

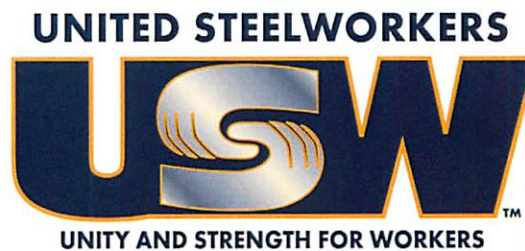
Labor Organizations Petitioning the U.S. Department of Labor for an
OSHA Workplace Violence Prevention Standard
for Healthcare and Social Assistance



A Union of Professionals

AFL-CIO

AMERICA'S UNIONS



July 12, 2016

The Honorable Thomas E. Perez
U.S. Secretary of Labor
200 Constitution Ave. N.W.
Washington, DC 20210

RE: Petition for an OSHA Workplace Violence Standard to Protect Workers in Healthcare
and Social Assistance

Dear Secretary Perez:

We write to petition the Department of Labor to promulgate a comprehensive workplace violence prevention standard to protect all workers in healthcare and social service settings under Section 6(b) of the Occupational Safety and Health Act. Overwhelming evidence demonstrates that every day, workers in these sectors face threats and assaults that are preventable, many suffering severe, often career-ending, injuries.

Although the Occupational Safety and Health Administration (OSHA) provides employers with guidance and resources for employers explaining how to develop comprehensive workplace violence prevention programs, these voluntary measures are inadequate to protect workers from work-related violence. The Department should act without delay to develop and issue a workplace violence standard for healthcare and social service settings.

OSHA has long recognized that healthcare and social service workers face significant risks of job-related violence, publishing its first *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* in 1996. Workers in these sectors alone suffered 52 percent of all the incidents of workplace violence reported to the Bureau of Labor Statistics (BLS) in 2014 and are twice as likely to suffer a workplace violence injury as other occupations. Workplace violence injury rates for state government workers in healthcare and social assistance were nearly 10 times higher than the private sector in 2014.

The problem has grown progressively worse. According to BLS, private sector injury rates of workplace violence in healthcare and social assistance increased 64 percent between 2005 and 2014; specifically, 110 percent in private hospitals and 102 percent in private psychiatric and substance abuse hospitals. Although OSHA has updated the guidance twice and issued an enforcement directive in 2011, healthcare and social assistance workers remain largely unprotected under the General Duty Clause of the Occupational Safety and Health Act.

Over the years, OSHA has used its authority under Section 5(a)(1) of the Occupational Safety and Health Act, the General Duty Clause, to cite employers for allowing a high-risk environment for violence on the job. The Agency has successfully brought forward major cases, citing employers for failing to provide a workplace free from recognized hazards, and for failing to implement simple control measures that would

prevent and minimize attacks. Sadly, many of these cases have only been brought to light after a worker has been killed or maimed. Relying solely on the General Duty Clause limits OSHA's abilities to enforce against a well-recognized hazard to require employers to implement preventive measures and to provide employers with a set of standard expectations to protect against violence at work. Voluntary guidelines and enforcement under the General Duty Clause have not led to the widespread adoption of preventive measures that are needed to protect healthcare and social service workers against violence at work.

A number of states have taken action to adopt laws to prevent workplace violence. New York is currently the only state with a comprehensive workplace violence standard, covering the public sector. Later this year, California is expected to issue comprehensive workplace violence prevention regulations for healthcare settings, spurred by the unions representing healthcare workers in that state. Connecticut, Illinois, Maine, Maryland, New Jersey, Oregon and Washington have passed laws requiring healthcare employers to implement prevention programs.

These actions have been insufficient to protect workers. Workplace violence remains a serious, significant and worsening problem. Workers are brutally attacked every day. These attacks should not be viewed as "just part of the job"; they are preventable. We therefore petition the Department of Labor for a workplace violence standard to protect all workers in the large and growing healthcare and social services sectors. Below, we document that workplace violence is a significant and serious hazard; show that it is recognized by the industry; demonstrate evidence of feasible abatement; and lay out the elements of a program standard.

Workplace Violence Is a Significant and Serious Hazard

Workplace violence in the healthcare and social assistance sectors has been described as ubiquitous, persistent and underreported, a problem that is tolerated and largely ignored.¹ The Joint Commission notes that hospitals were once considered safe havens, but now are facing "steadily increasing rates of crime, including violent crimes such as assault, rape, and homicide."² Social workers and others who provide mental health case management and nursing care in the community work in higher peril than in the past due to de-institutionalization and reliance on outpatient services.³ Although evidence of the frequency and severity of the problem has mounted over the years, employers have been reluctant to implement comprehensive prevention programs. More than 80 percent of U.S. employers report no change in their workplace violence prevention programming after a significant violent event, even though 35 percent cite negative effects such as increased absenteeism and reduced productivity.⁴

Type 2 workplace violence, whereby the perpetrator is a patient, client or visitor attacking a staff person, is the most common form of workplace violence in healthcare and social assistance.^a Type 2 incidents

^aType 1 violence means workplace violence committed by a person who has no legitimate business at the worksite, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.

Type 2 violence means workplace violence directed at employees by customers, clients, patients, students, inmates or any others for whom an organization provides services.

Type 3 violence means workplace violence against an employee by a current or former employee, supervisor or manager.

represented 75 percent of aggravated assaults and 93 percent of all assaults against employees in a small 2014 survey.⁵ Workers who care for patients or clients whose mental status is impaired through dementia or delirium, substance intoxication or decompensated mental illness face the highest risk.⁶ Social work and nursing caseworkers and managers who provide care during home visits face hazards related to the home environment as well as the mental status of the client or patient, including unsafe neighborhoods, the presence of weapons, drugs, hostile family members or pets.⁷ Working in isolation, whether in a homecare setting or within an institution, puts workers at risk for workplace violence. Inadequate staffing also increases the likelihood of violence.⁸ For example, patients and their families can become frustrated by long waits and perceived lack of caring by staff. Likewise, providers caring for too many patients or clients at once may fail to notice early signs of escalating behavior or may be unable to control an escalating situation without assistance from other staff.

According to BLS, there were 13 fatal assaults in healthcare and social assistance in 2014, a stark reminder of the gravity of this hazard.⁹ Between 2000 and 2011, there were 154 shootings with injury (fatalities and non-fatalities) either inside or on the grounds of American hospitals.¹⁰ A partial list of healthcare and mental health providers who were murdered in the course of duty is attached in Appendix A, page 18.

Thousands more workers were seriously injured from attacks on the job, resulting in lost time, restricted duty or medical care beyond first aid—statistics that remain persistently high. Between 2011 and 2013, the number of workplace assaults averaged 24,000 annually, and nearly 75 percent of those occurred in healthcare and social assistance settings.¹¹

In 2014, the rate of injuries from workplace violence in healthcare and social assistance settings was 14.4 per 10,000 full-time workers in the private sector. The rate was 19 for local government workers. For state workers, the rate was an incredible 135—nearly 10 times that of the private sector and 20 times the rate for the private, state and local government workforce as a whole. For people with occupations that put them in frequent and close physical proximity to patients and clients, the numbers are astronomical. State psychiatric aides experience a rate of 64 injuries per 10,000 workers. The rate for psychiatric technicians is 383, and the rate for healthcare support technicians is 255.

