, labor/management discussions can provide an important forum for voicing employees' concerns, making collaborative decisions, and bringing significant expertise and resources to the table. Patient advocates and other stakeholders can also provide valuable input.

Once the group is convened, the development process typically requires the collection of baseline data and other information to identify issues and inform decisions. Employees' opinions and experiences, which can be gathered through surveys, interviews, and focus groups, are crucial in assessing conditions and tailoring a program that will serve the needs of the specific healthcare setting.

When drafting questions for an employee or patient survey, it is important to consider how the data will be used and to frame questions in a way that will elicit the most helpful information. Responses should be confidential, and the survey should be simple to complete. Allowing employees to complete surveys on work time can increase participation. Focus groups, in which small groups of staff meet with a neutral facilitator, can also generate robust discussion about perceived risks and potential solutions.

Examples

Veterans Health Administration: convening stakeholders across a large organization

The Veterans Health Administration (VHA) is America's largest integrated healthcare system, with more than 1,700 sites serving 8.76 million veterans each year. The VHA has faced several challenges in addressing workplace violence: the vast size of the organization, a wide variety of settings (inpatient, outpatient, community settings, and specialty services), and a special population with notable incidence of post-traumatic stress disorder and other trauma. In 2000, the VHA formed a National Taskforce on Violence with representation from a variety of stakeholders from important VHA organizational units, labor partners, and outside agencies and experts. The taskforce reviewed violence within VHA, identified policy weaknesses and potential solutions, and made recommendations that included conducting a national survey. Results of this survey are described in "Worksite Analysis and Hazard Identification" on page 11.

Providence Behavioral Health Hospital: from labor concerns to collaborative action

In the late 1990s and early 2000s, registered nurses at Providence Hospital—a 104-bed behavioral health facility in Holyoke, Massachusetts—raised concerns about rising levels of violence and high rates of assaults by patients. With assistance from their union, the Massachusetts Nurses Association, the nurses brought their concerns to the bargaining table during contract negotiations. The union proposed research-based changes to hospital policies to address workplace violence. Through detailed negotiations, the nurses and hospital administrators worked together to include the following definitions and policies in the nurses' new contract:

> Violence is assaultive behavior from patients, visitors, other workers, physicians, or even family members. Violence is defined as, but not limited to, physical assaults, battering, sexual assaults, or verbal or non-verbal intimidation. ID badges will not reveal last name. The Hospital will have a policy and procedure relating to the detection, removal, storage, and disposition of potential or actual weaponry at admission or at any time during the Hospital stay. The Hospital agrees to provide security surveillance of Hospital grounds and parking areas. Both will be well lighted. Upon request, the Hospital will provide escorts to cars and physical protection to workers if necessary.
>
> The Hospital will initiate a policy and procedure for the prevention of violence or potential violence. It will also give training programs on how to safely approach potential assaults and prevent aggressive behavior from escalating into violent behavior. Consistent with the Hospital "Code Yellow" policy the Hospital will form a trained Response Team, available 24 hours and 7 days a week that, similar to a code team, can be immediately called to assist a nurse in any situation that involves violence. The employer will report the injury or illness to the appropriate agencies, i.e., Department of Industrial Accidents, police, etc. The employee also has the right to notify the police if he/she is being physically assaulted. Incidents of abuse, verbal attacks or aggressive behavior—which may be threatening to the nurse but not result in injury, such as pushing or shouting and acts of aggression towards other clients/staff/visitors—will be recorded on an assaultive incident report. The incident will be reported to the Risk Manager, the Providence Hospital Safety Committee, [and] Injury Review Committee for review and appropriate intervention. Copies of any documents relating to the incident will be given to the nurse affected. The employer will provide and/or make available to workers injured by workplace violence medical and psychological services.

The joint efforts of labor and management have led to more than a decade of collaboration on preventing workplace violence, a multidisciplinary task force, an open dialogue, a greater emphasis on prevention and de-escalation instead of restraint, and ultimately a decrease in the number and severity of assaults by patients.

New Hampshire Hospital: recognizing and adapting to change

The front entrance of New Hampshire Hospital.

As a state-run behavioral health hospital in operation since 1842, New Hampshire Hospital in Concord, New Hampshire, has a long history of treating patients with severe psychiatric conditions. However, a changing landscape has led to new challenges related to workplace violence. Until a few decades ago, the hospital had many more patients than it does today, and staff became very familiar with their patients because they were often committed for life. Now the hospital sees patients for shorter stays, and some of these patients have more acute challenges and pose more serious threats and problems than in the past, particularly with an uptick in involuntary commitments and referrals from EDs. New Hampshire Hospital has become more of a "last resort" as other facilities have closed or become full; at the same time, the medical community has pushed to reduce the use of restraints and seclusion. These changes in patient population, acuity, and treatment techniques—along with concerns raised by staff—led New Hampshire Hospital to realize that they needed to give their workers new tools to prevent and respond to workplace violence.

Nursing managers began with a series of focus groups to solicit input from direct care staff on all three shifts. To encourage employees to speak freely, meetings were conducted without supervisors present and were separated by discipline (nurses, physicians, mental health workers). This input helped managers to realize that many workers believed that violence was part of the job, which perpetuated acceptance of violence. The hospital addressed these issues over a few years by discussing workplace violence in labor/management meetings, adapting existing models to create a "Staying Safe" program (see Section 6: "Hazard Prevention and Control"), fostering dialogue and collaboration between clinical staff and campus police, implementing daily safety briefings, and creating a robust training program. New Hampshire Hospital now helps other hospitals start their own violence prevention efforts by writing articles, presenting at conferences, and sharing data and strategies with similar facilities in other states.

4. Management Commitment and Employee Participation

A strong commitment by management is critical to the overall success of the workplace violence prevention program. It is important for administrators, safety managers, and front-line supervisors not only to show that aggressive or violent behavior is unacceptable and will result in appropriate consequences, but also to provide an environment of trust where errors and incidents are viewed as opportunities to learn, with the overall goal of continuous improvement.

By creating a written workplace violence policy and posting it in publicly visible locations, management can provide a clear statement of the organization's position on workplace violence, explain the consequences for violation, and inform patients, visitors, and others of their responsibilities and the conduct that is expected of them.

Clearly defined policies and procedures and visible management involvement can also help encourage employees to report violent incidents or related concerns. Visible responses from management can help reassure workers that proper action will be taken to address their concerns, without fear of reprisal for reporting incidents.

All employees can bring important knowledge and perspectives to the workplace violence prevention program—especially caregivers who interact directly with patients. A joint management–employee committee can foster a participatory approach where employees and management work together on worksite assessment and solution implementation. The structure of management–employee teams varies based on the facility's size and the availability of personnel. Committees can include representatives from direct care staff; human resources, safety, security, and legal departments; unions; and local law enforcement departments. In addition, a focus on patient-on-employee versus employee-on-employee violence may require somewhat different human resources, legal, and clinician skills. It is essential that staff be given release time from patient care activities to attend meetings and conduct other committee work. To meet shared objectives, the committee can:

- Hold regular meetings and consider whether "ad hoc" meetings would be useful as well.
- Strongly encourage worker involvement in the decisions that affect their health and safety.
- Address employees' safety concerns in a timely manner.

Research has shown that interventions such as improved management commitment to a violence prevention program and employee engagement can lead to enhanced employee perceptions of safety.[4]

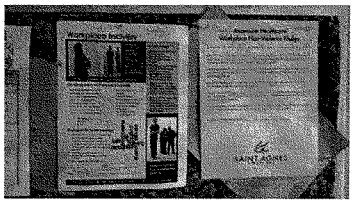
[4] Lipscomb, J., McPhaul, K., Rosen, J., Brown, J.G., Choi, M., Soeken, K., Vignola, V., Wagoner, D., Foley, J., and Porter, P. 2006. Violence prevention in the mental health setting: The New York State experience. *Canadian Journal of Nursing Research*. 38(4): 96–117.

Examples

Saint Agnes Hospital: a strong stance against violence

At Saint Agnes Hospital—an urban acute care facility in Baltimore, Maryland—administrators have put many policies and procedures in place to encourage associates to raise concerns and report violent incidents, and they have also taken steps to clearly show associates, patients, and visitors that violence is unacceptable and will have consequences. For example:

- Saint Agnes uses a secure, accessible electronic incident reporting program and requires a follow-up discussion to reflect on why an incident occurred and how it could have been prevented—all taking place in a blame-free environment.
- Managers encourage victims of violence to use the Employee Assistance Program (EAP), even if the victim says that he or she does not need to do so. Referring an associate to the EAP might be particularly important in the case of a serious incident such as a sexual assault. Managers also encourage victims to request an alternative provider if they feel the hospital's EAP does not have the expertise or approach needed to address the incident.
- With top administrators' support, Saint Agnes has notified some of its most violent repeat offenders that they are no longer welcome at the facility, and the hospital will not readmit them. This does not include the ED, though, as the hospital is required by law to see a patient who requires emergency care.
- If an associate wishes to press charges against a patient who assaulted them, the hospital helps them navigate the legal process and provides financial support.
- Managers and front-line staff speak openly about their concerns during Emergency Department Performance Improvement Committee (EPIC) meetings, monthly leadership meetings, daily opening and closing "flash meetings," and unit-level huddles.



At Saint Agnes Hospital, everyone signs a nonviolence pledge: administrators, front-line associates, and affiliates (e.g., contractors). Signs and posters throughout the facility emphasize the hospital's mission and the roles that staff, visitors, and patients can all play in creating a healing environment.

St. John Medical Center: commitment from the top, input from the front line, and a stand against bullying

In 2013, administrators at St. John Medical Center—a large urban hospital with affiliated facilities in Tulsa, Oklahoma—met with all three nurse shifts to discuss action plans for dealing with a behavioral health patient who needed round-the-clock observation. Managers met with caregivers and listened to their concerns; based on these meetings, the hospital convened a workplace violence prevention group.

Now, nursing leadership, physician leadership, and other administrators all support workplace violence prevention. The CEO of each facility or another designated administrator leads an interdisciplinary safety meeting every morning to review activity from the past 24 hours and discuss potential concerns during the next 24 hours. The CEOs also periodically accompany physicians and others on daily rounds, and a Threat Assessment Committee brings physicians, nursing, behavioral health, security, occupational safety and health, and human resources staff together to address workplace violence issues twice a month, or more often if needed.

St. John's leaders have recognized that a nonviolent workplace also requires action against bullying. Because bullying sometimes stems from clinical hierarchies—for example, a physician behaving dismissively toward a nurse—it is particularly

important to engage physicians when designing and implementing anti-bullying policies. At St. John, this engagement starts at the top, where the head of the medical staff has stated unequivocally that bullying will not be tolerated. St. John's electronic incident reporting system allows staff to report bullying and to route this report around their supervisor if he or she is the perpetrator. Nurses have become confident enough to report occasional bullying events by physicians, thanks to a "no fear" environment.

Providence Behavioral Health Hospital and the Massachusetts Nurses Association (MNA): lasting collaboration

Providence Behavioral Health Hospital's joint labor/management workplace violence task force has been collaborating on this issue since 2004. The hospital has developed a written "culture of safety" policy that emphasizes everyone's responsibility to look for safety concerns and bring them forward, a "stop the process" policy that allows any employee to speak up if they feel uncomfortable with a situation, and a joint labor/management safety manual that describes hospital policies, employees' rights, incident reporting tools, and other resources.

Administrators, managers, and front-line workers meet together in several forums:

- The workplace violence task force meets quarterly to maintain the safety manual, review incident reports, and develop new solutions as needed. All departments are represented on the task force, along with human resources and union representatives.
- Managers and front-line staff speak openly at monthly leadership meetings to discuss concerns, acknowledge mistakes, and develop solutions.
- Daily "flash meetings" at the start and end of each day allow staff and managers to discuss concerns and strategies for specific patients.
- Administrators show their commitment to safety by participating in these meetings, taking an official stance on violence prevention in their labor contracts (see Section 3, "Getting Started," for contract language), making frequent rounds, and providing funds for training. Staff have strong champions for safety in both their MNA chief representative—an RN with 29 years of experience, including as an inpatient psychiatric nurse—and the senior vice president who oversees the entire facility. The senior vice president worked as a nurse in community mental health for 30 years and understands the challenges firsthand.

Resources

Author	Title	Description	URL
OSHA	Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers	Voluntary guidelines for reducing workplace violence in the healthcare and social service sectors. The guidelines emphasize the importance of management support and employee engagement.	https://www.osha.gov/Publications/osha3148.pdf
Emergency Nurses Association	Workplace Violence Toolkit	Toolkit with templates and examples designed specifically for the ED.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/toolkitpg1.htm
American Nurses Association	Model "State" Bill: "The Violence Prevention in Health Care Facilities Act"	Example bill that requires healthcare entities to establish programs to protect workers from violence.	http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-WorkplaceViolence/ModelWorkplaceViolenceBill.pdf
ASIS International Healthcare Security Council	Managing Disruptive Behavior and Workplace Violence in Healthcare	White paper that provides supporting documentation on workplace violence for healthcare security professionals.	http://www.g4s.us/~/media/Files/USA/PDF-Articles/Hospitals%20and%20Healthcare/Council_Healthcare_WorkplaceViolence.ashx
American Nurses Association	Incivility, Bullying, and Workplace Violence	Position statement containing detailed recommendations and suggested resources for registered nurses and employers.	http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/Incivility-Bullying-and-Workplace-Violence.html

5. Worksite Analysis and Hazard Identification

Ongoing worksite analysis and hazard identification is critical to the success of a comprehensive workplace violence prevention program. Many facilities have found it useful to engage senior management, supervisors, and both clinical and non-clinical employees to assess risks together. A comprehensive assessment can include a records review, a review of the procedures and operations for different jobs, employee surveys, and a workplace security analysis.

Risk Factors for Workplace Violence in Healthcare

A risk assessment will often reveal many factors that could contribute to violence in the workplace. Some of these risk factors relate to patients, clients, and settings, including:

- Working directly with people who have a history of violence, people who abuse drugs or alcohol, gang members, or distressed relatives or friends of patients or clients.
- Lifting, moving, and transporting patients and clients.
- Working alone in a facility or in patients' homes.
- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident.
- Poorly lit corridors, rooms, parking lots, and other areas.
- Lack of a means of emergency communication.
- Prevalence of firearms, knives, and other weapons among patients and their families and friends.
- Working in neighborhoods with high crime rates.

Other risk factors are more organizational in nature, including:

- Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff.
- Working when understaffed in general—and especially during mealtimes, visiting hours, and night shifts.
- High worker turnover.
- Inadequate security and mental health personnel on site.
- Long waits for patients or clients and overcrowded, uncomfortable waiting rooms.
- Unrestricted movement of the public in clinics and hospitals.
- Perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges.
- An overemphasis on customer satisfaction over staff safety.

Reviewing Records, Procedures, and Employee Input

Facilities may find it useful to review the following types of records to identify trends and risk factors:

- Violence-related medical, safety, threat assessment, workers' compensation, and insurance records.
- Logs of work-related injuries and illnesses, as required by OSHA (OSHA Forms 300 and 301).
- First reports of injury, incident/near-miss logs, and other incident reports, including police reports, general event logs, or daily logs.

In addition to reviewing records, the workplace violence prevention committee can review procedures and operations for different jobs and conduct employee surveys to identify violence hazards. Employee questionnaires and detailed baseline screening surveys are useful tools for pinpointing tasks that put workers at risk of violence. Periodic anonymous employee surveys, conducted at least annually or whenever operations change or incidents occur, can help to monitor the effectiveness of previously implemented hazard control measures and identify new or previously unnoticed risk factors and deficiencies in the environment, training, or work practices.

