

**Cal/OSHA Advisory Meeting Minutes  
Workplace Violence Prevention in Healthcare:  
Facility Security and Law Enforcement  
Wednesday, November 19, 2014  
Oakland, CA**

Meeting Chairs: Deborah Gold, Kevin Graulich  
Notes: Grace Delizo, Mike Horowitz

**MEETING ATTENDEES**

**NAME**

**AFFILIATION**

Heather Appel	Committee of Interns and Residents (CIR)/SEIU
Terry Baker	CA Dept. of State Hospitals
Elizabeth Billberry	UC San Diego Health System
Gail Blanchard-Saiger	California Hospital Association (CHA)
Gerard Brogan	California Nurses Association
Jorge Cabrera	SoCalCOSH
Sgt. Arlisa Collins	San Francisco Sheriff's Dept.
Lt. Cindy Conner	LA County Sheriff's Dept.
Ingela Dahlgren	SEIU Nurse Alliance of California
Christina Garcia, MD	LA USC Medical Center
Surit Goldmacher	Worksafe
Meleah Hall	Special education teacher
Phil Hoffman	Kaiser Permanente
Katherine Hughes	SEIU121RN
William Hyndman	
Dorne Johnson	CA Dept. of State Hospitals
David Kernazitskas	Occupational Safety and Health Standards Board
Dennis King	SEIU121RN
Jeannie King	SEIU121RN
Mary Kochie	Cal/OSHA
Jollene Levid	SEIU 721
Felipe Linaroc	
Michael Musser	California Teachers Association
Richard Negri	SEIU 121RN
Rob Newells	UCSF Benioff Children's Hospital Oakland
Sgt. Tim O'Connell	Alameda County Sherriff's Dept.
Tami Olenik	LAC USC Medical Center
Anthony Roman	Scripps Health
Kim Rosenberger	SEIU, State Council
Corey Smith	CA Dept. of Developmental Services
Sarah Springer	SEIU121RN
Jora Trang	Worksafe
Lt. Roderick Wallace	
Adam Weinberg	UCSF Benioff Children's Hospital Oakland
Vickie Wells	City and County of San Francisco, Dept. of Public Health
Brendan White	California Nurses Association
Paul White	Securitas Healthcare Division

Sandra Williams  
Ed Wong

Alameda Health System

**Deborah Gold**, Deputy Chief, convened the meeting and welcomed attendees. She introduced co-chair, Kevin Graulich, Senior Safety Engineer, and other Research and Standards Health Unit staff – Grace Delizo and Mike Horowitz, Senior Safety Engineers; Steve Smith, Principal Safety Engineer; and Nancy Olsson, Office Technician.

The Division is holding these advisory meetings because two healthcare worker unions petitioned the Board to adopt a new standard that would address workplace violence in healthcare. Petition 538 was filed by the Service Employees International Union Local 121RN and Petition 539 was filed by the California Nurses Association. Copies of the petitions, the Board and Cal/OSHA (Division) staff evaluations, and the Standards Board decision are available at the table. This meeting is the third in a series of meetings.

Cal/OSHA has been working on the issue of workplace violence for over 20 years. In 1993, Joyce Simonowitz, Nurse Consultant for the Cal/OSHA Medical Unit, drafted the first guidelines on preventing workplace violence to come from an OSHA agency, which remains the basis for a lot of the ways people are advised to address workplace violence. Cal/OSHA has done a number of inspections on workplace violence in many different types of healthcare operations and its experience is summarized in the Division evaluations of Petitions 538 and 539.

The Occupational Safety and Health Standards Board is the only agency in CA that's authorized to adopt occupational safety and health regulations. At the June 2014 Board meeting, the Board adopted a decision which requested the Division to convene an advisory meeting on this issue and in that decision, they stated that it had determined that the necessity for improved workplace violence protection standards has been established.

The Division is therefore using this advisory process to determine what should be included in a workplace violence standard – to include how workplace violence is defined, what types of workplaces should be included, and how the issue of workplace violence can be addressed in the different environments.

The legislature passed and the Governor signed a bill addressing workplace violence in some healthcare operations, SB 1299. The rulemaking project required by this bill has been rolled into the process that's already been started regarding Petitions 538 and 539.