It is widely acknowledged that the injuries reported by BLS, which come from employer reports, are but the tip of the iceberg. The actual number of reportable injuries is as much as three times higher according to one study.¹² In a survey of two large forensic psychiatric hospitals in Washington State, 85 percent of the incidents were not reported.¹³ Reporting may be even lower in geriatric facilities. In one small study of certified nurse assistants in nursing homes, 95 percent of the assaults went unreported.¹⁴

Underreporting is common among the healthcare and social service workers who are members of our unions. They describe impediments to reporting that are corroborated by research. Sometimes workers do not report because the perpetrator's judgment was compromised due to dementia, delirium, mental illness or substance abuse. They do not blame the patient or client; or they feel that the perpetrator cannot be held accountable for an assault. Indeed, many patients in forensic psychiatric hospitals are labeled "not

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. (University of Iowa, 2001)

criminally responsible,” and staff persons perceive pressing charges against these patients to be a waste of their time. Other workers fail to report threats and assaults because they believe management will not respond to the report.¹⁵ At best, they think nothing will be changed; at worst, they think they will be blamed for the incident.

In some cases, employers discourage reporting by making the process time-consuming and onerous. Workers recount lengthy reporting forms that must be completed before the victim can go to the emergency department for treatment. Other members have informed us of hospital policy requiring them to report to the emergency department for treatment, no matter the need, effectively preventing all but the most acute assaults from being reported.

Some healthcare and social services employers claim that federal or state patient safety regulations prevent them from developing controls to protect workers from patient assaults, even telling employees that they (the workers) are obligated to use their bodies to shield patients from harming one another. Other employers actively discourage workers from pressing charges against the perpetrator, citing the effect it would have on the reputation of the facility. The current emphasis on patient satisfaction also affects reporting, as managers are encouraged to keep patients happy, even if they are combative or seeking drugs.¹⁶ Lastly, the perception among workers, managers, and even the public that violence is “part of the job” persists and justifies a lack of action that could prevent many injuries and reduce the acuity of many others.

Many healthcare and social assistance workers experience workplace violence on a routine basis. In a 2013 review of 17 studies of (non-psychiatric) hospital-based workplace violence, employees reported whether they had experienced verbal abuse, physical threats or physical assaults in the previous 12 months. Verbal abuse was experienced by 22 to 90 percent of the participants; physical threats were made to 12 to 64 percent of the participants; and 2 to 32 percent had been physically assaulted in the previous 12 months.¹⁷ In a study of 500 clinical psychologists, 81 percent reported at least one incident of verbal abuse, harassment or physical attack.¹⁸

Much of the academic research has focused on settings with the highest frequency and acuity of assaults, particularly hospital emergency and psychiatric departments, psychiatric hospitals and home health settings. Emergency department nurses reported very high rates, with 100 percent reporting verbal assault and 82 percent reporting physical assault in the previous 12 months.¹⁹ Approximately one-quarter of emergency room physicians reported physical assault in the previous year.²⁰ In a survey of all staff members at a forensic psychiatric hospital, the annual incidence of verbal abuse was 99 percent and physical assault was 70 percent.²¹ The percentage of home health workers reporting workplace violence in the previous year was 61 percent.²² The OSHA *Guidelines* note that facilities for drug treatment and those for the long-term care of people with cognitive impairment or dementia are also high-risk settings.

Although not as well documented, workplace violence does occur in other healthcare settings. In a 2014 retrospective survey of emergency services personnel, 80 percent had experienced physical violence during the course of their careers. In a study of more than 6,000 nurses (the Minnesota Nurses’ Study), the annual incidence of verbal and physical assaults was 39 percent and 13 percent respectively.²³ In

another study, one-third of pediatric residents reported being assaulted by patients or their families during their training.²⁴

These statistics do not describe the impact on workers who survive these incidents. We have interviewed scores of our members who have experienced workplace violence and continue to do their jobs in spite of the lack of protections. Their accounts include gun incidents and stabbings, people being thrown against walls, traumatic brain injuries, dislocated jaws and broken hips. They include people who have lost their careers and livelihood due to disabling injuries. Some have forever lost their health and sense of well-being, suffering from post-traumatic stress disorder. And some have lost their lives.

See Appendix B for a bibliography, page 22.

OSHA's Current Efforts Are Insufficient to Protect Workers

OSHA has recognized workplace violence as a serious safety and health problem for decades, and has taken a range of actions to address the problem. As noted, the Agency issued its first guidelines on workplace violence for healthcare and social service settings in 1996, which since have been updated twice. OSHA also has utilized its authority under the General Duty Clause to seek abatement of workplace violence hazards. But these efforts have been limited. Indeed, a search of the OSHA enforcement database finds that OSHA has issued approximately 45 citations under the General Duty Clause for workplace violence hazards, with the first citations issued in 1993.²⁵

In March 2016, in response to a congressional request, the Government Accountability Office (GAO) published a report on workplace violence in healthcare that evaluated the extent of the problem and OSHA's efforts to address it. After examining the three available federal data sets, surveying the published literature, and holding focus groups with healthcare workers, the GAO concluded that OSHA must do more to protect these workers. The report notes that OSHA has increased its enforcement efforts through the 2011 directive and National Emphasis Program and has provided more training for compliance officers. Approximately 65 percent of the inspections of healthcare facilities for workplace violence that OSHA conducted between 1991 and April 2015 took place between 2012 and 2014.

However, the GAO found that enforcement has been inconsistent and often dependent on the region. Three of the regions conducted 60 percent of the inspections, meaning that huge numbers of healthcare workers have not benefited from additional General Duty Clause inspections.²⁶ Moreover, only 5 percent (18 out of 344) of the inspections conducted in healthcare facilities between 1991 and early 2015 resulted in a General Duty Clause citation.²⁷

OSHA officials interviewed for the report acknowledged the potential benefits of having a specific workplace violence standard. These include "setting clearer expectations for employers, increasing employer implementation of workplace violence prevention programs, and simplifying the process for determining when citations could be issued."²⁸ The bar for issuing a citation under the scope of the General Duty Clause is very high. Citations occur too infrequently to act as an adequate deterrent for employers.

Industry Recognizes Workplace Violence as a Serious Problem

Recognition of the severity of workplace violence in healthcare and social assistance settings is amply documented by the number of professional associations and employers that have addressed the issue through position statements, decisions to support additional research, provision of guidelines or other resources for their members, and employer policies.