Patient Input

Patients and their families can also provide valuable input to help the workplace violence prevention team identify risk factors, understand patients' perspectives, and design effective solutions. Facilities have sought patient input in many different ways, such as:

- Patient surveys or other formal surveys.
- Informal surveys or focus groups. For example, one behavioral health hospital asked patients for input about what type of security presence in their unit (uniformed, etc.) would make them feel most comfortable and safe.
- Interviewing or surveying patients both before and after an intervention. For example, one behavioral health hospital installed a metal detector at its methadone clinic, and learned from clients that this intervention made many of them feel safer.
- Enlisting patients to participate in research to identify triggers to violence, daily activities that may lead to violence, and effective responses. (See New Hampshire Hospital's story on page 13.)

Walkthrough Assessment

Regular walkthrough assessments (such as environment of care rounds) can play a vital role in identifying and assessing workplace hazards. Walkthroughs may be conducted by members of the workplace violence prevention committee, including staff from each area and each shift, as well as facility maintenance or management personnel. They should cover all facility areas. The walkthrough itself is not the end of the assessment and review process: a complete process also includes post-assessment feedback and follow-up.

Violence can occur anywhere, but psychiatric services, geriatric units, and high-volume urban EDs, admission areas, and waiting rooms often present the highest risks. The key to protecting employees and patients is inspecting all work areas, including exterior building areas and parking areas, as well as evaluating security measures.

Examples

Veterans Health Administration: a comprehensive employee survey

In 2000, the VHA formed a National Taskforce on Violence with representation from VHA organizational units, labor partners, and outside agencies. After reviewing violence within the VHA and identifying policy weaknesses and potential solutions, the Taskforce conducted a national survey that generated responses from more than 70,000 full- and part-time VHA employees at 142 facilities.[5] The survey asked employees about job satisfaction, perceptions of safety, and whether they have experienced various types of violence in the workplace. Responses were analyzed by department/unit and by job category. The survey revealed the highest-risk departments (geriatrics, mental health, rehabilitation, and acute/specialty care) and occupations (registered nurses, licensed practical nurses, nursing assistants, and police/security) for assaults by patients. It also found that facilities with higher penetration of alternative dispute resolution training tended to have lower rates of assaults. Other results included information about coworker violence, including prevalence, the most common triggers, and the groups of employees who appear to be at the highest risk.

St. Cloud Hospital: from systematic "failure modes" analysis to proactive solutions

At St. Cloud Hospital, a 489-bed acute care hospital in St. Cloud, Minnesota, a string of violent events in 2010 prompted the Medicine care center director to conduct a chart review and start a dialogue with a wide range of colleagues to learn more about the prevalence of violence and try to identify precipitating factors or warning signs. The director's initial findings led administrators to establish an interdisciplinary workplace violence prevention group. This group used a technique called failure modes and effects analysis (FMEA) to identify and prioritize vulnerabilities. FMEA was originally created by reliability engineers for military and aerospace applications, and it has since spread to many other industries that are concerned with safety or quality. The technique takes various forms, but it generally involves a stepwise process to anticipate potential problems, identify causes and effects, and prioritize recommendations for improvement. At St. Cloud, an interdisciplinary team composed of leaders and direct care providers looked at each unit in the facility, then identified what could possibly go wrong ("failure modes"), root causes, and effects. Next, they scored each failure mode based on its probability of occurrence and the severity of the effects, which allowed the team to develop and prioritize a set of recommendations for proactive controls. One example of a potential failure mode was communication among the staff from one care area to another or from shift to shift about patient's risk of violence. FMEA tools are available from a variety of organizations, including a few that have tailored the approach for healthcare facilities.

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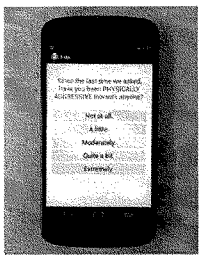
[5] For more information about the VHA's survey methods and results, see: Hodgson, M.J., Reed, R., Craig, T., Murphy, F., Lehmann, L., Belton, L., and Warren, N. 2004. Violence in healthcare facilities: Lessons from the Veterans Health Administration. *Journal of Occupational and Environmental Medicine*. 46(11): 1158–1165.

New Hampshire Hospital: exploring triggers for violence through research

New Hampshire Hospital, a state-run behavioral health facility, serves as a teaching hospital through its affiliation with the Geisel School of Medicine at Dartmouth College. This connection allows New Hampshire Hospital to serve as a living laboratory for ongoing research to identify precursors to violence and test new practices. Physicians engage patients as partners in their research, which is part of the hospital's drive for continual improvement. This connection to academic studies also helps to raise awareness of other new research and encourage staff members to adopt the best available evidence-based approaches.

One ongoing example is "Project Pause," which is examining whether a smartphone app can predict violence among a select group of acutely ill patients. During the research phase, patients carried smartphones (with cameras and games disabled) for seven days. Every two hours, the app would prompt them to answer questions about how they felt. The phones could detect ambient sounds (for example, if someone was screaming or talking to themselves) and track the location and movement of patients. Ultimately, the researchers aim to compare these self-assessment data with violent incidents and restraint and seclusion reports to determine whether the self-assessment tool has predictive value.



New Hampshire Hospital's "Project Pause" is a smartphone app for predicting violence. Patients answer self-assessment questions like the one shown here, and researchers compare the data with violent incident reports.

Resources

Author	Title	Description	URL
General information and risk assessment tools			
ECRI Institute	Violence in Health Care Facilities	Risk analysis report that discusses workplace violence and prevention strategies. The Western Health Risk Assessment Screening Tool is included under "Supplementary Materials."	https://www.ecri.org/components/HRC/Pages/SafSec3.aspx
Minnesota Department of Health	Preventing Violence in Healthcare: Gap Analysis	Worksheet designed to help healthcare facilities identify risks and implement best practices to prevent patient-on-worker violence.	http://www.health.state.mn.us/patientsafety/preventionofviolence/preventingviolencein healthcaregapanalysis.pdf
Emergency Nurses Association	Emergency Department Assessment Tool	Checklist to help assess threats in the ED.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/EDAssessmentToolSample.pdf
New York State Department of Labor	Workplace Violence Prevention Program Guidelines	Guide to assist public employers and employees in understanding key steps in establishing a workplace violence prevention program. Appendix 3 provides a workplace security checklist.	http://tinyurl.com/q6x5t3s
Institute for Healthcare Improvement	Failure Modes and Effects Analysis (FMEA) Tool	Downloadable and interactive online tools designed to help healthcare facilities apply the FMEA technique for worksite analysis and hazard identification.	http://www.ihi.org/resources/pages/tools/uremodesandeffectsanalysistool.aspx
Employee surveys			
Emergency Nurses Association	Workplace Violence Staff Assessment Survey	Survey to assess how staff view workplace violence and violence prevention. This resource is part of the Association's Workplace Violence Toolkit.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/Staff%20Assessment%20Survey_V1.doc

Author	Title	Description	URL
Washington State Department of Labor and Industries	Workplace Violence: Awareness and Prevention for Employers and Employees	Guidebook to help employers and employees recognize workplace violence, minimize and prevent it, and respond appropriately if it occurs. A sample employee survey on workplace violence hazard assessment is included in Appendix B.	http://www.lni.wa.gov/IPUB/417-140-000.pdf
New York State Department of Labor	Workplace Violence Prevention Program Guidelines	Guide to assist public employers and employees in understanding key steps in establishing a workplace violence prevention program. A sample employee questionnaire and focus group information are included in Appendix 4.	http://tinyurl.com/q6x5t3s
Civil Service Employees Association, Local 1000, AFSCME, AFL-CIO	Workplace Violence Prevention	1. General information on workplace violence 2. Workplace Violence Survey 3. Workplace Violence Focus Group Activity	1. https://cseany.org/osh/violence 2. https://cseany.org/wp-content/uploads/2013/02/Survey.pdf 3. https://cseany.org/wp-content/uploads/2013/02/Focus-Group-Activity.pdf
Walkthrough assessment			
OSHA	Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers	Voluntary guidelines for reducing workplace violence in the healthcare and social service sectors. The publication includes a set of inspection checklists.	www.osha.gov/Publications/osha3148.pdf
Civil Service Employees Association, Local 1000, AFSCME, AFL-CIO	Workplace Violence Inspection Checklist	Checklist for inspecting workplaces for risk factors.	https://cseany.org/wp-content/uploads/2013/02/Inspection-Form.pdf

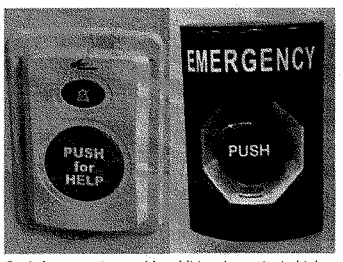
6. Hazard Prevention and Control

Once the records review and a walkthrough assessment are complete, the workplace violence committee can work toward addressing the hazards identified. To do so, healthcare facilities can choose from a variety of methods, procedures, and technologies intended to prevent violent incidents or to respond to them in the most effective manner when they do occur. Prevention and control allows employers to minimize or eliminate risks and liabilities as well as to meet their legal obligation to provide employees with a safe and healthy work environment.

In the field of workplace safety, the ideal choice is generally to eliminate a hazard altogether or to substitute a safer work practice. In healthcare, one example may be transferring patients to a more appropriate facility if they exhibit violent behavior that may not be appropriate in a less secure environment. Substitution is not always possible in a healthcare environment, though, but other options are available. These options fall into two major categories, **engineering controls** and **administrative and work practice controls**, which are best when used in combination to maximize prevention and control.

Engineering controls are physical changes to the workplace that either remove a hazard or create a barrier between workers and the hazard. These controls are often the next best option if elimination and substitution are not possible. Examples include:

- Changing floor plans to make exits more accessible and/or improve sightlines for staff.
- Improving lighting in remote areas or outdoor spaces for better visibility.
- Installing mirrors.
- Installing security technologies such as metal detectors, surveillance cameras, or panic buttons.
- Controlling access to certain areas (e.g., ICU, ED, birthing center, pediatric unit) with locked doors.
- Enclosing the nurses' station or installing deep counters.



Panic buttons can provide additional security in high-risk areas.

- Replacing furniture with heavier or fixed alternatives that cannot be easily used as weapons.

Administrative and work practice controls are changes to the way staff perform jobs or tasks, both to reduce the likelihood of violent incidents and to better protect staff, patients, and visitors should a violent incident occur. Administrative and work practice controls are appropriate when engineering controls are not feasible or not completely protective. Examples include:

- Procedures and tools for assessing and periodically reassessing patients with regard to their potential for violent behavior. Some facilities conduct threat assessments on a patient's admission and periodically afterwards. Research confirms the importance of formally assessing mitigating factors (including work, financial, psychological, social, and physical factors) as well as factors that increase risk (including anger and trauma, history of violence and arrests, alcohol use, and financial instability).[6,7] Such tools can improve the structuring and organizing of risk-relevant data and may enhance communication and decision-making.[8,9]

[6] Meloy, J.R., White, S.G., and Hart, S. 2013. Workplace assessment of targeted violence risk: The development and reliability of the WAVR-21. *Journal of Forensic Sciences*. 58(5): 1353–1358.

[7] Douglas, K.S., Ogloff, J.R., and Hart, S.D. 2003. Evaluation of a model of violence risk assessment among forensic psychiatric patients. *Psychiatric Services*. 54(10): 1372–1379.

[8] Meloy, J.R., White, S.G., and Hart, S. 2013. Workplace assessment of targeted violence risk: The development and reliability of the WAVR-21. *Journal of Forensic Sciences*. 58(5): 1353–1358.

[9] Meloy, J.R. 2006. Empirical basis and forensic application of affective and predatory violence. *Australian and New Zealand Journal of Psychiatry*. 40(6–7): 539–547.

- Procedures for tracking and communicating information regarding patient behavior.
- Special procedures for patients with a history of violent behavior.
- Adequate staffing on all units and shifts.
- Providing training in de-escalation techniques, workplace safety practices, and trauma-informed care. Trauma-informed care recognizes the lasting impacts of physical, psychological, and emotional trauma on a survivor, and it actively seeks to avoid re-traumatization. For example, caregivers should minimize coercive interventions and avoid introducing stimuli or cues that might remind the victim of a previous traumatic experience.
- Emergency procedures so all staff know what to do if an incident occurs.
- Policies and procedures that minimize stress for patients and visitors.

Engineering and administrative controls for various healthcare settings are discussed in more detail in OSHA's *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.*

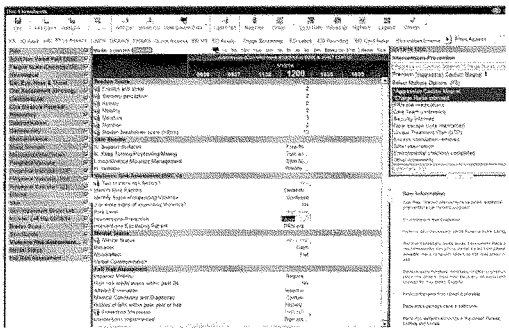
Engineering controls and administrative controls often work in concert to address risk in the healthcare setting. Both kinds of controls should be selected with careful regard to the nature of the hazard identified and the nature of the healthcare setting. For example, controls suitable for an urban ED might not be appropriate for a community care clinic. Instituting any combination of control and prevention methods requires a careful balance between providing a safe healthcare setting and maintaining a calming, welcoming, and workable environment for staff, patients, and visitors.

Implementing controls does not conclude the process of addressing workplace violence. Once controls are in place, periodic review and evaluation can ensure that they are adequately addressing hazards identified during the site assessment process, highlight areas of weakness, and help to identify new or emerging risks that might require modification of existing controls or adoption of additional measures. In addition, if an incident occurs, employers can help their workers by providing timely medical and/or mental healthcare services (as appropriate) and conducting a post-incident debriefing where all involved or affected staff meet to conduct a blame-free root cause analysis that considers what happened, what should have happened, why the difference, and how to prevent a similar problem in the future. Access to an employee assistance program can help a worker cope with the ongoing trauma and stress that often accompany an assault or injury.

Examples

St. Cloud Hospital: assessing every patient's risk of violent behavior

When St. Cloud Hospital's workplace violence committee convened in 2010 to review their incidents and risk factors, they recognized that their staff could benefit from a tool to assess individual patients and identify those who might require special precautions to prevent violent behavior.



St. Cloud Hospital's electronic medical records include a violence risk assessment conducted by a nurse every 12 hours, along with special precautions on the right side of the screen for patients deemed to be "high risk."

The team reviewed existing tools and found one that was specific to behavioral health. They modified this tool to include identifying if the patient has any risk factors for violence; if risk factors are present, additional questions are asked. The tool is efficient to complete. It is now integrated within the hospital's regular nursing assessment for all adult patients, which is completed electronically and tied into patients' electronic medical records. Each patient is assessed for potential violence risk when admitted to the hospital and again every 12 hours thereafter. A nurse records risk factors and signs of impending violence, such as irritability or confusion. A risk level is then assigned to each patient depending on how many risk factors and signs of impending violence he or she exhibits. If a patient is marked as "high risk," a list of potential interventions will appear in his or her electronic medical record, based on the individualized treatment plan that the staff develops. For example, the record might advise removing extra furniture from the patient's room. Some high-risk patients also have magnets on their doorframes to alert staff to take precautions. St. Cloud's patient assessment tool has been recognized as a model by the Minnesota Department of Health.

Veterans Health Administration: assessing patients and flagging records

The cornerstones of the VHA's violence prevention program are Disruptive Behavior Committees (DBCs) and the patient assessment process. A multidisciplinary DBC at each facility reviews incident reports referred by staff who are concerned that a patient may pose a safety risk to himself, other patients, and staff. As per VHA policy, the DBC, which is chaired by a senior mental health clinician, determines whether a specific consistent approach, which may include a security escort, is warranted for each patient visit. If a patient is determined to present "an immediate safety risk for seriously disruptive, threatening, or violent behavior," a Patient Record Flag (PRF) may be put on the patient's electronic health record to alert staff to the safest and most therapeutic approach for handling their visit. VHA facilities nationwide use a standardized definition and criteria for "disruptive behavior" to ensure a consistent assignment of PRFs and avoid overusing this designation.[10] DBCs are encouraged to convene at least monthly, and PRFs are activated in patients' electronic medical records the day after the DBC assigns them. PRFs are shared across all facilities that might treat a given patient.