During the Board's discussion of Petitions 538 and 539, two Board members specifically requested that we discuss the role of employers in relationship to the role of law enforcement in protecting healthcare workers. Others have raised the issues of the role of facility security and law enforcement, such as what is the threshold for involvement of facility security in altercations involving patients and how employers can help employees in reporting assaults to law enforcement. When we talk about facility security, we talk about both facility security that is hired directly by the facility and the increasing practice of hiring security from outside contractors. There have been concerns raised about the experience of the workforce that come from that context. By law enforcement, we're talking about the role of sworn personnel, but there may be unsworn personnel also furnished by law enforcement agencies to help out in different facilities. There's a wide variety of how different facilities are approaching this issue of facility security and we're going to learn from stakeholders about that, find out about any difficulties, and see where there may be an opportunity to improve.

In the document decision, the Board also requested the Division to provide them with information regarding any recommendations the Board may want to consider to provide to other agencies or policy makers that may be beyond the jurisdiction of Cal/OSHA. We're eager to hear from you and our panel members about all these issues.

There are handouts on Health and Safety Codes 1257.7 and 1257.8 which apply to certain hospitals in California and address the requirements for safety and security plans in those hospitals. These laws are not enforceable by Cal/OSHA but they do provide information about how most provisions have been successful or unsuccessful in California.

There are also handouts from by Jane Lipscomb, PhD, RN, FAAN which include talking about the typologies of workplace violence. We have violence that comes from a criminal intent (Type I). We have violence involving patients or clients or visitors – people that have a relationship to the institution, and there's a wide variety and distribution of that type of violence. We've been talking a little about Type I.5 where criminal activity may follow a patient or visitors into the hospital and provide a threat to employees that isn't necessarily specifically about the staff to patient interaction, but it becomes a staff to patient or visitor interaction. There's violence that comes from coworkers, former coworkers. There's violence that follows workers into the workplace like domestic violence. Most of the work has been focused on Type I and Type II violence, but we want to discuss all types as they pertain to the role of security and law enforcement.

There is a handout on the rulemaking process. Ms. Gold described the OAL rulemaking chart and the Administrative Procedures Act that governs how agencies can adopt regulations. For occupational safety and health standards, that is the Occupational Safety and Health Standards Board. The Standards Board has the authority to make any regulation necessary to protect the health and safety of employees at work. We are meeting to discuss in a pre-rulemaking phase to develop the regulation that is going to be proposed. This is a good time to have lots of input because a lot of where the rubber meets the road is in pre-rulemaking where we can have a robust process of information gathering.

She pointed out the current timeline is that we're working on a discussion draft for an advisory committee meeting in January or February and encouraged attendees to sign in to get on our e-mail list because that's how the Division circulates things and the list of attendees is helpful for the minutes. We'll have another meeting in March or April to finalize the draft that will be sent to the Standards Board. We're always open to e-mail input, things you want to send us, calling any of the staff working on the project to let us know of your concerns. SB 1299 said that the Board has to adopt a regulation by July 1, 2016 which means we'd like to get the proposal to the Standards Board to get noticed by June 1, 2015 because it's a one year process.

**Kevin Graulich** stated that the Division thought a panel would be a good way to introduce this topic, followed by a short question and answer session with the panel.

**Phil Hoffman**, National Executive Director of Security Services, Kaiser Permanente, has been with Kaiser for 24 years and they have 38 hospitals with over 700 medical office buildings and 100 administrative buildings. Their program focuses on the importance of conducting an annual assessment. Everybody mixes up the plan with the assessment, but the assessment is really the deep dive into the community environment, what is coming into your hospital, how are you protecting your assets and that forms into a management plan and determines how many staff you need. Their biggest benefit is a strong policy development with management as well as the employees. They have to be engaged, solicited and participate in recognizing and reporting

activities that are occurring at facilities so they can hone their management plan because they re-evaluate the plan. They're strong in the area of physical security – card access controls, cc TV applications – to offset the more expensive costs of security guard staffing and expedite a response to an event they didn't see coming. Lastly, they address staffing and protect patients and employees coming into work from the parking lots into the facilities. Once they get into the facilities, they isolate critical areas – pharmacies, urgent care, emergency department, specialty care areas where there is angst or anxiety by staff, where they have special concerns, procedures and training they want applied. The training aspect is key and will be a critical part of the discussion today, how much training is needed in the specialty departments and in the general population. Their program was founded on AB 508 or Health and Safety Code 1257. He feels that SB1299 is taking it in the right direction and establishes accountability where security for the longest time sat outside the Injury and Illness Prevention Program. We need to get better in the areas of reporting, accountability and standardize practices across a program within the healthcare industry.