The following professional associations have issued position statements acknowledging that workplace violence is a significant problem for their members and have called for prevention programs:

- American Association of Critical-Care Nurses
- American Association of Occupational Health Nurses
- American Industrial Hygiene Association
- American Nurses Association
- American Psychiatric Nurses Association
- American Public Health Association
- ASIS International (association for security professionals)
- Emergency Nurses Association
- International Association for Healthcare Security and Safety
- Society of Trauma Nurses
- Society for Human Resource Management

The following professional associations have provided resources for their members or have demonstrated support for the prevention of workplace violence:

- American Hospital Association (provides a link to OSHA's toolkit, *Preventing Workplace Violence: A Road Map for Healthcare Facilities*)
- American Medical Association (voted in support of prevention research)
- American Organization of Nurse Executives (provides guiding principles and resources)
- American Psychological Association (provides resources)
- Joint Commission (chapter in 2012 monograph, *Improving Patient and Worker Safety*)
- National Association of Social Workers (provides guidelines)

The Joint Commission's inclusion of workplace violence and discussion of violence prevention methods in its monograph *Improving Patient and Worker Safety* is significant due to the agency's position of authority in the healthcare industry. The Joint Commission certifies more than 20,000 U.S. healthcare organizations and programs. The fact that the Joint Commission has advised these organizations on workplace violence prevention demonstrates that the industry recognizes it as a hazard.

Moreover, the Joint Commission profiled three employers' workplace violence prevention programs as case studies in the monograph.²⁹ They include Lemuel Shattuck Hospital in Jamaica Plain, Mass.; Atlantic Health System in Morristown, N.J.; and the Veterans Health Administration. The VHA's efforts to deal with workplace violence are among the best known; the VHA began to address workplace violence in the late 1970s. The VHA's efforts include a thorough training program, an electronic medical records flagging system to alert all providers of patients with histories of violent behavior, and a national injury database.³⁰

Several other public and private employers have investigated or implemented workplace violence policies or prevention programs, demonstrating industry recognition. They include standards or policies developed by:

Colorado Home Health Care
Los Angeles County Department of Mental Health
MCGHealth Inc.
Mohawk Valley (New York) Psychiatric Center
New York State Office of Mental Health
Public Children Services Association of Ohio
Visiting Nurse Service of New York

They also include a report produced or commissioned by Massachusetts, *Protecting Our Caregivers from Workplace Violence*.³¹

There Are Reasonable and Feasible Solutions to Reduce Exposure to Workplace Violence

The workplace policies, practices and programs recommended by professional associations and industry groups and adopted by employers also demonstrate that there are reasonable and feasible solutions to reduce and minimize exposure to workplace violence in healthcare and social service settings. Like the *OSHA Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, many of these are based upon the establishment of a written program, which sets out policies, employer responsibilities and roles for workers, as well as providing for hazard assessment and risk evaluation, correction of hazards, post-incidence response, incident reporting and training. Security, staffing, job design and patient-specific risk factors are major factors to be addressed.

Research studies have confirmed that such policies and interventions are effective in reducing exposures and assaults. The GAO identified four quantitative peer-reviewed studies showing effective interventions against workplace violence:

- In a 2002 study of VHA hospitals, facility-wide implementation of alternate dispute resolution training was associated with reduced assault rates.³²
- In a study of VHA hospitals, implementation of a comprehensive workplace violence prevention program at 138 VHA healthcare facilities was associated with a reduction in assault rates from 2004 through 2009. The prevention program included assessing staff training needs and providing ongoing training on management of disruptive behavior, as well as workplace practices, environmental controls and security.³³
- In a third study of the VHA system, researchers described committee processes the agency uses to identify and flag disruptive patients. They surveyed chiefs of staff at 140 VHA hospitals. Facilities where chiefs of staff perceived the committee to be effective were associated with a reduction in assault rates. Executives who rated their committees as “very effective” worked at the facilities that experienced a significant reduction in rates from 2009 to 2010.³⁴

- In a 2010-11 study of emergency departments, researchers surveyed workers monthly for 18 months. A comprehensive workplace violence prevention program was implemented in three emergency departments, and three others served as control groups. Workers in both groups reported reductions in assaults. However, at the facility level, two of the emergency departments in the intervention group had a significant decrease in violence, which did not happen at any of the control locations.³⁵

An ongoing study in six Michigan hospitals by Judith Arnetz³⁶ and colleagues demonstrates that healthcare employers can use surveillance data to develop effective programmatic strategies, identifying areas of greatest risk and evaluating the impact of interventions. Using a centralized reporting system and database, the hospitals have been able to find trends and allocate resources to better target high-risk locations and job titles.

OSHA has highlighted examples of healthcare employers that have developed effective comprehensive workplace violence prevention programs: St. Agnes Hospital in Baltimore, Md.; St. John Medical Center in Tulsa, Okla.; and Providence Behavioral Health Hospital in Holyoke, Mass. have developed programs based on OSHA's guidelines, including management commitment and worker participation, reporting systems, ongoing assessment and solution-driven adaptations.³⁷

Moreover, OSHA has regularly prescribed or recommended the implementation of comprehensive workplace violence programs and/or specific control measures in General Duty citations and hazard alert letters as part of its enforcement activities, demonstrating that such abatement measures are appropriate and feasible. (Appendix C is a list of many General Duty Clause citations and hazard alert letters on workplace violence from OSHA to various employers, page 25).

Recommendations for a Comprehensive OSHA Workplace Violence Prevention Standard

Definition

We recommend that "workplace violence" be defined as proposed by the California Division of Occupational Safety and Health (Cal/OSHA) for its pending standard (8CCR§3342):

The term "workplace violence" means any act of violence or threat of violence that occurs at the worksite. Workplace violence includes the following:

- (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:*

"Type 1 violence" means workplace violence committed by a person who has no legitimate business at the worksite, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.

"Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.

"Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor or manager.

"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.

We recommend this definition because it is comprehensive and provides clarity. It includes any act or threat of violence, including those that do not result in injury. Any incident that includes the use of a weapon is defined as workplace violence, regardless of whether the weapon was deployed. It describes the typology of injuries, providing clarity on the sources and possible solutions for different kinds of workplace violence.

Scope

This petition is being filed under Section 6(b) of the Occupational Safety and Health Act, Public Law 91-596 84 STAT. 1590 91st Congress, S.2193 December 29, 1970, as amended through January 1, 2004, empowering the Secretary of Labor to promulgate new standards.

A workplace violence standard should cover all workers in the healthcare and social assistance industries, sectors that employ roughly 15 million people and are projected to expand 21 percent by 2024 as the baby boomer generation ages. As of 2014, approximately 2.5 million people worked in community and social services, 8.2 million worked as healthcare practitioners and technologists, and 4.2 million people were employed in healthcare support positions. BLS reports that by 2024, healthcare and social services together will add more jobs than all other sectors combined.³⁸ Many more people are employed in healthcare in positions not directly related to patient care, such as food and custodial services workers.

OSHA's *Guidelines* list the workplace settings that should be covered under the standard, broadly grouped as—

- Hospitals: general, specialty, psychiatric;
- Residential treatment institutions: long-term care and rehabilitation facilities, including nursing homes, assisted living facilities, residential facilities for persons with disabilities or for those in addiction treatment;
- Non-residential treatment/service agencies: clinics, mental health agencies, outpatient drug treatment centers, child protective service agencies; pharmacies;

- Community care mental health treatment centers: community-based group homes or residential programs; and
- Field work agencies: public and private agencies that provide care and case management in patients' or clients' homes or community, including in-home nursing care, mental health case management and counseling.