[10] See VHA Directive 2010-053 (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2341) for specific criteria and other requirements related to PRFs.

The VHA's threat assessment process combines clinical and actuarial approaches that are informed by the empirical literature. The VHA incorporated veteran-specific risk factors, both static (e.g., gender, prior assault status) and dynamic (e.g., recent alcohol abuse, homelessness, and employment status); risk mitigation factors; and setting risk factors (e.g., staffing issues) into its violence risk assessment instrument. The VHA's approach also requires professional judgment. Studies have found that this type of structured professional judgment instrument is significantly predictive of violence and performs as well as or better than other types of violence risk assessment.

The VHA continues to review and improve its threat assessment process. For example, VHA researchers recently worked on a quick screening tool that will help clinicians identify candidates in need of a more comprehensive assessment.[11] They evaluated a rapid five-item screening tool, called the Violence Screening and Assessment of Need (VIO-SCAN), to determine its predictive validity. This evidence-based screen covers a combination of factors such as probable post-traumatic stress disorder, alcohol misuse, financial instability, combat experience, arrests, and history of violence.

> **Example:** One large regional VHA system set up a DBC that includes key managers as well as representatives from five labor unions, police/security, and people with a full spectrum of clinical and service expertise. They took the lead and created a "Behavioral Rapid Response Team" (BRRT) to identify and address escalating behaviors through the intervention of a rapid response Mental Health Consult Team. The DBC also instituted a police check-in form for those outpatients who carry this order of behavioral restriction. The organization also addressed environmental design by using the Workplace Behavior Risk Assessment process to identify areas where physical safety aids such as panic alarms, locked doors, and furniture configuration should be considered. It created an "environmental risk assessment" in which an interdisciplinary team assesses a work site and recommends ways to mitigate risk. It also created a "Green Flag" alert system in which ancillary staff check with the inpatient's primary nurse to learn how to work safely with a patient who has a behavioral flag. Finally, the organization's Behavioral Emergency Review Committee evaluates all "code green" (mental health) emergencies and BRRT calls, as well as assault data.

Sheppard-Pratt Health System: "doing your homework" and lending a watchful eye

Milieu Safety Officers create a safe environment for staff and patients at Sheppard-Pratt.

At Sheppard-Pratt, a large behavioral health system headquartered in Towson, Maryland, many patients arrive upon referral from an ED. For these patients, violence prevention starts before they even arrive. Admissions staff can look up a patient's criminal record, and they take a detailed report from the ED, with nurses at Sheppard-Pratt talking with nurses at the ED, and physicians talking with physicians. These lateral conversations promote an open exchange of information. If the criminal record or ED report indicates a history of violence or aggressive behavior, Sheppard-Pratt can be prepared with extra clinical and security staff, and they can be ready to promptly administer emergency medications if needed to protect the patient or staff.

Sheppard-Pratt has also taken a unique approach with what it calls "Milieu Safety Officers"—specially trained, uniformed security staff who work in the milieu (common areas) in high-risk units. Milieu Safety Officers have no other assigned duties, so they can focus solely on the activity and mood in the unit, chatting with patients and keeping an unobtrusive eye on the area.

Milieu Safety Officers are specially recruited and trained for the job. Some have experience working in the Department of Corrections, so they can help other staff learn how to recognize and deal with criminal culture. They are also chosen for their interpersonal and verbal de-escalation skills, and they receive training in both security and mental health. They meet with new patients to get to know them and set expectations; they also participate as members of the treatment team and receive daily clinical patient information.

[11] Elbogen, E.B., Cueva, M., Wagner, H.R., Sreenivasan, S., Brancu, M., Beckham, J.C., and Van Male, L. 2014. Screening for violence risk in military veterans: Predictive validity of a brief clinical tool. *American Journal of Psychiatry*. 171(7): 749–757.

Sheppard-Pratt's Milieu Safety Officers have succeeded on many fronts. Units with Milieu Safety Officers have seen a decrease in violent injuries to workers, and staff report feeling safer where Milieu Safety Officers are present. Patients have also expressed that they feel safer with a uniformed officer present, and they often approach the officer to discuss their concerns or to get help—a testament to the rapport these people are able to build.

"Staying Safe" at New Hampshire Hospital

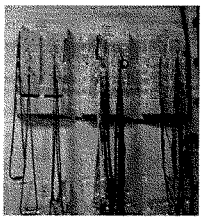
Like other leading behavioral health facilities, New Hampshire Hospital emphasizes the use of comfort rooms that include comfortable furniture, soothing colors, soft lighting, quiet music, and other sensory aids to help reduce patients' stress levels. Patients are free to access these rooms as they wish.

A member of New Hampshire Hospital's staff shows one of the facility's sensory rooms—a de-escalation strategy that has helped the hospital reduce patient-on-staff injuries.

Staff participate in the "Staying Safe" program, which trains staff to listen to patients, try to answer questions, and provide help to calm people and de-escalate situations before they turn violent. Before physical intervention with a patient, "Staying Safe" training demands that at least five staff be present and requires them to have a plan to manage the situation as safely as possible. Before the hospital implemented the five-person requirement, intervening alone was a major cause of injuries to staff.

Security is also an important part of New Hampshire Hospital's hazard control efforts. Campus police officers are commissioned by the state police force and are specially screened and trained for working in a mental health setting. Officers have been trained to respond to "code gray" (psychiatric) emergencies and assume a supportive role to staff. This type of response allows the officers to be present and immediately available if their services are needed. Campus police officers use defensive measures only when clinical staff have been unable to control the situation safely, there is extreme and imminent danger, and the nurse in charge specifically requests police assistance. This approach prevents the unnecessary use of force, which could escalate a situation and trigger a traumatic experience.

St. Vincent's Medical Center: technological solutions and a behavioral response team



Associates at St. Vincent's Medical Center wear badges with alarms that will alert the security office if they feel threatened.

While hospital administrators can implement engineering and administrative controls to mitigate hazards present within a healthcare facility, protecting workers who work outside the hospital, such as in patients' homes, presents a different set of challenges. These challenges include being able to ascertain whether a worker is in a violent or potentially violent situation, and being able to quickly locate and respond to the incident. In 2015, St. Vincent's Medical Center in Bridgeport, Connecticut, evaluated the implementation of a GPS duress alarm system that case workers can wear while making home visits. The hospital plans to implement these GPS units in the year ahead.

GPS alarms are just the latest in a line of technologies that St. Vincent's Medical Center has adopted to keep its associates safe. The threat of violence is elevated at St. Vincent's hospital because this large urban hospital frequently treats "forensic" patients from nearby correctional institutions. Some of these patients are known to have histories of violent behavior, but all such patients must be considered a risk because they may view the hospital as an escape opportunity. St. Vincent's director of safety and security has implemented a multi-pronged strategy to minimize risk to

employees, patients, visitors, and the community, including:

- Protocols for information exchange before patient arrival.
- A locked vestibule system where incoming forensic patients disrobe and change into hospital attire while being observed by trained staff through a one-way mirror.
- Electronic staff identification badges with a card that can be removed to trigger an alert to the security office. These badges carry GPS locators so that security staff can respond to the exact location of the alarm without delay.

St. Vincent's Medical Center also formed a Behavioral Response Team to help reduce risks. This multidisciplinary team comprises a forensic psychologist, ethics staff, human resources, security, and others. They meet ad hoc to review specific patient, associate, and family risk cases, and they also meet monthly to recap workplace violence issues and identify new solutions. For example, St. Vincent's hospital removed last names from many staff identification badges in the behavioral health unit after a stalking incident. Within the broader community, St. Vincent's Medical Center participates in an initiative called Street Safe Bridgeport, which aims to reduce gang violence.

Saint Agnes Hospital: a wide array of engineering and administrative controls

Saint Agnes employs a variety of engineering controls to prevent violent incidents at its urban campus in Baltimore, Maryland, including security cameras and panic buttons. The hospital has also incorporated subtle environmental details such as soothing wall colors, designated quiet areas, and noise reduction pads on doors to help keep patients and visitors more calm.

The hospital uses several administrative controls, too. Hospital-wide safety policies allow all patients to be searched for weapons and contraband upon admission or return from a pass. Patients at risk of violence or development are indicated with flags in their medical records, gray door signs, and gray gowns that are secured with three arm holes instead of strings, to reduce suicide risk. The hospital also uses color-coded lights installed above patient room doors throughout its "co-attending" unit for patients being treated for a medical diagnosis who also have behavioral challenges. The different colors of lights indicate who from the staff (e.g., a nurse, sitter, or maintenance worker) is with the patient in the room.

Saint Agnes worked for several years to get off-duty police officers from the local community to serve in the ED. The hospital specifically wanted officers from Baltimore's Southwest district, as they know the community, they are familiar with some of the hospital's more challenging patients, and they have positive relationships with staff. The CEO successfully pushed to get these officers in the ED because their presence can help to deter bad behavior.

Patients at risk of violent behavior wear gray gowns so Saint Agnes's associates can quickly identify them and make sure to take extra precautions. The gowns are also designed with no strings, to reduce suicide risk.

Providence Behavioral Health Hospital: de-escalation and openness to new methods

Providence's de-escalation strategies start with the nursing assessment and getting to know each patient—what stimuli might trigger a violent episode and what approaches can help to calm them—then communicating this information to staff (for example, on patient care boards) and using it as a basis for personalized therapeutic interventions.

Providence has successfully employed alternatives to restraints, an effort spurred in part by a Massachusetts state mandate to reduce the use of restraints. The most common form of restraint used is the "geriatric chair": a chair with a built-in tray that is placed in front of the patient to prevent a patient with dementia from wandering. Beyond the requirements of the state mandate, the hospital has implemented a no-restraint policy in its child and adolescent units.

As it works to continually reduce violence and improve patient care, Providence benefits from its medical and nursing staff's willingness to embrace new methods, more holistic approaches, biofeedback methods such as heart-brain coherence, and sensory strategies. Staff create individualized crisis prevention plans for patients and employ a variety of therapy options, including a sensory room with a cabinet full of activities that can occupy and calm patients, a weighted blanket (a known calming intervention), ball massage, a swing, talk therapy, and music therapy. These approaches have an added benefit because they can help patients learn coping strategies that will help them in their own lives after they leave the hospital.

Providence Hospital's sensory rooms provide a soothing environment for patients. The cabinet contains a variety of activities that can help to reduce a patient's stress and aggression.

Engineering controls also help Providence prevent violence. In addition to installing many security cameras, the hospital has installed a swipe card system on key entryways, the main staircase, and elevators. As a result of the MNA-negotiated labor/management violence task force, the hospital added metal detectors at two methadone clinics that it runs, where drug dependency and the anxiety of waiting in line had historically led to violent incidents. In a survey, patients reported that the metal detectors make them feel safer.

To provide a calmer environment for its patients, the hospital has reduced noise by limiting overhead pages and trying to reduce the instability and stress that can surround a shift change. For example, the children's unit runs a group activity at shift change time, led by someone who is not changing shift.

Holy Cross Hospital: a layered code system to drive appropriate response

Holy Cross Hospital—an urban acute care hospital in Fort Lauderdale, Florida—recognized that a single code (such as "code gray") does not capture the wide range of situations that could involve a potentially violent person. A uniform code could lead to responses that are excessive in some situations but insufficient in others. Thus, the safety team developed a more precise set of "subcodes" to indicate the degree of assistance needed. They use three levels:

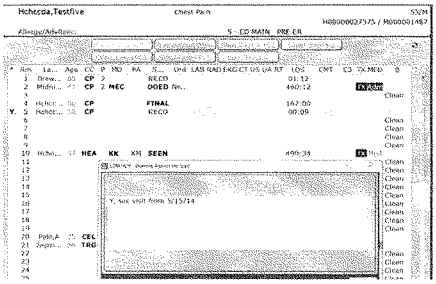
- Code Assist: calls for one security officer.
- Code Strong: calls for more support staff, including first responders, the nurse supervisor, and engineering staff. Engineering staff have been a helpful addition because they are available around the clock and can typically stop what they are doing and respond immediately. All of these responders take 8-hour training on crisis intervention and de-escalation.
- Code Strong with Intensivist: calls for the same response as a Code Strong, but also summons an intensive care physician who can immediately order medication or physical restraints if needed. Intensive care physicians are on site all day and night, and their participation in code response has eliminated what was previously a 20- to 60-minute wait that could leave caregivers vulnerable to an actively violent patient who needs more than just de-escalation.

"Here at Holy Cross, we have a strong commitment to the safety of our patients and our associates. We want the staff to always feel their calls for assistance for their personal safety will be heard and acted on. The healthcare world is ever changing: providing a safe workplace is a leading initiative for us."

—Taren Ruggiero, Vice President and Chief Nursing Officer, Holy Cross Hospital

This nuanced code system works in conjunction with several other controls. For example, Holy Cross has a cross-organizational Violence Prevention Advisory committee that reviews every Code Strong event and can choose to flag the electronic chart of a patient who repeatedly demonstrates violent behavior. The hospital's electronic medical record software is connected to a

marker on the ED tracking board that is visible if one of the flagged patients checks in, thus alerting staff to the presence of those patients. Holy Cross has also configured its software to scan the daily census; if any of these particular patients are on site, the system generates an email alert to key staff. Holy Cross has also developed a protocol to protect patients who may be domestic violence victims—for instance, by not giving out information about them over the phone. Executives, security staff, and others often tell people that violence is not tolerated. The message: "We love our patients, but patients have responsibilities too."



Green highlighting and a "Yes" indicator in the left column on Holy Cross's electronic patient tracking board indicate when a patient in the ED has a history of violence against staff.

Altogether, Holy Cross's program has generated positive results. The hospital has experienced an increase in the number of Code Strong calls, likely due to staff becoming familiar with the system and recognizing that it generates a response. A recent "Culture of Safety" survey found that staff have a substantially stronger perception of safety than they did a few years ago. Holy Cross's parent organization, Trinity Health, is using Holy Cross's program as a model for other facilities nationwide.

St. John Medical Center: access control and color-coding

Like other leaders in workplace violence prevention, St. John Medical Center has employed a variety of engineering controls and administrative controls throughout its facilities. Engineering controls include installing access controls on the ICU, ED, and pediatric areas, and employing panic buttons in most of the hospital's nursing units and all ICUs. In addition to the fixed-place alarms, nurse calls can now be sent from mobile devices, which set off alarms at the nurses' station. The ED's reception area is enclosed and locked, and the department is provided with impact-resistant glass.

Frequent patient assessments help staff assess risks. Staff assess patients on admission and every two hours thereafter using a risk assessment tool the hospital adapted from an Australian model found in a workbook called "Prevention and Management of Aggression in Health Services" (see "Resources" on page 24). For patients deemed to pose a risk of violence, St. John developed a "code orange" system in which orange magnets are placed on doorframes as a warning. Upon seeing an orange magnet, nurses look up a patient's history and enter the room with a team or a security officer, depending on the patient's care plan. Support staff consult the nurse's station to learn the appropriate protocol.