**Sergeant Tim O'Connell**, Alameda County Sheriff's Dept., stated that he is the unit commander for Children's Hospital and UCSF Benoit Hospital where sheriff deputies are there 24 hours a day/7 days a week. He also has deputies assigned at Alameda Health System. They are in the city of Oakland, a high profile area where criminal behavior might come into a hospital where it's not patient-based psychological issues. It could be street level problems that follow victims of violent crime into the hospital lobby which affects the neighborhood and employees' ability to come freely to work and is pretty dangerous.

**Cindy Conner**, Lieutenant with the LA County Sheriff's Dept. stated that she's been with the Department for over 27 years. She stated their custodial facilities are the largest in the world. They have the largest forensic psych patient facility in the world with the largest distribution of psychotropic meds. She currently works in the Sheriff's Dept. County Services Bureau which provides law enforcement safety and security to all of the county's healthcare system which is the 2<sup>nd</sup> largest in the nation. Her level of respect for healthcare providers has increased ten-fold because she had no idea what they're subjected to and what they endure. Their department has applied principles that have proven well in community-based policing – the ability to track trends within healthcare facilities to determine where the problems are, what activities are occurring so they can deploy resources appropriately, to identify whether a situation was preventable or non-preventable through perishable skill training, building off of current training, developing training with the Department of Public Health. She met with her agency's executives and they are on board with looking for solutions that are transparent and practical.

**Rob Newells**, Safety Coordinator for UCSF Benoit Children's Hospital Oakland, stated he has been with Children's Hospital for 10 years and safety coordinator for 4 years. They had a Cal/OSHA inspection based on workplace violence and the citation was based on training but the warning that came with it gave him the ammunition to go to administration and tell them they need programs and a better policy. They had a human resources policy on workplace violence but that only addressed employees and so he wrote one based on OSHA's guidelines from several years ago and worked it through committees and management. They accepted the policy and they started educating on making sure employees know that they can report, how to report, and where to report. The OSHA investigation gave them the impetus to implement their Threat Management team comprised of a Vice President, Human Resources, Nursing, Safety, Emergency Management, Security and Social Services. They talk about all threats, including workplace violence. The OSHA investigation gave them the ability to get a lot of things going and he'd like to think they're leading the way in some of this work.

**Surit Goldmacher**, nurse practitioner and researcher on workplace violence, stated that she is retired and also represents WorkSafe. One of her jobs was to head Employee Health in a number of medical centers in the Bay Area including UCSF, Children's Hospital, so she saw a lot of victims of workplace violence. Then she worked for the State Health Dept. where she did research on workplace violence and visited 135 hospitals throughout the state of California, and a number of them in LA. Some of the things she will say pertain to what she found in that research and their recommendations they came up with. One of the big problems was the disconnect between security and everybody else in the hospital, all the nurses and all the departments. The training was never together so when she would go to the emergency department or to psych where their research focused, ER and psych nurses didn't really get what security was supposed to do and vice versa. The training was separate so they didn't get a chance to talk to each other and engage on what would work and what doesn't work. She found that most Psych nurses would never call Security because they'd rather handle it themselves.

**Kevin Graulich** asked if anyone had questions or comments for the panel members.

**David Kernazitskas**, Occupational Safety and Health Standards Board, stated that he heard some of the accidents or cases where there is a coworker present, or there is a security guard or law enforcement and someone will still get hit. He asked the panel for their thoughts on the reasonableness of the standard because there's a tradeoff in how far to go, what should our expectations be in making a safe workplace, and how safe can we make these jobs.

**Tim O'Connell** stated that recently they've been working in the ER department where the main events occur. They work with the ambulance companies so they know when someone is coming in who's already shown their behavior out in the streets so once they come into Highland, there's a scalable system nurses use that calculates how a person's behaving – did he already bite somebody, threaten to bite someone. They get a score and once they get to a certain number, immediately an ER charge doc will come out and decide if medication is a possibility. If they get that right before they come into the facility, in the ambulance bay area, it reduces the occurrences for any staff to be injured. It's helped them out a great deal.