Elements of a Comprehensive OSHA Workplace Violence Prevention Standard

OSHA has many models to draw upon in the development of a standard, including its own guidelines; the New York State Public Employer Workplace Violence Programs (Code Rule 800.6), the pending Cal/OSHA standard (8CCR§3342), and the Veterans Administration. OSHA's Bloodborne Pathogen Standard is an example of a program standard that has successfully reduced workers' exposure to a dangerous hazard.³⁹

The responsibilities for complying with all aspects of the standard should remain with the employer. Among other elements, a workplace violence standard should require the following:

1. A Written Workplace Violence Prevention Program

Employers should be required to develop, implement and maintain a written workplace violence prevention program no later than six months following promulgation of the standard. The written program should be implemented and maintained at all times in all units, departments and physical spaces, including, but not limited to, satellite locations, parking areas and walkways. The program must be available and accessible to workers at all times. It must be available in paper and/or electronic format to OSHA compliance officers, former workers, and workers' representatives.

Development of and ongoing revision to the written program must be completed by a workplace violence prevention committee at the workplace. The makeup of the committee must be representative of a variety of departments or units, job classifications and shifts to adequately capture the different hazards associated with each.

The written program should include at a minimum:

- a. Procedures to be followed during the hazard assessment and evaluation determination;
- b. Details of the identified risks and results of the hazard determination;
- c. Procedures followed to select hazard control measures, following the hierarchy of controls;
- d. Controls the employer will put in place to eliminate or reduce worker exposure to workplace violence hazards;
- e. The system by which incidents of violence are reported and recorded;
- f. Details of employee training requirements, including mandatory topics and methods for providing training and evaluation of training effectiveness;
- g. Post-incident medical removal and assistance for workers who are assaulted or injured;
- h. Methods to investigate work-related incidents of violence;
- i. A plan to evaluate and update the program at least annually at the department, unit, facility and corporate level;

- j. A policy that prohibits the employer or any employer representative from taking retaliatory action toward an employee for seeking assistance from law enforcement or emergency services when a violent incident occurs; and
- k. The name of a competent person, by experience and training, in charge of the employer's plan.

The written program should include procedures by which the healthcare facility employer will coordinate implementation with other employers/subcontractors who employ workers within the facility, including, but not limited to, outsourced security departments and their employees. The written program must include specific procedures to guarantee the active involvement of frontline workers and their representatives.

The written program also should include procedures to review the effectiveness of the written program at least annually, and in conjunction with employees regarding their respective units, work areas, services or operations. The review shall include an evaluation of all components of the program, such as hazard assessment and hazard control measures. All components of the program, including engineering and administrative controls and training, must be evaluated at least annually. The written program must be updated at least annually. Evidence of implementation of updates must be shown.

Evidence of implementation of the written program must be made available and accessible to workers and their representatives. Such evidence may include minutes of the workplace violence prevention committee, incident investigation reports, assessments of risk and evaluation of controls, updates to the written program, worker questionnaires, or interviews with workers.

2. Hazard Assessment/Risk Evaluation and Determination

The written program should include procedures for hazard assessment and risk evaluation and determination for workplace violence in covered healthcare facilities and social assistance organizations. This should include, but not be limited to, a hazard assessment that is unit or department specific and covers all hours of operation and all physical locations. These procedures should include assessment, at least annually, of factors that may contribute to or help prevent workplace violence. These factors should include, but not be limited to, the following:

- a. Analysis of relevant data sources, including OSHA 300 logs, workers' compensation insurance reports, incident reports, police reports, site inspections and incident investigations. Analysis of data sources may be conducted on an ongoing basis, provided that all areas of the facility or business, such as units, departments, shifts or satellite locations are analyzed at least annually.
- b. Staffing, including staffing patterns and patient/client classification systems that contribute to, or are insufficient to address, the risk of violence;

- c. The sufficiency of security systems, including alarms, emergency response, and availability of security personnel;
- d. Job design, equipment and facilities;
- e. Environmental risk factors in each unit or work area and in each area of the facility, including areas surrounding the facility, as well as risk factors in field assignments; and
- f. Patient-specific risk factors, including a patient's mental status, treatment and medication status, history of violence as known to the facility, and any other conditions that may cause the patient to be nonresponsive to instruction or to behave unpredictably.

3. Hazard Correction

The written program should include procedures for the selection and implementation, in a timely manner, of corrective measures to prevent workplace violence. Locations, departments, units, shifts or job titles with high frequency or a history of high acuity must be identified. Employers must be required to use the hierarchy of controls to eliminate or mitigate each specific hazard. We recommend that OSHA provide examples of successful engineering and administrative controls. These controls should include, but not be limited to, the following:

- a. Maintaining sufficient numbers of trained staff, including security personnel, who are 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. Configuring facility spaces so that employee access to doors and alarm systems cannot be impeded, so that employees can maintain line of sight or other immediate communication in all areas where patients or members of the public may be present, and so that furnishings and other objects cannot be used as improvised weapons;
- c. Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility;
- d. Creating effective means by which employees can summon security and other aid and be alerted to the presence, location and nature of a security threat; and
- e. 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.

4. Post-Incident Response

The written program should include procedures for response following a workplace violence incident. These procedures should require providing immediate medical care or first aid to employees who have been injured in the incident. Individual trauma counseling should be offered to all employees affected by the incident, regardless of whether a physical injury occurred. The post-incident response should include procedures to review whether appropriate corrective measures developed under the written program were effectively implemented. The opinion of the injured employee and other personnel involved should be solicited regarding the cause of the incident and whether any measure would have prevented the injury.

5. Incident Reporting System and Record Keeping

The written program should include an incident reporting system to record all incidents of workplace violence, whether or not incidents result in injury. Incident report forms should capture: the names of victims, witnesses and perpetrator(s); job title(s) of the victim(s); time, date and location of the incident; a description of the incident and the events leading up to it; and related factors, such as staffing level or activities contributing to the event. Affected employees should be given an opportunity to fill out a section of the form pertaining to their own experience of the incident. Ease of use for the person who is reporting should be taken into consideration.

All staff should be trained to report all incidents of workplace violence, including threats, verbal abuse, combative behavior resulting in injury, assaults and “near misses.” There should be no retaliation for reporting incidents of workplace violence.

6. Training

The employer should provide workplace violence prevention training for all employees, contract workers and temporary staff. Training of new staff should be provided no later than 30 days following their start date. Training must be provided at least annually, when conditions change, when hazards are newly identified, and when requested by an employee. Training must include an opportunity for interactive questions and answers with a person knowledgeable about workplace violence prevention and the employer’s written program.