Resources

Author	Title	Description	URL
Patient assessment			
Emergency Nurses Association	High Risk Screening	Sample project plan to help healthcare facilities put a process in place to screen high-risk patients. This resource is part of the Association's Workplace Violence Toolkit.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/ENAactionplan9.doc
Veterans Health Administration	Directive 2010-053	Patient assessment checklist, criteria, and other requirements related to identifying and caring for patients at risk of violent or disruptive behavior.	http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2341
WorkSafe Victoria	A Handbook for Workplaces: Prevention and Management of Aggression in Health Services	Handbook with a behavior assessment form (page 76) that St. John Medical Center adapted to create its patient risk assessment.	https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0012/10209/Aggression_in_health_care.pdf
Other control and prevention strategies			
OSHA	Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers	Voluntary guidelines for reducing workplace violence in the healthcare and social service sectors, including lists of possible controls.	www.osha.gov/Publications/osha3148.pdf
Facilities Guidelines Institute	2014 Guidelines for Design and Construction of Hospitals and Outpatient Facilities	Design and construction guidelines that may help reduce the risk of workplace violence by promoting safer lighting, building layout, furniture, and more.	http://www.fgiguidelines.org/guidelines2014_HOP.php
The Joint Commission	Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation	Monograph discussing the connections between patient safety and worker safety. Section 3.4 provides information and case studies about violence prevention.	http://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf
CDC and NIOSH	Violence: Occupational Hazards in Hospitals	Brochure designed to increase awareness of risk factors and prevention strategies for violence in hospitals.	http://www.cdc.gov/niosh/docs/2002-101

7. Safety and Health Training

Training is a key component of a successful workplace violence prevention program. It helps healthcare workers learn to recognize potential hazards and learn how to protect themselves, their coworkers, and their patients. Training and reinforcement though role-playing and other means can provide employees with strategies that increase their confidence for handling potentially violent incidents before they arise and reduce the likelihood of violent incidents occurring. Education also reinforces that violence is not an acceptable part of healthcare work.

> "Practicing strategies *before* issues occur helps ensure the safety of all involved and the best outcome for the patient(s)."
>
> —Papa and Venella, 2013[12]

Objectives and Topics

Training programs are most effective when they are designed specifically for a facility or unit's particular risk profile—for example, training ED nurses within the ED and focusing on the most common threats they face at their facility. Organizations can study, adapt, and combine elements of model programs that are relevant to their facilities' conditions and needs.

Common training objectives include increased confidence among workers in de-escalating aggressive behavior and in managing aggressive behavior when it occurs. Specific topics might include:

- A review of the facility's workplace violence prevention policies and procedures.
- Policies and procedures for obtaining a patient's risk profile before admission, when feasible.
- Risk factors that cause or contribute to assaults.
- Policies and procedures for assessing and documenting patients' or clients' change in behavior.
- Location, operation, and coverage of safety devices such as alarm systems, along with the required maintenance schedules and procedures.
- Recognition of escalating behavior, warning signs, or situations that may lead to assaults.
- De-escalation techniques to prevent or defuse volatile situations or aggressive behavior.
- Approaches to deal with aggressive behavior in people other than patients and clients, such as relatives, visitors, or intruders.
- Proper use of safe rooms or areas where staff can find shelter from a violent incident.
- A standard response action plan for violent situations, typically referred to as "codes," including the availability of assistance, response to alarm systems, and communication procedures.
- More generally, what to do in case of a workplace violence incident—i.e., responsibilities of others who are not directly responding to the event.
- Self-defense procedures where appropriate.
- Progressive behavior control methods, including when and how to use medications or physical restraints properly and safely when necessary.
- Ways to protect oneself and coworkers, including working in teams when necessary.
- Importance of getting early assistance.
- Policies and procedures for reporting and recordkeeping.
- Policies and procedures for obtaining medical care, counseling, workers' compensation, or legal assistance after a violent episode or injury.

General recommendations for training content include:

- Add information about facility-specific policies, procedures, and potential risk factors when using existing packaged training programs.
- Ensure that training and policies cover all types of workplace violence, not just violence by patients against employees. Many training programs, policies, and procedures focus exclusively on the latter. These programs fail to address employee-on-employee or employee-on-patient violence, robbery and theft (such as theft of drugs, or of hospital or employee property), and domestic violence.
- Provide frequent opportunities to practice skills and demonstrate competency.

[12] Papa, A., and Venella, J. 2013. Workplace violence in healthcare: Strategies for advocacy. *The Online Journal of Issues in Nursing*. 18(1): Manuscript 5.

Who Gets Trained

All workers who are reasonably expected to interact with patients, including admissions staff, can benefit from workplace violence prevention training. So can supervisors and managers. Other support staff can benefit from awareness about their responsibilities in the event of a workplace violence incident. Affiliated physicians, temporary staff, and contract workers should receive the same training as permanent staff, and new and reassigned workers should receive an initial orientation that includes training in the prevention of workplace violence.

Because duties, work locations, and patient interactions vary by job, violence prevention training can be more effective if it is customized to address the needs of different groups of healthcare personnel, particularly:

- Nurses and other direct caregivers
- ED staff
- Support staff (e.g., dietary, housekeeping, maintenance)
- Security personnel
- Supervisors and managers

Nurses and other direct caregivers

Nurses, nursing assistants, mental health workers, and other direct caregivers spend much of their time interacting directly with patients, and they are often the first to encounter difficult situations. They can benefit from training in:

- The facility's workplace violence prevention plan
- Warning signal recognition
- Threat assessment
- Working with patients with violent behavior
- Violence escalation cycle and violence-predicting factors
- Verbal and physical de-escalation techniques
- Self-defense, with a hands-on component

Direct caregivers can also benefit from specialized violence prevention training tailored to the specific patient populations they work with—for example, behavioral health patients, the developmentally disabled, and geriatric patients with Alzheimer's and other forms of dementia.

Emergency department staff

ED nurses experience physical assaults at one of the highest rates of all nurses. Nurses in the ED may find themselves exposed to patients who have a history of violence, aggressive behavior associated with certain psychotic disorders, substance abuse, dementia, and other conditions. The ED is a fast-paced, unpredictable environment; when patients arrive, the staff must treat them—sometimes without knowing much about their history or what drug(s) might be influencing their behavior. Many EDs, particularly those in large urban settings, treat patients who are themselves the victims of traumatic violence, and the background level of violence in the community can spill over into the ED. Moreover, the experience of traumatic injury or mental illness, pain, and the anxiety of an emergency room visit can trigger aggressive reactions. In addition to general training common to all direct caregivers, ED nurses should be trained in safety procedures related to restricting access or movement in the physical environment, such as locking access doors to prevent secondary violence from retribution in cases of gang violence or domestic violence.

Support staff

Housekeeping, food service, maintenance, and other support staff can benefit from workplace violence prevention training, especially if their duties take them to patient areas or if they otherwise have contact with patients. All staff should be aware of systems that rely on environmental symbols, such as color codes to convey safety information about individual patients, as well as what code situations announced over the public address system (e.g., "code gray") mean and how they should respond. Other safety precautions include staying a safe distance from the patients, not leaving maintenance tools unattended, and not allowing patients to reach for gowns and bags with strings while delivering laundry.

Security personnel

Security personnel need to know the layout of the facility, including entrance and exit points and how to restrict or control access. They need specific training on the unique needs of providing security in the healthcare environment, including the psychological components of handling aggressive and abusive behavior, and ways to handle aggression and defuse

> "Security training must balance the need to provide patient-focused care with the need to protect one's personal safety."
>
> —The Joint Commission, 2009[13]

[13] The Joint Commission. 2009. Preventing violence in the emergency department—ensuring staff safety. *Environment of Care News*. 12(10): 1–3,11.

hostile situations. They also need training in policies and procedures detailing how and when security personnel interact with patients during code situations.

Supervisors and managers

Supervisors and managers must be trained to recognize high-risk situations, reduce safety hazards, encourage employees to report incidents, and ensure that employees seek appropriate care after experiencing a violent incident. Additional training should involve the process for post-event management of employees who were directly involved in a workplace violence event.

Format and Frequency

Safety training can take several forms:

- **Classroom plus hands-on instruction.** Workplace violence prevention training has traditionally taken the form of classroom instruction (e.g., seminars) combined with active "learning by doing" in the form of role-plays, simulations, and drills. Interactive exercises make training more effective by allowing participants to practice and apply the skills they have learned, such as de-escalation and self-defense techniques.
- **Just-in-time training.** Some facilities have designated one or more trainers or "safety coaches" for each unit or floor. These individuals can offer guidance and coaching in real-time—for example, if they see a colleague struggling to de-escalate an agitated patient. They can also run ad hoc or scheduled refresher sessions, which may be particularly useful and relevant to workers because the training takes place in their own work environment.
- **Web-based training.** This increasingly popular approach offers fidelity of presentation and automated documentation while requiring minimal supervision and allowing flexible timing and pace. However, it does not provide hands-on practice with physical skills, which are widely considered to be an essential element of many programs. Thus, Web-based training may be more effective when paired with live instruction and practice—a "blended" approach. The National Institute for Occupational Safety and Health (NIOSH) has developed a Web-based training program (www.cdc.gov/niosh/topics/violence/training_nurses.html) to help healthcare workers learn about the key elements of a comprehensive workplace violence prevention program, how organizational systems impact workplace violence, how to apply individual strategies, and how to develop skills for preventing and responding to workplace violence.

Regardless of format, healthcare organizations often find it helpful to have a team of trained workplace violence prevention trainers in-house. These trainers can attend a more in-depth course offered by an outside training provider, then become certified to train others.

Many healthcare organizations have improved results by providing annual refresher training for their direct caregivers. In high-risk settings and institutions, refresher training may be needed more often, perhaps monthly or quarterly, to effectively reach and inform all workers. For example, in a review that evaluated the effect of nonviolent crisis intervention (NCI) training on the number of code purple (security) incidents in an acute-care tertiary ED, the authors expected code purples to decrease as progressively larger numbers of staff were NCI trained. However, this did not occur. Rather, reduction of code purples was correlated with the number of staff who had been recently trained (in the past 90 days), implying a temporary effect of NCI training and suggesting that more frequent training is needed.[14] Managers can increase participation by compensating employees for the time they spend in training and by making the training available for all shifts.

Evaluating and Improving Training Programs

All training programs should include an evaluation component. At least annually, the team or coordinator responsible for the program should review the content, methods, and frequency of training. Program evaluation may involve supervisor and employee interviews, testing, observing, and reviewing reports of how staff have responded to threatening situations.

[14] Gillam, S. 2014. The quantitative impact of nonviolent crisis intervention training on the incidence of violence in a large hospital emergency department: A quality improvement study. *Proceedings of the Fourth International Conference on Violence in the Health Sector: Towards Safety, Security and Wellbeing for All.* 116–120.

Active Shooter Preparedness

An increasing number of healthcare facilities have begun to incorporate violence-themed situations called "active shooter" scenarios into their training programs. An active shooter is a person who is actively engaged in killing or attempting to kill people in a confined and populated area, such as a hospital ED. The shooter might target specific people or choose victims randomly. Scenarios that could lead to an active shooter situation might include rival gang members being treated in the ED, an estranged ex-husband visiting the maternity unit in violation of a restraining order, or a former patient or family member distraught over perceived misdiagnosis or mistreatment of a relative.

Although active shooter situations are rare, they can have a huge impact on a healthcare organization and the broader community. Because these situations are often over quickly before law enforcement arrives, healthcare organizations must prepare and train their staff to respond appropriately. The Joint Commission identifies the following steps that healthcare organizations can take to prepare for active shooter incidents:[15]

- Involve local law enforcement in your plans
- Develop a communication plan
- Assess and prepare your building
- Establish processes and procedures to ensure patient and employee safety
- Train and drill employees
- Plan for post-event activities

Some hospitals have obtained funding for active shooter exercises through grants from the Department of Homeland Security. See "Resources" on page 33 for more information about active shooter preparedness.

[15] The Joint Commission. 2014. Preparing for active shooter situations. *Quick Safety*. Issue Four (July). http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_Four_July_2014_Final.pdf.

Examples

Veterans Health Administration: standardizing training nationwide

The VHA has been a leader in the training and education in prevention and management of disruptive behaviors. VHA workplace violence training comprises four modules:

- Overview and introduction
- Verbal de-escalation
- Personal safety skills (including physical "break-away" or self-defense skills)
- Therapeutic containment

All employees complete mandatory introductory training, and facilities assign additional modules to each employee based on the type and severity of risk for exposure to disruptive and unsafe behaviors. Each VHA facility has certified trainers on staff, and they track all training in a national training database. Employees assigned to additional levels of training undergo biennial skills assessments by certified trainers. If unable to pass these assessments, they must repeat the training. Employees can request additional training above their assigned level.

Saint Agnes Hospital: "train the trainer" and creative approaches

Training for associates at Saint Agnes Hospital addresses de-escalation, personal protection, bullying, domestic violence, and active shooter scenarios. In addition to introductory training for most associates, security staff and workers in high-risk areas—the ED, a "co-attending" unit for patients being treated for a medical diagnosis who also have behavioral challenges—receive six-hour nonviolent crisis intervention (de-escalation) training. Patient sitters also receive six-hour training; they are certified nursing assistants who are assigned to stay with a patient at all times, based on the patient's needs (for example, suicidal patients and right-sided stroke victims). Instruction is delivered by a group of Saint Agnes staff who have been certified as trainers. Managers purposely selected a diverse group of trainers—bedside nurses, team leaders, nursing supervisors, human resources staff, critical care personnel, medical/surgical staff, and security workers—with the aim of providing mentors, coaches, and "champions" throughout the hospital.

Saint Agnes has made efforts to extend training to support staff and affiliates (e.g., contractors), and they use a variety of methods to keep the message fresh. For example, ED staff go through a panic button scavenger hunt as part of their orientation, and the staff newsletter includes information about a "code of the month."

New Hampshire Hospital: de-escalation, trauma-informed care, and mental health training for security officers

As part of its "Staying Safe" program, New Hampshire Hospital places a strong emphasis on de-escalation training to minimize the need for physical intervention. This behavioral health hospital offers nonviolent crisis intervention and de-escalation training, along with custom modules based on best practices and research. All staff receive some form of training, including administrators. Trauma-informed care training has become mandatory for nursing staff, and all staff receive training on cultural diversity and boundaries. All campus police officers must go through five weeks of mental health worker education in addition to their state police training.

Providence Behavioral Health Hospital: training for all staff

Providence Behavioral Health Hospital provides all medical and nursing staff, mental health workers, and security personnel with nonviolent de-escalation training. They also use a Massachusetts Department of Mental Health–sponsored training program called the Collaboration, Assessment, Recovery Environment (CARE) curriculum. CARE is a four-hour training focused on restraints and seclusion. The hospital makes de-escalation training available to workers in support services, such as dietary and housekeeping. The hospital has in-house trainers who are certified by an outside training provider, which allows for more flexibility in scheduling. Sessions are offered three or four times per month, and staff take an annual refresher.

The hospital pays for hands-on self-defense training for everyone whose work takes them out into the community, and it also offers "community awareness" training that focuses on situational awareness. Managers get specialized training on workplace violence too, including information about the investigation process and other legal matters related to filing workplace violence reports.

Citizens Memorial Health Care: de-escalation training in long-term care

Citizens Memorial Hospital/Citizens Memorial Health Care Foundation (CMH) operates six skilled nursing homes, a hospital, and several other healthcare services in southwest Missouri. Nursing homes can pose risks for workplace violence, particularly when caring for patients with Alzheimer's disease and/or dementia, which can lead to confusion and combativeness. As part of its comprehensive safety and health management system, CMH provides nonviolent crisis intervention and de-escalation training to all workers in its Alzheimer's and dementia special care units, as well as to security staff and workers in certain other areas. As a result of these efforts and others, CMH has kept its injury rates and turnover rates below the national average. CMH's continuous improvement shows how many of the same techniques that can be used to prevent violence in hospitals can also be applied to long-term care.

CMH incorporates role-play into its nonviolent crisis intervention and de-escalation training.