**Phil Hoffman** stated that it's going to be a difficult situation because people behave differently when they come in the facilities – 90% will want to be there and to get help, then there are others that will be brought in by law enforcement not under their own decision making, and some that will have higher expectations and are just mad at the world. The key is management of aggressive behaviors, training the staff including the receptionist to detect early what is out of sorts. There have been a deluge of behavior holds 5150s, 1799s legal medical holds. He feels that uniformed security presence tends to de-escalate the situation, not just 5150s and 1799s. It gives caregivers ease of mind but also a set of independent eyes looking to see if it's getting to the level of a restraining situation. The key is early detection in this process and everybody has a piece in the game – from the receptionist to intake, mention it to the triage nurse, mention it to the doctor that's coming in. The more you start building that case you may want to introduce an intervention activity or walk in and say we're here to help you and need your cooperation and get their commitment to not get out of hand. That's a learned event that you're not going to learn in a 40-minute training. It really requires a quarterly refresher to remind staff that this is going on and it's a critical piece.

**Tami Olenik**, LAC USC Medical Center, asked how to change the culture. When reporting incidents on campus, it doesn't fare well competing for healthcare dollars when the general

public gets wind that there's been an incident on campus. Most recently there's been a proposal to remove their security check-in points because it's not user friendly.

**Cindy Conner** stated that she is an advocate of contraband screening which evolved out of the Holleran Study which was done in the early 70's at the request of Board supervisor Gloria Molina. Another weapons screening went in after an incident where a nurse was stabbed in the neck with a pair of scissors, one of many weapons of opportunity that can be found in hospitals or workplaces. She stated that it depends on how it's packaged and presented. There are a number of ERs that screen with metal detectors. She agreed with Phil about prevention by anticipating aggressive behavior or what she refers to as rapid cognition, when the hair goes up on the back of your neck. You may not be able to identify it but it doesn't feel right. We're really trying to change the culture within the healthcare environment, and she's been pushing for that paradigm shift from healthcare providers as far as putting up the red flag or calling and asking for help as opposed to just pushing through it and then something bad happens.

She gave an example at Harbor UCLA and an individual came through weapons screening and she had contact with him. The alarm went off and it was his belt buckle, so she had him redirect and go through. He made his way into an area of the hospital he shouldn't have been in and the nurses didn't feel right and called to report to the Sheriff's Department that they had a suspicious person in the area. They responded immediately and his behavior escalated and he started making sounds. Everybody got up and started moving out of the room. He picked up a pencil and stabbed it in the nurse's neck. Cindy felt this situation was not preventable; the nurses did everything they were trained to do. That shift is slow but it's coming. She would like to have seen defensive moves as taught in CPI training, but the tactics that are provided take continuous practice even for law enforcement. She would also like to see a shift from patient safety to employee safety too when they're in a situation. They have a reasonably objective standard in law enforcement that pertains to all of us as far as our own personal safety is concerned.

**Rob Newells** stated that change takes time and they have a patient safety coordinator office and Mr. Newells is in the department of health and safety, so his whole job is about making sure it's a safe place to work and it's a safe place for patients to get care. It took a hostage situation that resulted in a non-physical injury to get them to the point where they got an armed security officer 24/7 in the emergency department which gave them the ammunition to go to administration to get the money to get the Alameda Sheriff's Dept. deputy onsite 24/7 and that's one officer by himself 24/7. They have the ability to call for back up if they need it and that comes quickly when it's the sheriff by themselves. Then it took getting the officer staffed to then get a comprehensive weapons-free campus policy. It was a battle back and forth even with security. You're going to end up screening everyone at some point, it's hard not to, but it takes time and it takes baby steps. You have to recognize you're gaining ground a little at a time.

**Surit Goldmacher** stated that one of the things that gets written up will have to deal with this very issue in terms of screening. It's not okay for one hospital to say we really haven't had any incidents or we've only had one incident in 5 years. Maybe we'll do something like the TB standard where you have 3 cases you do this or if you have 5 cases..., but she thinks it's important that it's a piece of this.