Training must, at minimum, address:

- a. The existence and location of the workplace violence prevention program;
- b. The workplace violence hazards identified in the facility and in each unit, work area, service or operation;
- c. Policies and procedures designed to prevent and protect workers, such as use of engineering and administrative controls and when to seek help from co-workers or security staff;
- d. The incident reporting system; encouragement to report and the need to report all incidents;
- e. Identification of risk factors;
- f. Identification of escalating behavior and de-escalating techniques;
- g. Physical holds; and

- h. Post-incident protocols, such as provision of medical and psychological care for victims and witnesses.

Training should be targeted to meet workers' specific needs based on exposure level. Workers such as emergency department and psychiatric hospital staff, who regularly come into contact with high-risk patients or clients, should receive additional and specific training. Training should be adapted to the particular conditions and hazards in the workers' settings. For example, hospital staff in maternity units may not encounter violent patients and visitors as frequently as emergency department staff, but they should be prepared for situations that can arise when new mothers are mentally ill or addicted, domestic partners are abusive, or infants will be placed in foster care. Workers who care for geriatric or cognitively impaired patients or clients and workers in home care settings also have specific training needs.

Workers with relatively low exposure to high-risk patients or clients still should be trained to know the policies and procedures in the event of high-acuity events, such as an active shooter incident. Managers need training that will inform their decision-making, such as making safe staffing assignments, stressing the need to report all incidents, knowing how to respond during and after an incident, and making safe equipment purchases.

Training effectiveness should be assessed as part of the ongoing evaluation of the effectiveness of the workplace violence prevention program.

Conclusion

A comprehensive workplace violence prevention program, grounded in a baseline hazard assessment and ongoing investigation and assessment, can reduce and prevent the frequency and severity of many instances of workplace violence.

The need is urgent to develop a program standard to protect the 15 million people who risk their safety and well-being every day they go to work to care for the sick, the disabled, the elderly and the mentally ill. Workplace violence should not be “just part of the job” for these dedicated individuals, but it is and will remain so until they are protected by an enforceable standard.

We therefore request that the Department of Labor act without delay to develop and issue a workplace violence standard to protect healthcare and social service workers from unnecessary injuries and deaths.

Sincerely,

A handwritten signature in black ink, appearing to read 'Randi Weingarten', with a long horizontal flourish extending to the right.

Randi Weingarten, President
American Federation of Teachers

AFL-CIO

American Federation of Government Employees

American Federation of State, County and Municipal Employees

Communications Workers of America

International Brotherhood of Teamsters

Service Employees International Union

United Steelworkers









Cc: David Michaels, Ph.D., MPH, Assistant Secretary of Labor for Occupational Safety and Health

- ¹ Phillips, J. "Workplace Violence Against Healthcare Workers in the United States, *New England Journal of Medicine*, 374: 17 (April 28, 2016) p. 1661.
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Appendix A
Examples of Workplace Violence Deaths
of Healthcare and Social Service Workers 1998 to 2016
 (Note: This list is not all inclusive.)

Year/State	Name/Position	Incident Description	Photo
2016 Louisiana	Dr. Elbert Goodier III, Urologist	Shot in his medical office by a patient.	
2015 Massachusetts	Dr. Michael Davidson, Cardiovascular Surgeon	Shot and killed at the hospital by son of a deceased patient.	
2014 Pennsylvania	Theresa Hunt, Mental Health Caseworker	Shot and killed by a psychiatric patient inside a mental health facility.	
2014 Vermont	Lara Sobel, Social Worker	Shot and killed in the parking lot by a client who had recently lost custody of her child.	
2014 New York	Evelyn Lynch, RN	Severely beaten by a patient, while working alone, resulting in life-threatening brain injuries. She remains in a coma and is not expected to recover.	
2013 Texas	Gail Sandidge, RN	Died in a stabbing attack by a visitor at a medical complex.	
2012 Pennsylvania	Michael Schaab, Milieu Therapist	Shot and killed at a mental health clinic, by a former patient.	

2012 Florida	Stephanie Ross, Healthcare Caseworker	Stabbed to death by her patient during a visit at his home alone.	
2011 Oregon	Jennifer Warren, Mental Health Worker	Killed while delivering medication to a patient's home.	
2011 Massachusetts	Stephanie Moulton, Counselor	Abducted and killed by a client at mental health residential home where she worked.	
2011 New York	Elenita Congco, RN	Attacked by a patient at a psychiatric center. The injuries were so severe, they resulted in physical and psychological trauma. This led to her early death.	
2010 California	Donna Gross, Psychiatric Technician	Murdered by patient at state criminal mental health facility.	
2010 California	Cynthia Barraca Palomata, RN	Died after assault by inmate at a correctional facility.	
2010 Michigan	Carrie Lynn Johnson, Home Care Nurse	Killed while caring for patient; intruders entered, shot and killed them both, and then set the house on fire.	
2009 Florida	George Tiller, MD	Shot and killed by anti-abortion protester while entering his clinic.	
2008 Massachusetts:	Diruhi Mattian, Psychotherapist	Stabbed to death by teenage client during visit to his apartment.	

2007 New York State	Syndia Jean-Pierre Brye, Home Healthcare Aide	Shot to death while taking care of an elderly man in his home.	
2006 Kentucky	Boni Frederick, Social Service Aide	Murdered by the father of an infant she was visiting at client's home.	
2004 Washington	Marty Smith, Mental Health Professional	Murdered by a patient while making home visit.	
2004 Kansas	Teri Zenner, Social Worker	Stabbed to death while making home visit.	
2003 California	Erlina Ursua, MD	Strangled and beaten to death by mentally ill patient while performing medical exam.	
2000 Kansas	Waneta Boatright, RN, Home Health Nurse	Shot and killed while making a home health visit.	
1999 Ohio	Nancy Fitzgivens, Social Worker	Killed during a home visit to a couple whose seven children she had placed with relatives.	
1998 Michigan	Lisa Putnam, Social Worker	Killed during home visit.	
1998 New York	Judith Scanlon, Intensive Case Manager	Murdered while making a home visit.	

1998 Connecticut	Donna Millette Fridge, Social Worker	Stabbed by a client while walking to work at a community mental health outreach program.	 A photograph of a dark, rectangular gravestone for Donna Marie Millette-Fridge. The inscription on the stone reads: "DONNA MARIE MILLETTE - FRIDGE", "BELOVED WIFE OF ROBERT AND MARTIN", "JUN 14 1922", and "SEP 27 1998". A small cross is visible on the right side of the stone.
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Appendix B
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Appendix C

Abatement Methods in OSHA General Duty Clause Citation Cases and Selected Hazard Alert Letters

General Duty Clause Citation Cases

Nov. 25, 1998

Employer: New York State Office of Mental Health and Buffalo Federation of
Neighborhood Centers

State: New York

Victim: Judith Scanlon

Abatement Measures:

- (1) Training;
- (2) Accountability system;
- (3) Safety protocols for home visits;
- (4) Accompanied visits;
- (5) Means to summon assistance.