Sheppard-Pratt Health System: training in real time

Sheppard-Pratt has offered de-escalation training and annual refreshers to workers for many years, but its trainers have found that they can achieve even stronger results by offering training directly at the unit level throughout the year. This large behavioral health system has a team of trained trainers embedded in units throughout its facilities. These trainers, known as the "Green Team" because they wear lanyards with green beads, are available to coach and mentor their colleagues in real time. For example, a trainer might step in to help a colleague who is having difficulty with charting or with de-escalating a patient. They also provide monthly refresher training to their colleagues regarding holds. Real-time, in-unit training offers the benefit of realistic demonstration, an immediate opportunity to apply a skill, and the relevance that comes with learning in one's actual work environment.

Active shooter training at Mercy Medical Center

In 2015, Mercy Medical Center in Springfield, Massachusetts, conducted a full-scale active shooter exercise with three scenarios: gang violence in the ED, a behavioral health escalation incident, and an estranged ex-boyfriend in the maternity unit. Staff from many units participated in the drill, including managers and staff from the ED, the Family Life Center, Providence

Behavioral Health Hospital, the security team, and human resources. The hospital coordinated the drill with the Massachusetts State Police and Springfield city police (including their Special Weapons and Tactics [SWAT] team), local tactical EMTs, and affiliated private security companies. Observers included other regional hospitals, school and college security, the Massachusetts Emergency Management Agency, the Homeland Security Council, long-term care facility representatives, and the Air Force Reserves, all seeking to learn and apply information to their own exercises. Evaluators noted participants' situational awareness, law enforcement response, communication, emergency operations, and treatment and triage. The exercise was followed by an open and blame-free evaluation that identified opportunities for improvement.

Mercy Medical Center's active shooter drill involved a large number of people in realistic scenarios—fake blood and all.

Active shooter training at Centennial Hills Hospital

At Centennial Hills Hospital Medical Center in Las Vegas, Nevada, the Emergency Preparedness and Trauma Coordinator designed and developed an active shooter exercise in collaboration with the Las Vegas Metro Police MACTAC (Multi Assault Counter Terrorism Action Capabilities) initiative and experts from the Nevada National Security Site. The exercise was called Operation Wilcox, in memory of a victim of a 2014 Las Vegas–area active shooter incident, and it received national attention. The exercise was part of Centennial Hills's innovative LIVE Project, which provides training, education, resources, and options for healthcare workers on how to handle an active shooter. "LIVE" is an acronym that stands for:

- **L—Leave (or Lockdown).** Have an escape route and plan in mind. Leave your belongings behind. Lock down in your area.
- **I—Invisible.** Hide in an area out of the shooter's view. Block entry to your hiding place.
- **V—Violence.** As a last resort and if your life is in danger, use violence to stop the shooter.
- **E—Evade.** Evading detection from the shooter is the best option.

The LIVE Project was presented at The Joint Commission's 2015 Emergency Preparedness Conference, and it includes a video that the hospital produced.

Centennial Hills Hospital Medical Center's LIVE Project trains healthcare workers on how to deal with an active shooter. The training includes a video, from which this screenshot was taken.

Resources

Author	Title	Description	URL
General training materials			
NIOSH	Workplace Violence Prevention for Nurses	Free Web-based training program to help healthcare workers learn about the key elements of a comprehensive workplace violence prevention program, how organizational systems impact workplace violence, how to apply individual strategies, and how to develop skills for preventing and responding to workplace violence.	http://www.cdc.gov/niosh/topics/violence/training_nurses.html
International Labour Organization, International Council of Nurses, World Health Organization, and Public Services International	Framework Guidelines for Addressing Workplace Violence in the Health Sector: The Training Manual	Workplace violence training manual for the healthcare industry, developed by a group of international organizations.	http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_108542.pdf
Emergency Nurses Association	Emergency Department Workplace Violence Training: Competency Documentation	Checklist for evaluating an employee's comprehension and competency as it relates to workplace violence prevention. This resource is part of the Association's Workplace Violence Toolkit.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/Competency_V1.doc
The Joint Commission	Preventing Violence in the Emergency Department: Ensuring Staff Safety	Article on violence prevention in EDs.	Available for purchase at: http://www.ingentaconnect.com/content/jcaho/09/00000012/00000010/art00001
The Joint Commission	Sentinel Event Issue 45: Preventing Violence in the Healthcare Setting	*Sentinel Event Alert* identifying underlying causes and ways to reduce violence.	http://www.jointcommission.org/sentinel_event_alert_issue_45_preventing_violence_in_the_health_care_setting_/default.aspx
Health Services Executive Ireland	Linking Services and Safety: Together Creating Safer Places of Service	Findings and recommendations from a working group on violence and aggression in the healthcare sector.	http://www.hse.ie/eng/staff/safetywellbeing/policyteam/strategyworkrelatedAggression.pdf

Author	Title	Description	URL
Active shooter preparedness			
Hospital Association of Southern California	Active Shooter Drill Materials	Table of resources for planning an active shooter drill.	http://www.hasc.org/active-shooter-drill-resources
Healthcare and Public Health Sector Coordinating Council	Active Shooter Planning and Response in a Healthcare Setting	Guidance document intended to help healthcare facilities prevent, respond to, and recover from an active shooter event.	https://www.fbi.gov/about-us/cirg/active-shooter-and-mass-casualty-incidents/active-shooter-planning-and-response-in-a-healthcare-setting
U.S. Department of Health and Human Services, U.S. Department of Homeland Security, Federal Bureau of Investigation, and Federal Emergency Management Agency	Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operation Plans	Report designed to encourage facilities to consider how to better prepare for an active shooter incident.	http://www.phe.gov/Preparedness/planning/Documents/active-shooter-planning-eop2014.pdf
MESH	Surviving an Active Shooter in a Healthcare Environment	Training video based on guidelines established by the Department of Homeland Security.	https://vimeo.com/meshcoalition/review/108575641/dd69fdb233
The Joint Commission	Quick Safety: Preparing for Active Shooter Situations	Advisory article on active shooter situations. This "Quick Safety" feature is not a standard or a *Sentinel Event Alert*, but rather an effort to raise awareness and provide assistance to Joint Commission–accredited organizations.	http://www.jointcommission.org/issues/article.aspx?Article=h1wY0qOAjXjKMD9Np15aXCoh6JDFt4iaFxb%2F%2FTKfNWE%3D
California Hospital Association	Hospital Code Silver Activation: Active Shooter Planning Checklist	Checklist to help plan for an active shooter event.	http://www.calhospitalprepare.org/sites/main/files/file-attachments/cha_active_shooter_checklist_12-19-12.doc
New York State Health Emergency Preparedness Coalition	Active Shooter: Tools/Resources	Web page with resources related to active shooter training.	https://www.urmc.rochester.edu/emergency-preparedness/preparedness-and-response-tools-resources/active-shooter.aspx

8. Recordkeeping and Program Evaluation

Recordkeeping and evaluation are vital to assessing the effectiveness of workplace violence prevention programs, identifying overlooked hazards, and determining what additional preventive measures could be adopted to ensure continual improvement. Regular review and reevaluation of policies and procedures, as well as additional review and evaluation when new violent incidents occur, can help a workplace violence prevention committee keep its program current and responsive to changing circumstances and needs.

Managers can improve program performance by sharing data with all employees. Discussion of safety trend data involves employees in safety awareness, creates opportunities for improvement, and provides motivation to achieve continuous improvement. Staff can help to identify deficiencies and offer suggestions to improve the program. Changes to the program can be discussed at regular meetings of the workplace violence prevention committee, with union representatives, and with other employee stakeholder groups.

Reporting

Accurate records of incidents, assaults, hazards, corrective actions, patient histories, and training can help employers to:

- Determine the severity of their workplace violence problems
- Identify any trends or patterns in particular locations, job categories, or departments
- Evaluate methods of hazard control
- Determine whether programs are working
- Identify training needs

Accurate tracking of workplace violence depends on the ease with which employees can report a wide range of incidents or "near-misses"—and the extent to which employees perceive that reporting will lead to positive results.

Clearly defined policies and procedures that encourage workers to report violent incidents or present their other concerns to management are one key to effective reporting. Examples include procedures to ensure that, pursuant to the OSH Act, employees are not retaliated against for voicing concerns or reporting injuries (Section 11c, 29 U.S.C. 660(c)). Section 11(c) of the OSH Act and implementing regulations at 29 CFR 1904.36 prohibit discrimination against an employee for reporting a work-related fatality, injury, or illness. Additionally, reporting procedures must protect employee and patient confidentiality, either by presenting only aggregate data or by removing personal identifiers if individual data are used, so that individual data are only available to those staff who need to follow up on the incident. Prompt follow-up can also encourage more reporting because it shows employees that their reports are taken seriously.

A variety of different report forms are used in different healthcare settings—some electronic, some paper-based—and the content and format of the incident report can be tailored according to the facility needs. Some facilities use the same reporting system for all types of safety and health-related incidents. See the "Resources" table at the end of this section for samples of violent incident report forms that can be customized to suit a facility's needs.

Recordkeeping

OSHA's regulation at 29 CFR 1904 requires private sector employers and many public sector employers, including many healthcare establishments, to record and report work-related injuries or illnesses. First, employers with 10 or fewer employees at all times during the calendar year are partially exempt from keeping records. Second, establishments in certain lower-hazard industries, including medical offices, are also partially exempt.

Employers covered by Part 1904 must record work-related injuries and illnesses that result in:

- Death
- Days away from work
- Restricted work
- Transfer to another job
- Medical treatment beyond first aid
- Loss of consciousness
- Significant injury or illness (e.g., cancer, chronic irreversible disease, fractured or broken bones, or a punctured eardrum) diagnosed by a physician or other licensed healthcare professional

Injuries and illnesses that are caused, contributed to, or significantly aggravated by events or exposures in the work environment are considered work-related for OSHA recordkeeping purposes. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures in the work environment, unless an exception in Section 1904.5(b)(2) specifically applies.

Employers keep records using the following forms:

- **OSHA Form 300: Log of Work-Related Injuries and Illnesses.** Employers covered by this regulation must record each recordable injury or illness on the OSHA 300 Log.
- **OSHA Form 301: Injury and Illness Incident Report.** For each case recorded on the 300 Log, employers must also prepare a 301 Incident Report. This form provides additional detailed information about each case entered on the 300 Log.
- **OSHA Form 300A: Summary of Work-Related Injuries and Illnesses.** At the end of each year, employers are required to prepare a summary report of all injuries and illnesses on the 300 Log. Employers must post this form from February 1 through April 30 of the following year.

OSHA makes these forms available on its public website at www.osha.gov/recordkeeping and provides guidance on how to record cases. Employers may use alternate forms to record injuries and illnesses, provided such forms include the same information as the OSHA forms. Many healthcare facilities use their workers' compensation forms as equivalent forms. All OSHA recordkeeping forms, or equivalent forms, must be maintained by the employer for five years. The recordkeeping regulation also gives employees the right to review their injury and illness records, and employers must provide copies to employees within one business day of a request.

In accordance with Section 18 of the *Occupational Safety and Health Act of 1970*, 21 states and Puerto Rico have elected to develop and operate State Plans for occupational safety and health programs, which must be at least as effective as federal standards and must cover public sector workers (see the map below). Healthcare facilities in these states should consult their state programs for additional recordkeeping guidance. Five other states and the U.S. Virgin Islands have State Plans that only cover public sector employment.

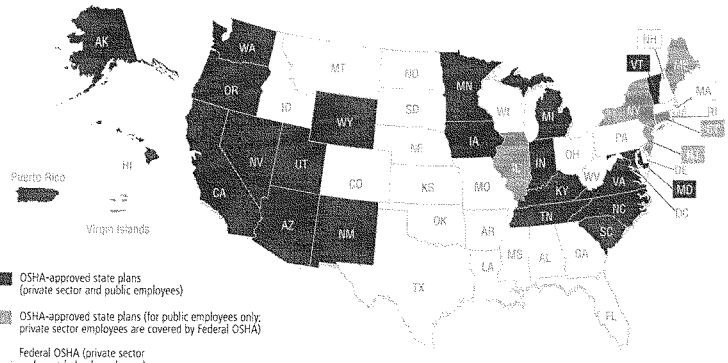
A 2014 update to OSHA's recordkeeping regulation requires all employers, including those in partially exempt industries, to report any work-related fatality to OSHA within 8 hours of learning of the incident. The revised regulation also requires all employers to report work-related inpatient hospitalizations, amputations, and losses of an eye to OSHA within 24 hours of learning of the incident. These events can be reported to OSHA in person, by phone, or by using the reporting application on OSHA's public website at www.osha.gov/recordkeeping.

Program Evaluation

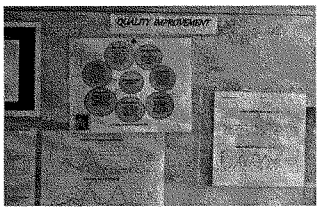
According to OSHA's *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, processes involved in a comprehensive workplace violence prevention program evaluation typically include:

- Establishing a uniform definition of violence, reporting system, and regular review of reports.
- Reviewing reports and minutes from staff meetings on safety and security issues.

OSHA-Approved State Plans



Source: www.osha.gov/dcsp/osp



Bulletin boards in staff areas can help keep employees aware of program performance. For example, this board in a behavioral health hospital shows employees how they are doing in their quest to reduce the use of restraints and seclusion.

- Analyzing trends and rates in illnesses, injuries, or fatalities caused by violence relative to initial or "baseline" rates and sharing data with management at all levels.
- Measuring improvement based on lowering the frequency and severity of workplace violence.
- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate how well they work.
- Surveying workers before and after making job or worksite changes or installing security measures or new systems to evaluate their effectiveness.
- Tracking recommendations through to completion.
- Keeping abreast of new strategies available to prevent and respond to violence as they develop.
- Surveying workers periodically to learn if they experience hostile situations while doing their jobs.
- Complying with OSHA and state requirements for recording and reporting injuries, illnesses, and fatalities.
- Establishing an ongoing relationship with local law enforcement and educating them about the nature and challenges of working with potentially violent patients.
- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving worker safety.

Records that should be analyzed during program evaluation include the following:

- OSHA Log of Work-Related Injuries and Illnesses and Injury and Illness Incident Report (OSHA Forms 300 and 301).
- Medical reports of work injury, workers' compensation reports, and supervisors' reports for each recorded assault.
- Records of incidents of abuse, reports filed by security personnel, and records of verbal attacks or aggressive behavior that may be threatening.
- Information recorded in the charts of patients with a history of past violence, drug abuse, or criminal activity.
- Documentation of minutes of safety meetings, records of hazard analyses, and corrective actions recommended and taken.
- Records of all training programs, their attendees, and the qualifications of the trainers.

Additional evaluation tips include:

- Using the same tools for re-evaluation as for the initial worksite assessment and hazard identification process, to allow for consistent data comparison
- Working closely with the workplace violence prevention committee to learn what has worked in reducing violence or to learn about barriers that have been encountered.
- Examining only those incident reports that have been submitted since the last assessment took place, to avoid any overlap.
- Documenting all assessments as well as all changes introduced based on the results.
- Making sure to assess the quality and effectiveness of training programs rather than simply noting their presence.

It is important to evaluate all aspects of the workplace violence program systematically. Regular review is necessary to identify deficiencies and opportunities for improvement. The core elements are all interrelated, and each is necessary to the success of the overall system.

Examples

Ascension Health: standardizing reporting and definitions

Ascension Health is the nation's largest Catholic and not-for-profit health system, with more than 150,000 associates at 1,900 locations, including more than 100 hospitals. Ascension has standardized a definition of workplace violence across its locations, which has helped to ensure consistency in reporting and subsequent data analysis. The definition includes lateral (employee-on-employee) violence. Ascension defines workplace violence as:

> A threat or act of violent behavior, against oneself, another person, or a group that either results in or has a high likelihood of resulting in injury, death or psychological harm. These events may involve patients or family members, visitors, volunteers, vendors, physicians or other associates. Examples include bullying, hostility, intimidation, or use of physical force, weapons or power.