**Phil Hoffman** stated that SB 1299 is going to call out a website where we're going to list the events that have occurred in a facility and that's a concern. "We want you to come because it's a place of healing, oh and by the way there've been 62 assaults..." I think we're going to have to work closely with OSHA to frame what that report is going to look like because we always

want our medical facilities to be a place where you can come, a place of safe harbor where you can get treatment. They're going to have to be master spin doctors. He's seen inconsistencies across the program where an incident in one facility may be considered an assault and then go unreported in another. They're facing patients with dementia more and more that hit a nurse with no intent. Surit added that nurses don't report that unless they're hurt. Phil added how will that be recorded and displayed. Hospitals are going to have to work with OSHA so that it doesn't put them at a disadvantage and become a competition for membership, resources, etc.

**Rob Newells** stated that's why they don't have their Workplace Violence Prevention in Security because that's a signal that it's a piece of the puzzle but they have to make sure they're pulling in Employee Health, Human Resources, personal interviews with staff, because a lot of times they're reporting to Security and the only incidents getting reported to Employee Health were those that would go on the OSHA 300 log. He had to talk to the Employee Health supervisor and they agreed that anytime anyone got injured by a patient or family member, even if it didn't go on a log, she would notify Rob so he could keep the report. It can't be just Security, Employee Health or Human Resources. There has to be somebody putting it all together.

**Cindy Conner** stated that in law enforcement there is the letter of the law and spirit of the law. They know what penal codes are and what constitutes a crime, but if you have no victim you have no crime meaning that dementia patient who hits the nurse. What they have is a mechanism that the County Board of Supervisors mandated, the Security Incident Report which whenever anything happens – you get hit by a patient – you are required to let your supervisor know. The Sheriff's Dept. will respond, however if there's a non-desirous victim they fill out an information sheet so they're able to track it so they know. But if there's a crime involved, more significant, they take the criminal report. So they have the ability to track a reported incident, a non-desirous, an incident where there's criminal intent. They also have all the college campuses in Los Angeles and the Clery Law requires them to report any criminal events that have occurred on the campus. So be careful with the spin thing because if you look at the Clery for USC, she doesn't think it's impacted the parents sending their kids to that campus. There are tracking mechanisms in place that can be utilized to track events at hospitals.

**Richard Negri**, SEIU Local 121RN, stated that when we talk about spin wheels we have to talk about the phenomenal amount of healthcare workers who are frequently given a wand so that they're almost doing a security job. They're doing various amounts of what folks would consider a security assessment instead of doing healthcare. They're seen as a pre-security role and that's hard, as a patient advocate and worker advocate, to see a nurse doing a security role. He pointed out there's a difference between a first responder and an immediate responder. He feels that if a facility that has a need for a 24-hour immediate responder, then that individual should be there and be employed at work with the amount of training that many people in the room have. And if that individual needs backup, that's where a first responder would come in.

**Cindy Conner** stated they utilize that concept at some of their locations. In LA County, they have 3-tiered security. They utilize Securitas guards at a fixed post at a lot of their facilities. They have white shirts on their way to becoming a deputy sheriff. They're sheriff-trained security officers and also carry a gun that are roving and deployed in areas based on stats knowing where incidents are more likely to occur like the ED site where they're primarily focused on immediate presence response and, if need be, the deployment or the request for a deputy sheriff to respond. Law enforcement is very unique because the reality is security is not cheap, whether it's private or you have law enforcement. She stated that what Richard Negri is hitting on is a valid idea and they're deploying it at some locations.

**Dr. Christina Garcia**, LA USC Medical Center, stated that the security they have in place are not allowed to intervene and put their hands on a patient. They could have many security guards in the ED, psych wards, but if they can't intervene healthcare workers are still at risk. It's her understanding that the only time someone can put their hands on a patient being violent, whether they have mental illness or substance abuse or dementia, is if they're a doctor or nurse or the Sheriff's only if they turn the case over and say to the Sheriff's that they need them to arrest this patient. Then it's up to the Sheriff to decide whether there's probable cause to make that arrest or take them off the facility. What ends up happening in a lot of situations is that they have a violent patient that's being treated by a medical staff but it's not a medical problem. It's a violence problem and it's something that needs to be dealt with on the Sheriff's side or the security side. It's not something medical staff can do. She can have a nurse tell her that she has a violent patient and that she needs to write for medication, or put more restraints. But the patient has the right to be evaluated every hour, come out of restraints, and not receive the medication the next time and they're calm for 20 minutes before they try to strike again. From a medical standpoint, their hands are tied. So they want whatever they can do for training and to work together.