2004

Employer: Alameda County Medical Center

State: California

Abatement Measures:

- (1) Hazard inspection procedures to prevent use of an isolated exam room;
- (2) Attendant policies preventing staff working alone with potentially violent patients;
- (3) Enforcement of observation/assault policies, dress code and response to unauthorized possession of H&P exam documents;
- (4) Alarm system.

April 19, 2004

Employer: Washington State Department of School & Health Services DBA Ranier School

State: Washington

Abatement Measures:

- (1) The employer would provide all cost data on the interventions to Labor & Industries;
- (2) Evaluate incident reports and other data, identify deficiencies in data systems and develop corrective plans, and present the findings to the Safety Committee to help develop recommendations;
- (3) Review relevant employer policies and correct deficiencies;
- (4) Develop and conduct an employee survey and develop actions in response to problems identified;
- (5) Develop a written workplace violence prevention program with input from employees;
- (6) Conduct a review of the current and alternate programs for management of physical aggression by clients;
- (7) Review effectiveness of employee involvement on the Safety Committee;
- (8) Agreement to hold safety meetings in each house of the facility;
- (9) Establish a professional team to provide expertise for cases involving aggression/assault by clients;
- (10) Review the remote alert system.

June 8, 2009

Employer: Tryon School operated by New York State

State: New York

Victim: Renee Greco

Abatement Measures:

- (1) Training as per the employer's policy;
- (2) Provision of and training on security systems such as alarms and panic buttons, hand-held alarms, and arrange for reliable response system when alarms are activated.

July 26, 2010

Employer: Acadia Hospital

State: Maine

Abatement Measures:

- (1) Screening of patients upon admission, use of metal detectors to discover weapons, and closed circuit TV and surveillance systems;
- (2) Conduct extensive training on the workplace violence policy to recognize and respond to violent behavior and inform patients that violence won't be tolerated (11 specific training items are listed);
- (3) Implement a flagging and communication system to inform employees about aggressive and violent patients;
- (4) Ensure that the security department is trained to act as a response team and that relationships are established with the police department;
- (5) Configure furniture and rooms so employees have escape routes and secure furniture or items so they can't be used as weapons;
- (6) Limit employees from working alone or in secluded places (like elevators and stairwells) with patients and consider use of a buddy system;
- (7) Develop and implement specific actions employee shall take when there is an incident of workplace violence, for example, an alarm and response system;
- (8) Develop and implement a system for reporting and recording incidents of workplace violence and reporting them to the police;
- (9) Create a standalone workplace violence plan for the hospital containing six elements, including a risk assessment, detailed training requirements and an annual review.

Sept. 10, 2010

Employer: Franklin Hospital Medical Center

State: New York

Abatement Measures:

- (1) Screen patients for potential weapons;
- (2) Use metal detectors, closed circuit TV, and surveillance systems to screen patients for violence;
- (3) Employee training, which lists 11 specific elements, including addressing escalating behavior, including de-escalation techniques, recognizing warning signs, responding to violence, and using various calming techniques;
- (4) Implement a flagging and communication system;
- (5) Configure furniture and rooms so employees have escape routes, and secure furniture or items so they can't be used as weapons;

- (6) Limit employees from working alone or in secluded places (like elevators and stairwells) with patients and consider use of a buddy system;
- (7) Develop and implement specific actions employee shall take when there is an incident of workplace violence, for example, an alarm and response system;
- (8) Develop and implement a system for reporting and recording incidents of workplace violence and reporting them to the police;
- (9) Create a standalone workplace violence plan for the hospital containing required elements, including a risk assessment, detailed training requirements and an annual review;
- (10) The standalone workplace violence policy also includes a detailed list of control measures: alarms, panic buttons, cellphones, radios, installed and hand-held metal detectors, closed circuit video, curved mirrors, employee safe rooms for use during emergencies, time out or seclusion rooms, arrangement of furniture to prevent entrapment, minimal furniture or objects that can be used as weapons, bright effective lighting, administrative controls via policy and procedures, staffing, escorts and other issues.

(Note: The settlement agreement withdrew these citations and replaced them with a requirement for the hospital to establish a taskforce with its unions and employees to develop and implement a comprehensive workplace violence prevention program.)

Jan. 20, 2011

Employer: Norfolk Suffolk Mental Health Association

Victim: Stephanie Moulton

State: Massachusetts

Abatement Measures:

- (1) Provide employees with duress alarms connected to a continuously monitored and automatic response system;
- (2) Install panic buttons in employees' offices;
- (3) Install recording security camera systems to monitor behavior;
- (4) Develop and implement a standalone written workplace violence program with six key elements, including risk assessment, implementation of control measures, training, reporting and record keeping, and periodic review;
- (5) Conduct additional training to teach employees to notify clients that violence won't be tolerated, how to recognize warning signs and respond to violence;
- (6) Determine behavioral history of new/transferred clients;
- (7) Conduct criminal offense and sexual offender records checks;
- (8) Conduct a buddy system based on a risk assessment at least for second and third shifts;
- (9) Establish flagging systems such as chart tags, log books, verbal census reports for patients with assaultive behavior and train staff how to use them;
- (10) Develop a system to communicate about incidents of violence to staff who may have contact with the involved client;
- (11) Provide staff with GPS location capability to monitor employee location;
- (12) Obtain hand-held scanners to scan all guests and their property;
- (13) Issue private-channel radios (walkie-talkies) to improve communication and support among staff.

2010

Employer: California Department of Mental Health, Napa State Hospital

Victim: Donna Gross

State: California

Abatement Measures:

- (1) The injury and illness program was ineffective in that it did not indicate the administrator in charge;
- (2) The escort policy was not enforced;
- (3) Failure to analyze incident causes;
- (4) Training was ineffective as it did not address stalking by patients and how to respond to assaultive patient behavior;
- (5) Ineffective communication systems when confronting patients engaged in prohibited behaviors;
- (6) Ineffective procedures for identifying and evaluating hazards;
- (7) No alarm systems when traversing the grounds to and from work or when escorting patients;
- (8) Delayed response to alarm systems by responders;
- (9) Employer failed to take action upon being notified of violent behavior by patients and by the specific patient who murdered Donna Gross and failed to enforce its ground pass rules.

Abatement Measures in the FACE program report to the federal NIOSH director regarding this case:

- (1) As part of their Injury and Illness Prevention Program, managers of forensic psychiatric facilities should develop and implement a comprehensive written workplace violence injury prevention program;
- (2) Security personnel or co-workers should accompany individual employees when walking through open or unsecured areas;
- (3) As part of an emergency response plan, personal alarms worn by employees should be operational throughout all areas of the facility;
- (4) The facility should assign hospital police officers and/or security personnel to locations where they can monitor patients for assaultive behavior;
- (5) The facility should implement policies for issuing and suspending grounds passes for patients at risk of committing violent assault;
- (6) The report recommends establishment of a workplace violence prevention committee and details components of a comprehensive workplace violence prevention program.

Oct. 6, 2011

Employer: The Renaissance Project, Inc.