All Ascension hospitals use an electronic incident reporting system for occupational injuries and illnesses called DOERS (Dynamic Online Event Reporting System), which is intended to be a point of entry resource available from any computer connected to the hospital's intranet. Every associate can enter a report using a secure login. Each report is routed to the hospital's occupational health staff, security director, and human resources. A report will also go to the associate's manager. However, in events of workplace violence the associate can check a box to exclude his or her manager if the report concerns a sensitive issue such as bullying by a supervisor. Hospital policies require managers to follow up promptly with any employee who submits a report.

By encouraging reporting, making it easy and accessible, providing confidentiality, following up on every report, and emphasizing a "no fear" environment, Ascension's hospitals have increased the number of reports they receive, even while injury rates and incident severity have decreased or remained steady. For example, at St. John Medical Center in Tulsa, Oklahoma, reporting more than doubled when components of a comprehensive workplace violence prevention initiative were adopted; Saint Agnes Hospital in Baltimore, Maryland, saw a 75 percent increase in reports of workplace violence. Many of the reports involve "near-misses" or precursor events, which Ascension encourages associates to report because they provide opportunities for learning and proactive intervention.

Veterans Health Administration: systematic annual program evaluation

Every fiscal year, each VHA facility conducts a Workplace Behavioral Risk Assessment (WBRA) to evaluate the level of risk for behavioral incidents and the mandatory training processes. An interdisciplinary team conducts the WBRA, including the DBC chair, a Veterans Affairs (VA) police officer, the patient safety officer or his/her designee, and often a labor partner or union workplace safety representative. The team reviews DBC records, VA police data, and data from the VHA's Automated Safety Incident Surveillance and Tracking System. After completing a WBRA, a facility receives guidance on continual improvement from national program staff.

Resources

Author	Title	Description	URL
Incident reporting and recordkeeping			
Minnesota Department of Health	Metropolitan Hospital Compact: Management of Violence in the Healthcare/ Workplace Setting Template	Policy template and guide to implementing a violence prevention program. The appendices include the Threat or Event Assessment Tool, Incident Response Form, Domestic Violence Assessment, Violence in the Workplace Response Algorithm, and Hospital Violence Data Tracking form.	http://www.health.state.mn.us/patientsafety/preventionofviolence/mcviolenceprevtoolkit.pdf
Civil Service Employees Association, Local 1000, AFSCME, AFL-CIO	Workplace Violence Incident Report Form	Form for reporting a violent incident in the workplace.	https://cseany.org/wp-content/uploads/2013/02/Incident-Report.pdf
New York State Department of Labor	Workplace Violence Prevention Program Guidelines	Appendix 2 contains a Workplace Violence Incident Report.	http://tinyurl.com/q6x5t3s
North Carolina Department of Labor, Occupational Safety and Health Division	Workplace Violence Prevention Guidelines and Program for Health Care, Long Term Care and Social Services Workers	Guide to identifying risk factors and implementing an effective violence prevention program. The Violence Incident Report Form is included at the end.	http://www.nclabor.com/osha/etta/indguide/ig51.pdf
Emergency Nurses Association	Sample Safety Event Form	Sample incident report filled out with example responses. This resource is part of the Association's Workplace Violence Toolkit.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/SampleSafetyEventForm.pdf
Washington State Department of Labor and Industries	Workplace Violence Awareness and Prevention for Employers and Employees	Guidebook to help employers and employees recognize workplace violence, minimize and prevent it, and respond appropriately if it occurs. A sample assault incident report form is included in Appendix B.	http://www.lni.wa.gov/IPUB/417-140-000.pdf
OSHA	Injury and Illness Recordkeeping and Reporting Requirements	Official federal regulations, explanatory text, training forms, and answers to frequent questions regarding an employer's obligations to record and report certain types of injuries that occur in the workplace.	www.osha.gov/recordkeeping

Author	Title	Description	URL
Other program evaluation resources			
CDC and NIOSH	Violence: Occupational Hazards in Hospitals	Brochure designed to increase awareness of risk factors and prevention strategies for violence in hospitals.	http://www.cdc.gov/niosh/docs/2002-101
OSHA	Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers	Voluntary guidelines for reducing workplace violence in the healthcare and social service sectors. Example checklists are included.	www.osha.gov/Publications/osha3148.pdf
ECRI Institute	Violence in Health Care Facilities	Risk analysis report that discusses workplace violence and prevention strategies.	https://www.ecri.org/components/HRC/Pages/SafSec3.aspx
Emergency Nurses Association	ED Workplace Violence Project Plan: Post-Incident Response Program	Sample project plan for a post-incident response program. This resource is part of the Association's Workplace Violence Toolkit.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/ENAactionplan16.doc

9. General Resources

Author	Title	Description	URL
OSHA	Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers	Voluntary guidelines for reducing workplace violence in the healthcare and social service sectors.	www.osha.gov/Publications/osha3148.pdf
Emergency Nurses Association	Workplace Violence Toolkit	Toolkit with templates and examples designed specifically for the ED.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/toolkitpg1.htm
Minnesota Department of Health	Prevention of Violence in Health Care Toolkit	Website with a variety of resources and models for preventing violence in healthcare settings. Tools and examples have been developed by various hospitals and agencies and compiled by the state of Minnesota.	http://www.health.state.mn.us/patientsafety/preventionofviolence/toolkit.html
The Joint Commission	Emergency Management Resources—Violence/Security/Active Shooter	Web page with resources on violence prevention.	http://www.jointcommission.org/emergency_management_resources_violence_security_active_shooter

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Workplace Violence Prevention and Related Goals

The Big Picture

A workplace violence prevention program can complement and enhance your organization's strategies for compliance, accreditation, and quality of care.

Workers in hospitals, nursing homes, and other healthcare settings face significant risks of workplace violence. Leading healthcare organizations have shared some of their solutions and shown that one does not need to tackle workplace violence in isolation. This document illustrates how a workplace violence prevention program can complement and enhance your organization's strategies for compliance, accreditation, and quality of care.

Regulatory Compliance

Federal Requirements

Although OSHA has no specific standard on the prevention of workplace violence, an employer has a general duty to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." This requirement comes from Section 5(a)(1) of the *Occupational Safety and Health Act of 1970* (OSH Act).

In addition to the federal OSHA program, 26 states, Puerto Rico, and the U.S. Virgin Islands have OSHA-approved State Plans. Of these State Plans, 22 (21 states and Puerto Rico) cover both private and state and local government workplaces. The remaining six State Plans (five states and the U.S. Virgin Islands) cover state and local government workers only. These state plans must be "at least as effective" as Federal OSHA (Section 18(c) of the OSH Act).

Section 11(c) of the OSH Act provides protection for employees who exercise a variety of rights guaranteed under the Act, such as filing a safety and health complaint with OSHA. In states with approved state plans, employees may file a complaint under the OSH Act with both the state and Federal OSHA. More information can be found at www.whistleblowers.gov.

In 2015, OSHA published an update to its *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (see "Resources" at the end of this publication). These voluntary guidelines provide a compendium of research-based strategies to help prevent violent injuries to healthcare workers, and they emphasize the value of a comprehensive written workplace violence prevention program.

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e healthcare facilities to develop and maintain a violence prevention program. Subsequent state state law. Currently, California is working on updating state requirements.

n California, Washington, New York, New Jersey, and Connecticut require healthcare employers ention programs. In New York, the law applies to public workplaces but not to the private l specific healthcare settings such as acute psychiatric care, long-term and residential care, or violence prevention legislation can be models for other states that are considering their own

From 2007 to 2013, the rate had fallen to 54.5 claims per 10,000 FTEs—a decre coincides with Washington's 2009 rule that required hazard assessments, training violence.

Source: Foley, M., and Rauser, E. 2012. Evaluating progress in reducing workplace violer compensation claims rates, 1997–2007. *Work*. 42: 67–81. (Updated data provided by t

ice, home care agencies, uation and treatment facilities

n a hazard assessment and ition plan. Training must s identified in the violence days of an employee's start occurring during the last five

centers, and home

ents and record ntion plan. The utes of the facility, ency procedures, ion and training. : who has assaulted quest to have a e healthcare may rovides the employee g must occur within vided as needed

SB-1299)
hiatric, and certain other types of hospitals

e to develop a safety plan, which must be updated based This plan should take into account physical layout, staffing, appropriate responses, and coordination with local law violent behavior and evaluate trends. Affected employees and in worksite analysis. Safety and health training is required.

s of August 2015:

Illinois (405 ILCS 90/)
Who is covered: Mental health and developmental disability facilities
Penalties for perpetrators: Yes
Illinois' law requires a violence prevention plan to be implemented based on findings from a risk assessment and record review. The plan must be reviewed at least once every three years and must take into account the facility's physical layout, personnel policies, first-aid and emergency procedures, reporting of violent acts, and employee education and training. All affected employees must be trained within 90 days of their start date, and they must receive periodic refresher training. The facility must keep records of workplace violence incidents.

New York (Labor Law Article 2)
Who is covered: Public facilities with at least 20 full-time permanent employees, including state-run healthcare and social service facilities
Penalties for perpetrators: Yes
New York's law requires a risk assessment of the workplace, which includes consideration of hazards such as working late, working alone, and exchanging money. Each facility must have a violence prevention plan that addresses the identified hazards. Employees are required to complete training at the start of employment and annually thereafter. Each facility must have a system for reporting incidents. Strong requirements for employee involvement have served as a model for other states' laws.

Maine (Sec. 1. 22 MRSA
Who is covered: Hospitals
Penalties for perpetrators:
Maine's law requires a sa to be implemented annua have a process to receive threats of violent behavio

Connecticut (Public Act
Who is covered: Hospital health, outpatient and a facilities with 50 or more
Penalties for perpetrator
Connecticut's law require representation among m must meet quarterly, con implement a violence pre request accompaniment assaulted them, or they keep detailed incident re within 24 hours (with so

New Jersey (P.L. 2007, Chapter 236)
Who is covered: Hospitals and nursing homes
Penalties for perpetrators: Yes
New Jersey's law requires a violence prevention committee to conc and develop a violence prevention plan. At least half of the commi The assessment must consider the facility's layout, crime rate in su surrounding areas, communication and alarm devices, and staffing review and a review of existing policies. The plan must specify risk establish a post-incident response system. Employees must receive precipitating factors of violence and appropriate responses. Record kept for five years.

Maryland (Senate Bill 483)
Who is covered: Hospitals, state residential facilities, and nursing homes licensed for 45 beds or m

Accreditation

Many healthcare organizations pursue accreditation by an independent accreditation body, The Joint Commission being the largest. While The Joint Commission's healthcare standards and accreditation process have long focused on protecting patient safety, many of the standards and management systems designed to ensure patient safety can also be adapted and applied to worker safety. In addition, efforts to improve worker safety often have the result of improving patient care. Joint Commission–accredited healthcare organizations often already have building blocks in place to reduce workplace violence and other worker safety risks.

The Joint Commission's accreditation manual has several standards related to workplace violence, spread across four chapters of the manual.[1] The manual lists the accreditation requirements specific to workplace violence in different healthcare organizations, including hospitals, doctors' offices, nursing homes, office-based surgery centers, behavioral health treatment facilities, and providers of home care services. Particularly relevant standards include:

- Environment of Care (EC)
- Emergency Management (EM)
- Leadership (LD)
- Performance Improvement (PI)

For example, developing a strong safety culture, addressed in Joint Commission Standard **LD.03.01.01** for hospitals ("Leaders create and maintain a culture of safety and quality throughout the hospital"), is a key aspect of ensuring both worker and patient safety.[2] A strong safety culture includes managing and mitigating the risk of harm as reflected in Standard **EC.02.01.01** ("The hospital manages safety and security risks"). It also includes empowering staff to report incidents without fear of reprisal, which is included in Standard **LD.04.04.05** ("The hospital has an organization wide, integrated patient safety program within its performance improvement activities"). Reporting enables healthcare organizations to track and analyze incidents to inform both proactive and reactive risk reduction. Standard **EM.02.02.05, EP 3** ("The Emergency Operations Plan describes how the hospital will coordinate security activities with community security agencies [for example, police, sheriff, National Guard]") provides another connection, as it requires preparation for emergencies such as an active shooter situation. Although these three examples come from The Joint Commission's hospital standards, safety expectations are also in place for other settings such as long-term care, ambulatory care, behavioral health, and home care.[3]

"The organizational culture, principles, methods, and tools for creating safety are the same, regardless of the population whose safety is the focus."

– The Joint Commission. *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation.*

[1] Joint Commission. 2015. *2015 Comprehensive Accreditation Manual for Hospitals (CAMH)*. 2015. Oakbrook, IL: Joint Commission Resources.

[2] Joint Commission. 2015. *2015 Comprehensive Accreditation Manual for Hospitals (CAMH)*. 2015. Oakbrook, IL: Joint Commission Resources.

[3] Standards reprinted here with The Joint Commission's permission.

Workplace Violence Prevention and Related Goals: The Big Picture

The Joint Commission's *Improving Patient and Worker Safety: Opportunity for Synergy, Collaboration and Innovation*[4] highlights additional synergies between patient and worker health and safety activities. To successfully integrate patient and worker safety, the document recommends:

- Encouraging leaders to make patient and worker safety core organizational values.
- Identifying opportunities to integrate patient and worker safety activities across departments and programs.
- Understanding and measuring performance on safety-related issues.
- Implementing and maintaining successful worker and patient safety improvements.

The Joint Commission shares recommendations, policies, procedures, and other information to help facilities prevent workplace violence. For example, it adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious events learn from those events and implement actions to prevent future events.[5] A sentinel event is a patient safety event that results in any of the following: death, permanent harm, or severe temporary harm and intervention required to sustain life. In 2014, The Joint Commission added to its list of events considered sentinel: rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital.[6] Reporting a sentinel event to The Joint Commission is optional, but it can provide crucial data to help The Joint Commission and others identify causes, track trends, extract lessons learned, and ultimately contribute to better prevention strategies. The Joint Commission's sentinel event data collection and analysis processes protect the confidentiality of the patient, the caregiver, and the hospital.

A comparison between broader safety and health management system elements and the elements of performance found in related Joint Commission standards can be found in OSHA's *Safety and Health Management Systems and Joint Commission Standards*.[7]

OSHA and The Joint Commission have established an alliance to provide healthcare workers and others in the healthcare industry with information, guidance, and access to training resources to help protect employees' health and safety. Free resources, including many articles, are available at www.jcrinc.com/about-jcr/osha-alliance-resources.

Similar connections between accreditation and worker safety can be found in standards from other accrediting organizations, such as the Healthcare Quality Association on Accreditation (HQAA), Accreditation Association for Ambulatory Health Care (AAAHC), Accreditation Commission for Health Care (ACHC), and Commission on Accreditation of Rehabilitation Facilities (CARF). For example, CARF accredits programs primarily in the areas of aging, behavioral health, substance abuse treatment, and child and youth services. Its Standard 1.H.13 refers to "comprehensive health and safety inspections" conducted by the external authorities, including OSHA. The standard requires a healthcare facility to submit a written report to CARF that identifies health and/or safety areas inspected, issues that were discovered during the inspection, and an action plan for improvement. The 2015 *CARF-CCAC Standards Manual* is available for download at bit.ly/1JBpOXD.

[4] Joint Commission. 2012. *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation*. www.jointcommission.org/improving_Patient_Worker_Safety.

[5] Joint Commission. 2014. Sentinel event policy and procedures. www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/default.aspx.

[6] Reprinted here with The Joint Commission's permission.

[7] OSHA. 2013. *Safety and Health Management Systems and Joint Commission Standards*. www.osha.gov/dsg/hospitals/documents/2.2_SHMS-JCAHO_comparison_508.pdf.

Patient Safety

Increasingly, healthcare facilities are integrating their *patient safety* and *worker safety* programs and managing them together using a common framework. Doing so makes sense, because many of the risk factors that affect patient safety also affect workers. For instance, a violent confrontation or intervention can result in injuries to both workers and patients, and caregiver fatigue, injury, and stress are tied to a higher risk of medication errors and patient infections.[8]

In addition, the tools used to monitor, manage, and improve patient safety have proven equally effective when applied to worker safety. For example, if your facility is Joint Commission accredited, you may be able to adapt existing compliance monitoring tools and infrastructure to address occupational safety. Several hospitals use their "environment of care" rounds to monitor for conditions that could affect either patient or worker safety.

Strategies to improve patient safety and worker safety can go hand-in-hand—particularly those that involve nonviolent de-escalation and alternatives such as sensory therapy. The nationwide movement toward reducing the use of restraints (physical and medication) and seclusion in behavioral health—which is mandated in some states—along with the movement toward "trauma-informed care," means that workers are relying more on approaches that result in less physical contact with patients, intervening with de-escalation strategies *before* an incident turns into a physical assault, preventing self-harm by patients, and ultimately equipping patients with coping strategies that can help them for life. The results can be a "win-win" for patient and worker safety.

A Culture of Safety

An organization's culture is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to objectives such as quality and safety. Many leading healthcare organizations are reducing injuries to both patients and workers by fostering a "culture of safety" characterized by an atmosphere of mutual trust, shared perceptions of the importance of safety, confidence in the efficacy of preventive measures, and a no-blame environment. Typical attributes of a culture of safety include:

- Staff and leaders who value transparency, accountability, and mutual respect
- Safety as everyone's first priority
- Not accepting behaviors that undermine the culture of safety
- A focus on finding hazardous conditions or "close calls" at early stages before injuries occur
- An emphasis on reporting errors and learning from mistakes
- Careful language to facilitate conversation and communicate concerns

"Workplace safety is inextricably linked to patient safety. Unless caregivers are given the protection, respect, and support they need, they are more likely to make errors, fail to follow safe practices, and not work well in teams."

—National Patient Safety Foundation, Lucian Leape Institute. *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care*

"Safety is safety. We don't differentiate between patient and associate safety. We practice and encourage safety behaviors for both patients and associates. The behaviors we promote are exactly the same."

—Kate Henderson, Vice President and Chief Operating Officer, UMC Brackenridge

"Where some hospitals would limit their approach to medication, we use a more holistic approach. We work with patients as individuals, to find out what has a calming effect on them, and help them put that into practice. The result can be a positive change that lasts the rest of their lives."

—Cindy Chaplin, RN, BSN, Nurse Educator, Massachusetts Nurses Association Local Unit Chairperson, Workplace Violence Task Force Co-Chair, Providence Behavioral Health Hospital (Holyoke, Massachusetts)

[8] Rogers, A.E., Hwang, W.T., and Scott, L.D. 2004. The effects of work breaks on staff nurse performance. *Journal of Nursing Administration*. 34(11): 512–519.

High Reliability Organizations: Five Operational Processes

Sensitivity to operations: Workers in HROs are mindful of procedures and interactions between team members. This heightened situational awareness sensitizes them to minor deviations and enables them to respond appropriately.

Reluctance to simplify: When outcomes deviate from established plans, HROs question conventional explanations for why things went wrong and explore the entire potential scope of the problem.

Preoccupation with failure: No matter how enviable their track records, HROs never let success breed complacency. They focus unceasingly on ways the system can fail, and encourage staff to always listen to their "inner voice of concern" and share it with others.

Deference to expertise: Team members and organizational leaders in HROs defer to the person with the most knowledge relevant to the issue they are confronting. This may involve deviating from the traditional physician, nurse, and technician hierarchy.

Resilience: HROs acknowledge that, despite considerable safeguards, errors will sometimes occur. By anticipating and planning for such situations, they can contain and minimize the adverse consequences.

Many healthcare organizations have strengthened their cultures of safety by embracing two sets of principles:

- **High reliability organization (HRO)** principles arose from air traffic control, nuclear power, and other industries characterized by complex systems with innate risks that must be managed effectively to avoid catastrophe. The Joint Commission has endorsed the use of similar principles to transform healthcare into a high reliability industry.[9] The Joint Commission promotes an environment of "collective mindfulness" in which employees look for and report small problems or unsafe conditions before they pose a substantial risk, and when they are easy to fix. The identification and careful analysis of errors can reveal weaknesses in protocols or procedures that can be remedied to reduce the risk of future failures.
- **"Just Culture"** involves creating an atmosphere of trust, encouraging and rewarding people for providing information on how errors occurred, so the sources of error can be analyzed. This can result in changes that improve safety. As Lucian Leape, MD, explains: "Approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes."[10]

In hospitals and other healthcare organizations, HRO and "Just Culture" can benefit both patients and workers, with the goal of improving safety for all.

Example: "Tapping Out"

Sometimes a healthcare worker finds him- or herself in a verbal power struggle with an agitated patient, or finds that he or she is getting frustrated and not making progress. At **Providence Behavioral Health Hospital** in Holyoke, Massachusetts, other colleagues are encouraged to recognize this type of situation and "tap in" by telling the first worker something like "You have a phone call—and it's your supervisor." Sometimes all it takes is a new face to get a patient to calm down, and the emphasis on caring language allows the first worker to exit the situation gracefully. This type of focus on collaboration and respectful language is a hallmark of a "culture of safety."

[9] See, for example, www.jointcommission.org/highreliability.aspx.

[10] Leape, L. 2000. Testimony, United States Congress, United States Senate Subcommittee on Labor, Health and Human Services, and Education. January 25, 2000.

Example: "Culture of Safety" at Ascension Health

Ascension Health is the nation's largest Catholic and not-for-profit health system, with more than 150,000 employees (associates) at 1,900 locations, including more than 100 hospitals. Although all of these hospitals have dedicated safety professionals available, they cannot be everywhere at all times, nor can they expect to be experts in all the operations of a modern hospital. Recognizing this, several Ascension hospitals have adopted HRO principles to provide all associates with tools, resources, authority, and accountability that make it possible for everyone to integrate associate safety into their daily activities, just like they do for patient safety.

Key components of Ascension's program include:

- Empowering associates
- Making safety routine and visible
- Training
- Management visibility and commitment

For example, **University Medical Center Brackenridge** (UMC Brackenridge) in Austin, Texas, provides high reliability safety training to 100 percent of staff and on-site contractors. Safety coaches throughout the hospital receive additional training. Training tools include videos, staff testimonials, and role-playing in an on-site simulation laboratory.

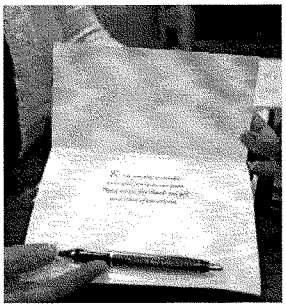
At **St. Vincent's Medical Center** in Bridgeport, Connecticut, each day begins with a "safety huddle" led by a senior executive. Representatives from all departments, including both clinical and non-clinical services, are required to attend. Together they review any patient or associate safety events or concerns, recognize "good catches" (near-misses), and share updates on the status of safety-related projects or initiatives. These daily exchanges, fostered in an open, no-blame environment, help create an atmosphere of trust and cooperation. Several other Ascension hospitals use a similar approach.

Ascension Health's hospitals teach associates to intervene in situations using the "language of care." For example, any associate can stop the process by saying "I have a concern"—akin to the idea that any employee in a factory can stop the assembly line if he or she sees something wrong. Other examples:

- It's not a "near-miss"; it's a "good catch."
- With patients, "We're doing [x] for your safety."

Additionally, nurses—or even pastoral care staff—may take the lead in responding to certain security events, in partnership with security staff, so as to keep the focus on caring for the patient.

To remove barriers to reporting, Ascension Health has adopted computer-based reporting systems that emphasize reporting of "good catches" to provide opportunities to proactively reduce hazards. An associate who reports a concern will likely be engaged in follow-up discussion, root cause analysis, and response. **Saint Agnes Hospital** in Baltimore, Maryland, increased reporting by 75 percent using this approach. At UMC Brackenridge, senior administrators show their appreciation by writing a thank-you note to any associate who makes a "good catch."



Any UMC Brackenridge associate who makes a "good catch" receives a thank-you note from the leadership team.

Safety and Health Management Systems: A Comprehensive Approach

A workplace violence prevention program can fit effectively within a broader safety and health management system, also known as an injury and illness prevention program. Under this type of program, employers and employees continually monitor the workplace for hazards and then cooperate to find and implement solutions. All of this happens within a Plan-Do-Study-Act management system framework that should be familiar to healthcare administrators. A comprehensive safety and health management system can effectively manage a wide range of worker safety risks in healthcare, including workplace violence; patient handling (e.g., lifting); bloodborne pathogens; slips, trips, and falls; and more. This approach can go hand-in-hand with HRO principles and practices.

Almost all successful safety and health management systems include six core elements that are very similar to the elements of a workplace violence prevention program:

Safety and Health Management System Element	Overview	Workplace Violence Prevention Program Element
Management leadership	Managers demonstrate their commitment to improved safety and health, communicate this commitment, and document safety and health performance. They make safety and health a top priority, establish goals and objectives, provide adequate resources and support, and set a good example.	Management commitment and worker participation
Employee participation	Employees, with their distinct knowledge of the workplace, ideally are involved in all aspects of the program. They are encouraged to communicate openly with management and report safety and health concerns.	
Hazard identification and assessment	Processes and procedures are in place to continually identify workplace hazards and evaluate risks. There is an initial assessment of hazards and controls and regular reassessments.	Worksite analysis and hazard identification
Hazard prevention and control	Processes, procedures, and programs are implemented to eliminate or control workplace hazards and achieve safety and health goals and objectives. Progress in implementing controls is tracked.	Hazard prevention and control
Education and training	All employees have education or training on hazard recognition and control and their responsibilities under the program.	Safety and health training
System evaluation and improvement	Processes are established to monitor the system's performance, verify its implementation, identify deficiencies and opportunities for improvement, and take actions needed to improve the system and overall safety and health performance.	Recordkeeping and program evaluation

OSHA's Voluntary Protection Programs (VPP) recognize employers who have achieved excellence in occupational safety and health through adoption of a safety and health management system. Visit www.osha.gov/dcsp/vpp to learn more.

Example: Integrating Workplace Violence into a Comprehensive Safety and Health Management System

Citizens Memorial Hospital/Citizens Memorial Health Care Foundation (CMH) operates six skilled nursing homes, a hospital, and several other healthcare services in southwest Missouri. Nursing homes can pose risks for workplace violence, particularly when caring for patients with Alzheimer's disease and/or other forms of dementia, which can lead to confusion and combativeness. Other significant safety challenges at nursing homes include patient lifting. CMH began to address these issues in 1997 by setting up comprehensive safety and health management systems to drive continual improvement. All six nursing homes became VPP Star worksites and have maintained this recognition ever since.

Each of CMH's nursing homes has an employee-based safety committee that meets monthly, conducts monthly inspections, and reviews incidents. Administrators and managers (including the CEO) go on frequent rounds to build relationships with front-line staff and learn about their concerns, and they encourage employees to report all incidents and near-misses using an electronic system. All staff take a personal safety training course, and workers in the Alzheimer's and dementia special care units and certain other employees take nonviolent crisis intervention training with periodic refreshers. As a result of these efforts, CMH has kept its injury rates consistently below the national average, which is a requirement to maintain VPP Star status. It has also achieved a turnover rate well below the national average in its skilled nursing facilities.[11]

> "Keeping our employees and patients safe is at the core of who we are and what we do at CMH. Focusing on safety means our employees are prepared for the unexpected and our patients receive the high quality care they deserve."
>
> —Donald J. Babb, CEO/Executive Director, Citizens Memorial Health Care Foundation

Resources

- OSHA: Worker Safety in Hospitals (www.osha.gov/dsg/hospitals)—a suite of informational products and tools to help hospitals assess workplace safety needs, implement safety and health management systems, implement workplace violence prevention programs, and enhance their safe patient handling programs. In particular, see *Preventing Workplace Violence: A Road Map for Healthcare Facilities* for a detailed discussion of the core elements of a workplace violence prevention program.
- OSHA: Workplace Violence (www.osha.gov/SLTC/workplaceviolence)—resources related to workplace violence, including OSHA's *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*.
- The Joint Commission: *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation* (www.jointcommission.org/improving_Patient_Worker_Safety).
- The Joint Commission: Patient Safety Systems (www.jointcommission.org/patient_safety_systems_chapter_for_the_hospital_program).
- The Joint Commission: *Quick Safety*, Issue 5, "Preventing Violent and Criminal Events" (www.jointcommission.org/assets/1/23/Quick_Safety_Issue_Five_Aug_2014_FINAL.pdf).
- OSHA: Injury and Illness Prevention Programs (www.osha.gov/dsg/topics/safetyhealth).

This document is advisory in nature and informational in content. It is not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by OSHA standards or the *Occupational Safety and Health Act*.

[11] According to the national average for 2012 from the American Health Care Association's Skilled Nursing Staffing Survey: www.ahcancal.org/research_data/staffing/Documents/2012_Staffing_Report.pdf.

[Additional submissions by Chairwoman Adams follow:]

Workplace Safety and Health: https://www.govinfo.gov/content/pkg/CPRT-116HPRT37460/pdf/CPRT-116HPRT37460.pdf

Occupational Safety and Health Administration Instruction: https://www.govinfo.gov/content/pkg/CPRT-116HPRT37461/pdf/CPRT-116HPRT37461.pdf

Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers: https://www.govinfo.gov/content/pkg/CPRT-116HPRT37462/pdf/CPRT-116HPRT37462.pdf

[Additional submission by Mr. Courtney follows:]

Workplace Safety and Health: https://www.govinfo.gov/content/pkg/CPRT-116HPRT37460/pdf/CPRT-116HPRT37460.pdf

[Questions submitted for the record and their responses follow:]

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March 15, 2019

Ms. Jane Lipscomb, RN, Ph.D.
519 First Street
Annapolis, MD 21403

Dear Dr. Lipscomb

I would like to thank you for testifying at the February 27, 2019, Subcommittee on Workforce Protections hearing on "Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Friday, March 29, 2019, for inclusion in the official hearing record. Your responses should be sent to Jordan Barab of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Subcommittee on Workforce Protections
"Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence"
Wednesday, February 27, 2019

Rep. Alma S. Adams (NC)

1. Mr. Rath testified that "Congress should exercise that prerogative only when the issue to be regulated is fully understood and the remedy is obvious."

   Do you think that workplace violence against health care and social service workers is fully understood? Are the remedies obvious?

2. Would this bill, or an OSHA standard issued under this legislation compromise patients' rights or confidentiality?

3. Can you elaborate on why the General Duty Clause is so burdensome for OSHA to use?

4. Do you agree with Mr. Rath's testimony that "OSHA has relatively limited knowledge and experience in the health care industry."

5. Can you explain how this bill and an OSHA standard would also protect patients?

6. Can you explain how having a violent incident log that would contain information about every incident would help facility administrators and workers prevent future incidents?

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March 15, 2019

Mr. Angelo McClain, Ph.D., LCSW
Chief Executive Officer
National Association of Social Workers
750 First Street, NE, Suite 800
Washington, D.C. 20002

Dear Dr. McClain:

I would like to thank you for testifying at the February 27, 2019, Subcommittee on Workforce Protections hearing on "Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Friday, March 29, 2019, for inclusion in the official hearing record. Your responses should be sent to Jordan Barab of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Subcommittee on Workforce Protections
"Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence"
Wednesday, February 27, 2019

Rep. Alma S. Adams (NC)

1. If this bill is passed and OSHA issues a standard, how would it protect case workers who must go into people's homes? We can't expect people to make changes in their home, can we?