Victim: Leland Wood

State: New York

Abatement Measures:

- (1) Evaluate the staff communication log to identify clients who exhibit violent behavior and incorporate measures that reduce the likelihood of clients committing violence in the workplace, i.e., increasing security, identifying potential weapons of opportunity and disallowing access to them, transferring violent client to an alternative treatment facility capable of treating such clients, etc.;
- (2) Develop an emergency communication plan and train employees on the plan;
- (3) Develop and implement engineering controls, such as installing panic buttons in employees' offices, issuing hand-held alarms or noise devices, issuing private-channel radios where risk is apparent or may be anticipated, ensuring a reliable response system when an alarm is triggered, establishing a reliable means of emergency communication to notify security personnel and law enforcement in the event of an attack;

- (4) Develop and implement administrative controls, such as locking staff offices during the night shift, implementing a buddy system, determining the behavioral history of new/transferred patients, establishing a system to identify clients with assaultive behavior problems. Any incident should trigger a review of log books and an evaluation of the current program and procedures to determine the effectiveness of workplace controls. The employer should implement any necessary changes to prevent recurrences, and should follow written security procedures in order to prevent employee exposure to workplace violence;
- (5) Ensure sufficient security presence/personnel on facility floors at all times (particularly evening and night shifts) and ensure that doors are locked in the evening and that procedures are in place for (re)entry to the facility;
- (6) Establish open communication between security employees and other employees to help identify problematic clients and/or situations that could result in an incident;
- (7) Train security personnel in crisis intervention, and workplace violence prevention policies and programs;
- (8) Conduct an annual site-specific workplace violence hazard analysis using recognized guidelines and publications such as, but not limited to, OSHA's *Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers* (Publication No. OSHA 3148-01R 2004) and NIOSH's *Violence: Occupational Hazards in Hospitals* (Publication No. 2002-101), to identify hazards, conditions, operations and/or situations that could lead to violence. The employer must address and correct any deficiencies identified during the annual hazard analysis.

2013

Employer: Corizon, contractor at Rikers Island Correctional Facility

State: New York

Abatement Measures:

- (1) Develop and implement a written program;
- (2) Conduct a hazard review that assesses incidents, facility layouts, and records to develop new procedures that will make improvements;
- (3) Assess incentives for inmates, security measures and surveillance;
- (4) Assess staffing and also the number of corrections officers assigned;
- (5) Reduce wait times and inmate frustration level;
- (6) Consider escape routes for employees and provide personal alarm systems;
- (7) Provide training on workplace violence and site-specific training upon hire and periodically;
- (8) Develop a stress management program;
- (9) Teach employees to recognize early warning signs of potentially violent people and what to do to prevent violence;
- (10) Develop post-incident services to deal with injury and trauma of employees.

2016

Employer: AndVenture, Inc. (DBA Epic Health Services)

State: Maryland

Abatement Measures:

Development of

- (1) a written, comprehensive workplace violence prevention program;
- (2) a workplace violence hazard assessment and security procedures for each new client;
- (3) procedures to control workplace violence such as a worker's right to refuse to provide services in a clearly hazardous situation without fear of retaliation;
- (4) a workplace violence training program;
- (5) procedures to be taken in the event of a violent incident in the workplace, including incident reports and investigations;
- (6) a system for employees to report all instances of workplace violence, regardless of severity.

Selected Hazard Alert Letters

Jan., 2015

Employer: National Beef Packing

State: Kansas

Abatement Measures:

- (1) Enhance your company's Rules of Conduct and Prevention Program to ensure that a clear policy of zero tolerance of workplace violence is communicated. Provide additional workplace violence training to supervisors, superintendents and general superintendents, including administration, on steps to take when verbal and nonverbal threats and related actions are observed or reported. Ensure those steps are documented and are consistently enforced.
- (2) Assemble a multidisciplinary team, comprised of employees/union members, security, medical, human resources, administration etc., to implement and maintain the workplace violence program. Assign the responsibility of the program to individuals or teams with appropriate authority, training and skills. Enlist the assistance of consultant(s) regarding your program's implementation to include training and staff education.
- (3) Conduct mandatory training for employees: (a) how to recognize early stages of possible aggressive/combatative behavior; (b) how to avoid or mitigate a potential violent encounter; and (c) how to seek assistance if a violent episode appears imminent. This training needs to be in the language of the employee to ensure comprehension.
- (4) Periodically inspect the workplace and evaluate the employees' task to identify any potential hazards, conditions, operations and situations that could lead to aggressive and/or combative behavior by workers.
- (5) Analyze trends in workplace violence incidents to determine possible similarities indicating where resources are needed to proactively control any tensions prior to violence.
- (6) Develop a culture awareness program to help employees better recognize and understand how people from diverse culture backgrounds model different behavior.
- (7) Provide post-incident procedures and services. All workplace violence programs should provide comprehensive treatment for employees who are victimized personally or may be traumatized by witnessing a working place violence incident. Employees should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of its severity.

May 22, 2015

Employer: Cutchins Programs for Children & Families, Inc.

State: Massachusetts

Abatement Measures:

- (1) Develop or review policies such as Workplace Violence Prevention Policy, Physical Intervention Policy, and Safety Policy to ensure that the following elements are integrated into a comprehensive workplace violence prevention program that addresses:
 - a. A Workplace Violence Policy Statement, including responsibilities of all staff for workplace violence hazard assessment, prevention, management accountability, and review of incidents and injuries, which is shared with staff and clients; ensuring that clients, clients' relatives, and employees are clearly informed that violence or threats are not permitted and will be investigated, and consequences will be imposed; and implementing appropriate consequences for violent behavior, in accordance with treatment plans, and ensuring they are applied in every instance;
 - b. A Hazard/Threat/Security assessment, including records review of incidents, work with the loss prevention carrier, inspection of the worksite, and employee survey;
 - c. Implementation of workplace controls and prevention strategies, including procedures that maximize safety and minimize the likelihood of assaultive behavior;
 - d. Continuing training and education of all staff with a focus on the specifics of Cutchins' program. Provide refresher training on de-escalation on a quarterly basis for new hires and include real-world scenarios during training events;
 - e. Develop effective client containment strategies, in accordance with treatment plans;
 - f. Implement a system for reporting safety concerns internally, and provide employees with assurance that concerns can be reported without fear of retaliation;
 - g. Address worker protections during client transport off campus and during outings.
- (2) Implement a system for alerting employees to a client's history of violent behavior:
 - a. Determine the behavioral history of new clients;
 - b. Ensure client information is exchanged during shift changes; establish a procedure such as chart tags, log books, or verbal census reports for identifying clients with a history of violent behavior;
 - c. Implement procedures to ensure communication of any incident of workplace violence to any staff who might come in contact with the client, so that staff who may not have access to the client's daily chart are aware of previous acts of aggression or violence;
 - d. Develop a hazard identification process to identify clients with a tendency toward violence.

May 27, 2015

Employer: West Bay Residential Services

State: Rhode Island

Abatement Measures:

- (1) Need for a more effective follow-up evaluation of employees injured during resident handling in order to determine the root cause of the injury, and effective corrective action;
- (2) Need for a more effective follow-up of employee injuries occurring as a result of resident handling activities to ensure that resident handling protocols outlined in the resident's care plan do not subject employees to injury;
- (3) Need for additional resources when transferring residents;
- (4) Develop an effective workplace violence prevention program.