2. Do you think there is sufficient hard evidence to justify an OSHA standard that covers social service workers?

3. NASW has published "Guidelines for Social Service Safety."

   - Do you have any way of tracking how many employers of NASW members have implemented these recommendations?

   - If you find that employers of your members have not implemented these recommendations, do you have any way to enforce them?

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March 15, 2019

Ms. Patricia Moon-Updike
3951A E. Edgerton Avenue
Cudahy, WI 53110

Dear Ms. Moon-Updike:

I would like to thank you for testifying at the February 27, 2019, Subcommittee on Workforce Protections hearing on "Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Friday, March 29, 2019, for inclusion in the official hearing record. Your responses should be sent to Jordan Barab of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Subcommittee on Workforce Protections
"Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence"
Wednesday, February 27, 2019

Rep. Alma S. Adams (NC)

1. When workers were injured in your workplace, did they commonly report their injuries to management? Were they encouraged to report?

2. After workers were injured in your workplace, did management conduct an investigation?

   a. Were workers allowed to participate in that investigation?

   b. Were employees allowed to see the results of the investigation or recommendations?

   c. Were changes made after the investigations?

3. Public employees in your state of Wisconsin and 23 other states are not covered by OSHA, despite the fact that they do the same work as private sector employees and suffer higher rates of injuries in health care institutions. And according to the BLS, state government health care and social service workers were almost 9 times more likely to be injured by an assault than private-sector health care workers in 2017.

   Do you think that all public employees should be covered by OSHA? Why?

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March 15, 2019

Mr. Manesh Rath, J.D.
Partner
Keller and Heckman, LLP
1001 G Street, NW, Suite 500 West
Washington, D.C. 20001

Dear Mr. Rath:

I would like to thank you for testifying at the February 27, 2019, Subcommittee on Workforce Protections hearing on "Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Friday, March 29, 2019, for inclusion in the official hearing record. Your responses should be sent to Jordan Barab of the Committee staff. He can be contacted at the main number 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Subcommittee on Workforce Protections
"Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence"
Wednesday, February 27, 2019

Rep. Alma S. Adams (NC)

1. You stated during the hearing that "OSHA has a number of standards that it has been able to effectively implement in less than two years." Can you name all OSHA standards in the past 20 years that OSHA has been able to issue in less than two years?

Ranking Member Virginia Foxx (NC)

1. Mr. Rath, federal safety and health regulations tend to be very technical, as it takes experts to carefully research and analyze the issue. Would you agree that during OSHA's history, Congress has typically deferred to the agency to prioritize and issue regulations? And why is that?

Q1 – Yes, workplace violence is well recognized and sufficiently understood in the health care and social assistance sectors. The remedy is recognized by both government and professional certifying bodies such as The Joint Commission, namely a comprehensive workplace violence prevention program modeled after the 2015 OSHA Guidelines.

Q2 – In no way would patients' rights or confidentiality be compromised by an OSHA standard on workplace violence. Patient personal health information is not needed to develop and implement a violence prevention program.

Q3 – OSHA's General Duty Clause (GDC) is a burdensome tool to prevent workplace violence in the health care and social assistance workplace because any time OSHA investigates and cites an employer for the hazard of workplace violence under the GDC, OSHA need to meet following elements of the general duty clause violation: 1) whether there was a risk of workplace violence hazard to employees; 2) whether the industry and employer recognized the hazard; 3) whether the hazard was causing or likely to cause death or serious physical harm; and 4) whether the abatement measures specified by OSHA in the Citation would materially reduce the hazard of workplace violence. Whereby a standard would eliminate the need to demonstrate each of these elements are met each time they investigate the hazard.

Q4 – OSHA has a long track record of inspecting and evaluating the health care industry, beginning with inspecting the industry for chemical hazards including waste anesthetic gases and ethylene oxide beginning in the 1980s, blood borne pathogens and musculoskeletal disorders beginning in the 1990s and more recently workplace violence. In 2015, OSHA established a special emphasis program for in-patient health care settings to include the following hazards: Musculoskeletal disorders (MSDs) relating to patient or resident handling, workplace violence (WPV), Bloodborne pathogens (BBP), Tuberculosis (TB), and Slips, trips and falls (STFs). OSHA has a vast amount of experience in the health care sector.

Q5 – This bill and an OSHA standard would also protect and promote patient safety by reducing the risk of violence from patients and visitors who not only assault workers, but also other patients. Health care worker health and safety and patient safety are inextricably linked. When patient violence is left unchecked, patients also suffer the consequences of such assaults both in terms of increased risk of injury and when care is compromised because health care workers become injured and can no longer provide high quality care.

Q6- A required violence incident log would reduce the well-recognized problem of underreporting of incidents of workplace violence. A more complete reporting and analysis of incidents of workplace violence would allow health care organizations to understand the magnitude of the problem in their workplace and identify risk factors for violence that could then be prevented by the implementation of appropriate hazard controls.

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Responses to Questions for the Record
From the National Association of Social Workers
March 29, 2019

1. **If this bill is passed and OSHA issues a standard, how would it protect case workers who must go into people's homes? We can't expect people to make changes in their home, can we?**

   The standard would be instrumental in mitigating risks and improving safety for social services workers whose workplace includes the homes of clients and other setting outside the walls of their employer organization. Measures such as "buddy systems", GPS tracking systems, escorts and pre-visit assessments to identify and address potential threats would be required to be instituted.

   We cannot expect clients to make changes to their home. That is why it is essential that workplaces have in place effective home visit safety measures such as those listed above.

2. **Do you think there is sufficient hard evidence to justify an OSHA standard that covers social service workers?**

   Yes, we believe there is ample and growing evidence to justify such a standard. This includes evidence provided to Congress in the 2016 GAO report, "Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence", as well as surveys and other research which we cited in our written testimony.

   Further justification for H.R. 1309 is the fact that it is essential that settings providing social services be healing environments. When a client harms a social worker or other professional in these environments, it is traumatizing for the client, not just the person they harmed. This experience disrupts the therapeutic process and can set back progress by months if not years. Clients witnessing violence are also traumatized, which impedes their progress. Through common sense safety measures, workplaces can reduce or eliminate this primary and secondary trauma, resulting in better outcomes not just for clients but also for the larger community.

3. **NASW has published "Guidelines for Social Worker Safety in the Workplace".**

   a. **Do you have any way of tracking how many employers of NASW members have implemented these recommendations?**

No. While we know anecdotally that many workplaces are following all or part of these guidelines and that social workers find them very helpful, NASW does not have the ability to track implementation, beyond gathering anecdotal accounts or conducting surveys of member social workers.

   b. **If you find that employers of your members have not implemented these recommendations, do you have any way to enforce them?**

No. NASW is a voluntary membership 501(C)6 trade association representing individual social workers, not organizations, and is not in the position enforce its guidelines or standards. We rely on the federal government and state governments, including regulatory agencies, to institute enforceable safety frameworks to protect social workers, especially those employed by public agencies.

Wisconsin Federation of Nurses & Health Professionals AFT, AFL-CIO
A Union of Professionals

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March 27, 2019

The Honorable Robert C. Scott
Chairman
Committee on Education and Labor
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

The Honorable Alma S. Adams
Chairwoman
Subcommittee on Workforce Protections
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

Dear Representative Scott and Representative Adams:

Thank you for the opportunity to testify before the Subcommittee on Workforce Protections during the February 27 hearing, Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence and for the opportunity to add to the record. My responses to additional questions are below.

1. When workers were injured in your workplace, did they commonly report their injuries to management?
   During my time at Milwaukee County Behavioral Health Division, I witnessed nurses being kicked, slapped, and verbally abused by patients. It was not common to report these incidents. This treatment by patients was part of the culture and was accepted as being a part of the job. The unspoken assumption was that if you were assaulted, you had not moved out of the way fast enough.

   Were they encouraged to report?
   I was not aware of any encouragement to report these incidences. The culture of this facility was that risk of injury was assumed to be inherently part of the job due to the population of patients. Also, there was a fear that if you complained or reported incidences too frequently, it would appear that you were "weak" or "not able to do your job," so you just said nothing.

2. After workers were injured in your workplace, did management conduct an investigation?
   a. Were workers allowed to participate in that investigation?
   b. Were employees allowed to see the results of the investigation or recommendations?
   c. Were changes made after the investigations?

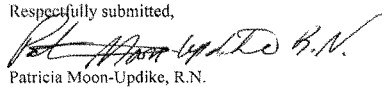
I am not aware of any investigation of my assault. I was only asked for my account of events for Workers Compensation management purposes. I have no knowledge of any investigations of incidents of workplace violence with or without workers' participation or review of the findings. Wisconsin's Act 10, which placed limited on public employees' collective bargaining rights also precluded the union from participating in an investigation.

3. Public employees in your state of Wisconsin and 23 other states are not covered by OSHA, despite the fact that they do the same work as private sector employees and suffer higher rates of injuries in health care institutions. And, according to BLS, state government health care and social service workers were almost nine times more likely to be injured by an assault than private-sector healthcare workers in 2017. Do you think that all public employees should be covered by OSHA? Why?

   I absolutely I feel that ALL workers should be covered by OSHA. When there is lack of oversight, there is a lack of accountability. There was no state agency responsible for protecting workers at my facility and that is still the case today. Workers were and are still getting hurt—and no one knows about it. There are no safety protocols in place and the employer has no incentive to implement them, or even record assaults. How can healthcare employees trust that a self-governing, bottom-line obsessed, patient satisfaction-oriented facility has the employees' lives as a priority if not directly being overseen by OSHA to do so?

   All workers deserve workplace safety protection. State and local public employees do some very difficult and dangerous jobs, including working in jails and prisons and caring for forensic patients (persons found unfit to be tried for a crime or found not guilty due to mental illness) in state psychiatric hospitals. These workers face risks that are generally not found in the private sector. They deserve protection from OSHA.

Respectfully submitted,



Patricia Moon-Updike, R.N.

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March 29, 2019

Via Electronic Mail

Chairman Robert C. "Bobby" Scott
Committee on Education and Labor
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515

Re: Responses to Questions from Subcommittee on Workforce Protections Hearing on "Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence"

Dear Chairman Scott:

Thank you again for the opportunity to testify at the February 27, 2019, Subcommittee on Workforce Protections hearing on "Caring for Our Caregivers: Protecting Health Care and Social Service Workers from Workplace Violence."

Enclosed please find my responses to additional questions submitted by the Subcommittee members following the hearing.

Respectfully,

Manesh K. Rath

Enclosure

Rep. Alma S. Adams (NC)

Question: You stated during the hearing that "OSHA has a number of standards it has been able to effectively implement in less than two years." Can you name all OSHA standards in the past 20 years that OSHA has been able to issue in less than two years?

Answer: Below please find a list of U.S. Occupational Safety and Health Administration (OSHA) standards that, over the last 20 years (1999-2019), were promulgated within two years from the date on which OSHA published a Notice of Proposed Rulemaking (NPRM). This is an appropriate method of measurement because the following existing materials, and other available materials, should place OSHA in approximately the same position:

(1) The 2015 "Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers" published by the Occupational Safety and Health Administration of the Department of Labor in 2015;
(2) The materials OSHA has developed for the SBREFA panel on this topic;
(3) The BLS Database;
(4) The 2016 GAO report entitled, "Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence";
(5) The existing California standard and the materials from that rulemaking, which OSHA should place in its docket.

The proposed OSHA standard before this Subcommittee is not a comprehensive health standard that requires complex and extensive analysis and modeling of human and animal data to develop and justify a permissible exposure limit.

We note that our response does not include Direct Final Rules, which are expedited rulemakings that go into effect if the agency does not receive significant adverse comments within a specified period. Our response also does not include technical amendments to standards.

1. Occupational Exposure to Beryllium:
   NPRM released August 7, 2015. Final rule published January 9, 2017.
2. Commercial Driving Operations:
   NPRM released January 10, 2003. Final rule published February 17, 2004.
3. Cranes and Derricks in Construction:
   NPRM released October 9, 2008. Final rule published August 9, 2010.
4. Cranes and Derricks in Construction: Revising the Exemption for Digger Derricks:
   NPRM released November 9, 2012. Final Rule released May 29, 2013.
5. Dipping and Coating Operations:
   NPRM released April 7, 1998. Final Rule released March 23, 1999.
6. Updating OSHA Standards Based on National Consensus Standards: Eye and Face Protection:
   NPRM released March 13, 2015. Final Rule released March 25, 2016.

7. Occupational Exposure to Hexavalent Chromium:
   NPRM released October 4, 2004. Final rule released February 28, 2006.
8. Safety Standards for Signs, Signals, and Barricades:
   NPRM released April 15, 2002. Final rule published September 12, 2002.
9. Nationally Recognized Testing Laboratories – Fees:
   NPRM released August 18, 1999. Final rule published July 31, 2000.

Ranking Member Virginia Foxx (NC)

Question: Mr. Rath, federal safety and health regulations tend to be very technical, as it takes experts to carefully research and analyze the issue. Would you agree that during OSHA's history, Congress has typically deferred to the agency to prioritize and issue regulations? And why is that?

Answer: Yes, it has been our experience that Congress has deferred to OSHA to prioritize areas for regulation and determine the appropriate content of its rules because:

(1) OSHA is tasked with gathering the best available information, through BLS data and inspections, as to what hazards are causing or contributing to the most significant harm to employees, in terms of frequency and severity;
(2) OSHA is better positioned to make a preliminary determination as to whether a standard is the most appropriate intervention and, if so, to determine the appropriate content of a cost-effective rule to address the hazard without being unduly influenced by current headlines or political pressures;
(3) OSHA, through the SBREFA and traditional rulemaking process, is in a better position to provide stakeholders with an understanding of the contemplated rule and a meaningful opportunity to participate in the development of the rule by educating the agency and other stakeholders on the technical, economic and public policy issues raised by the initiative.

When enacting the Occupational Safety and Health Act, Congress also recognized that OSHA would develop, through the inspections and monitoring of injury and illness data, a sense of impending regulatory priorities and potential hazards. Congress also expected OSHA to work with industry and labor cooperatively to develop practices and standards to advance workplace safety. This rulemaking process should be a regulatory function that incorporates stakeholder contributions in a manner that is free from political process.

OSHA can develop standards on its own initiative, or through its advisory committees that develop specific recommendations that represent management, labor, and state agencies. These advisory committees include the National Advisory Committee on Occupational Safety and Health (NACOSH) and the Advisory Committee on Construction Safety and Health.[1]

[1] See https://www.osha.gov/OCIS/stand_dev.html/

OSHA also consults with the Small Business Administration and the Office of Management and Budget when required by the Small Business Regulatory Enforcement and Fairness Act (SBREFA).

Additionally, OSHA can set standards based on recommendations from the National Institute for Occupational Safety and Health (NIOSH). Congress created NIOSH as a research agency "focused on the study of worker safety and health…NIOSH has more than 1,300 employees from a diverse set of fields including epidemiology, medicine, nursing, industrial hygiene, safety, psychology, chemistry, statistics, economics, and many branches of engineering."[2] Congress contemplated that NIOSH would develop a better understanding of occupational safety and health issues, experimental programs, research, funding, and resources to recommend new or improved occupational safety and health standards.[3]

Overall, OSHA has the authority, delegated by Congress, as well as access to these valuable resources, data, and stakeholder expertise to inform the agency on how to best craft appropriate standards and set priorities.

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[2] https://www.cdc.gov/niosh/about/default.html.
[3] 29 U.S.C. 671(d).

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[Whereupon, at 5:04 p.m., the subcommittee was adjourned.]