Oct. 2, 2015

Employer: UHS of Westwood Pembroke Inc.

State: Massachusetts

Abatement Measures:

- (1) Carefully review admissions to ensure your staff are equipped to handle acute patients who have a history of violent behavior. If an admitted patient has a known history of violent behavior from previous institutions, increase staffing levels for the unit and inform all workers of the potential risk of violent behavior.
- (2) Conduct a workplace analysis with a step-by-step look at the facility to find existing or potential hazards for assaults and workplace violence. This process should involve record analysis, tracking of injuries, and monitoring trends of injuries based on location, shift changes and staffing levels. Work analysis should include review of personnel ability to respond to unit crisis on all shifts. Review the staffing grid on all shifts to ensure that it reflects the daily acuity of the patient as well as patient census and to ensure workers are able to work without putting themselves at risk for a violent assault.
Change the present grid to increase staffing levels on the acute units and other units where attacks are occurring. Ensure that extra staff is in place when a patient's condition requires a one-to-one watch and when there has been a history of attacks in a unit. An increase in staff levels has the potential to decrease injuries in the workplace. The workplace analysis and any changes should be shared with the violence prevention committee and risk management so that the trends can be studied and acted upon.
- (3) Provide panic buttons that are carried by workers throughout their shift to call for help in any location in the event of an escalating situation with a patient. Evaluate the work space for any blind spots in hallways. Install mirrors where feasible or other devices in acute units to give workers a better view of the work area and potential risk from a violent patient.
- (4) Continue to evaluate and improve upon your present violence prevention program. Ensure management commitment and employee involvement in a workplace violence prevention committee dedicated to reducing injuries in the workplace.
A written program for preventing workplace for healthcare workers should include sections with specific details in the following areas: (a) management commitment and employee involvement, (b) implementation of the written program, (c) worksite analysis (d) hazard prevention and control, (e) training and education, and (d) record keeping and evaluation.

Nov. 5, 2015

Employer: Ariel Clinical Services

State: Colorado

Abatement Measures:

- (1) Develop a stand-alone written comprehensive Workplace Violence Prevention Program that includes the following elements:
 - a. A Workplace Violence Policy Statement that includes the responsibilities of all staff;
 - b. An explanation to clients that there is a zero tolerance for workplace violence;
 - c. A system for reporting safety concerns internally;
 - d. Establish a liaison with law enforcement representatives;
 - e. Determine the behavioral history of new clients and establish a system such as chart tags, log books or verbal census reports to identify clients with assaultive behavior problems;
 - f. Periodic review of the program; make updates as necessary.
- (2) Worksite Analysis and Hazard Identification:
 - a. Implementation of workplace controls and prevention strategies to maximize safety and minimize the likelihood of assaultive behavior;
 - b. Incident investigation;

- c. Hazard/Threat/Security assessment including records review, inspection of the worksite, and employee survey;
 - d. Put procedures in place that would communicate to staff any incident of workplace violence so that employees who might not have access to client charts would be aware of a client's previous acts of violence or aggression.
- (3) Safety and Health Training:
- a. Ensure that training is sufficient to make all employees aware of the company workplace violence policy, and how that written policy can be accessed. Training should also include, but not be limited to:
 - i. Instructing all employees to state clearly to clients and employees that violence is not permitted or tolerated;
 - ii. Train all employees on effective methods for responding during a workplace violence incident;
 - iii. Train all employees on recognizing clients or others who are exhibiting aggressive behavior, and on techniques for timely de-escalating the behavior;
 - iv. Instruct all employees about risk factors that cause or contribute to assaultive behaviors;
 - v. Training should be conducted at orientation and annually as refresher training.
- (4) Hazard Prevention and Control
- a. Prepare contingency plans to treat clients who are acting out;
 - b. Implement and maintain a buddy system as appropriate based upon a complete hazard assessment;
 - c. Implement and maintain a procedure for staff to request and obtain double coverage when necessary;
 - d. Evaluate residence locations for possible installation of engineering controls, such as, but not limited to, security cameras and/or equipment to summon assistance when needed, such as an electronic alarm and/or walkie-talkies as well as other means to ensure employee safety, such as GPS tracking systems, and door locks for staff quarters.

Dec. 15, 2015

Employer: Brigham and Women's Hospital

State: Massachusetts

Abatement Measures:

- (1) Ensure that all buildings are staffed so that security staff is readily available to respond to incidents while at same time the security stations remain staffed. Evaluate response time and ways to improve.
- (2) Ensure that security staff is available to stay with patients when a nurse requests such assistance after calling a code gray.
- (3) Ensure that all staff is aware of the Staff Protection Policy which outlines Security's response when called to assess a situation. Ensure that staff has a way to provide feedback as to the effectiveness of Security's response to incidents. Periodically review past responses and lessons learned to update and adjust the current policy.
- (4) If patients have physically assaulted others or displayed aggressive behavior during earlier hospital stays and there are indications that their behavior is unpredictable, create a safety plan with the Security Department. Ensure that intake staff and unit staff are aware of this patient's past history and the safety plan. Ensure that security staff remains until the patient is discharged.
- (5) Evaluate high-risk areas, such as the emergency room, and keep security staff and/or a police officer in unit during times where there is a heightened risk of violence from incoming patients.
- (6) Investigate the potential benefits of portable panic buttons for nurses or other staff to carry while working with patients and family members who may be violent due to known psychological

disorders and aggressive behaviors. Ensure that users and responders are trained prior to implementation. Ensure that testing and maintenance of the panic buttons are conducted per the manufacturer's directions.

- (7) Continue to ensure that all doors are locked after business hours and all card access equipment is operational throughout the hospital facility.
- (8) Although BWH has a written policy, the Firearms or Dangerous Weapons Policy, which prohibits any person, including patients, visitors or staff from keeping a weapon on their person while on hospital property, no notices of this policy were observed at the multiple entrances to the hospital. Post notices at hospital entrances to communicate the policy to all persons, including patients.

Jan. 29, 2016

Employer: NHS Stevens Center ACT Program

State: Pennsylvania

Abatement Measures:

- (1) Use the "buddy system" when delivering medications to consumers in the field.
 - (2) Prohibit employees from working alone in the office unless the door is locked and ensure that adequate staffing is in place at the office when consumers are on site.
 - (3) Install a secured entry system with an intercom that allows visitors to be buzzed into the facility.
 - (4) Establish a list of "restricted visitors" where necessary.
 - (5) Provide staff members with security escorts to parking areas when safety concerns arise, such as potential stalking incidents.
 - (6) Establish a daily work plan for field staff to keep a designated contact person informed about their whereabouts throughout the workday. Have the contact person follow up if an employee does not report in as expected. Require employees to call into the office before and after delivering medications to consumers in the field.
 - (7) Require the use of mobile panic alarms for field use and consider installing panic buttons for use in the office.
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