**Cindy Conner** stated the training has not come their way and the Sheriff's Dept. has been doing a lot of training for what Dr. Garcia is dealing with. They will train a nurse that wants to give meds to a patient in an aggressive, combative stance to wait and slow it down, assess the situation instead of forcing the issue. Law enforcement is working collaboratively with medical staff to determine if it's an emergent situation to give the patient meds, or is something that they can deescalate and communicate to give the meds. Is it a medical or law enforcement situation? Law enforcement is not an entity of the hospital and this is a fine line that the Joint Commission CMS dictates as to when they can intervene. They will intervene and won't wait until somebody gets hurt or a violent act occurs. Cindy stated that LA USC has a good policy that clearly delineates when law enforcement can engage. There are also HIPAA issues they've been working with county counsel for Dept. of Health Services and law enforcement so that everything is in sync. What it comes down to is a training issue because she sees from tracking violent patients that there is a better way to deal with it. Most injuries to staff members occur when they rush into situations too fast because they want to get to their next patient or task and she encourages them to slow it down and look at the situation as a team. If it's a medical emergency where you have a patient that's possibly injuring themselves or doing something potentially life threatening, then law enforcement has the right to go in right away. It's a delicate balance that requires training.

**Rob Newells** stated they use a behavioral emergency response team that is led by psychiatry and includes security and law enforcement so everybody shows up when there's a behavioral emergency response call. If there's a dangerous situation the Sheriff's deputy can step in, but it's led by the psychiatrist that's in charge so there's always a team approach in that situation.

**Phil Hoffman** stated that it's a management issue. When you ask for guard services, there are different levels of training and recruiting. Kaiser has given 12 extra hours of training in de-escalation behaviors for areas where they see more uptake of agitated patients or patients getting out of hand. They're given hand techniques on how to de-escalate and they put them in paramilitary uniform to make them stand out. General security officers are there to observe and report. What you need to call out in contracts is a higher expectation, a higher skill set and recruit to that. The staff will see a 180, a visual difference, they've been trained differently. You take what you've developed and take that to staff and say, "Look I'm one security officer and it would be nice if I had a nurse or a backer pile on too to help." It's the team approach and until you get the confidence and get that specialty officer you're looking for, it's not a lot of money.



Also it's a lot of pride of ownership, you'll see the officer walking tall, feeling more responsible and it's a win-win for everybody. So he goes back and looks for all the niche areas in a facility that's causing problems and how he can ramp up the training and the recruitment.

**Gail Blanchard-Saiger**, California Hospital Association, stated that the panel is made up of sophisticated law enforcement and hospital relationships. She's trying to get small 25-50 bed hospitals in the far north that are stressed with their staffing as well as the law enforcement. She's heard repeatedly where a hospital will call and law enforcement doesn't have the resources there and has to prioritize, so there are challenges. They're seeing productive, cooperative, excellent relationships between law enforcement and hospitals but there are 58 counties and it's not equal. She's concerned and doesn't want this to be a standard of expectation for them.

**Cindy Conner** acknowledged that LA is a large county, but she can talk to smaller communities like Downey and law enforcement does not have a good relationship with healthcare providers and there's a huge gap. There are those fortunate to have law enforcement or robust security system in place, but the vast numbers of law enforcement officers are completely unaware of what is going on inside their hospitals. She's been on various committees and has heard people say that they have these great relationships, but it's not so much. She stated that there is a need to bridge the gap and look at what resources are already in place in communities that need to be built upon.

**Phil Hoffman** stated that it's all about leverage in small communities. There are a lot of security suppliers in healthcare where it may be their expertise. It's not the number of officers you're looking for; it's getting the right officer to meet your situation. "If you're a 50 bed hospital, I hate to go below 2 officers because in most circumstances where there's a lot of activity you need back up. But in most cases when you can only have 1 officer, then spend the extra \$5/hour to get the right trained officer from a supplier that has a vetted program that will work that and scale it down. From that, use it as a platform to say that puts more burden on the employees when we're in a crisis situation."

**Richard Negri** stated that, whether at a small facility or huge facility, the nurses, doctors, techs are giving quality healthcare to the best of their ability to save a life or move a patient along in their healing process. We should realize that spending a little money for the type of security and the training is important for their members as well as the other union's members.

**Rob Newells** stated that before they had a contract and had a deputy onsite, they had to deal with calling 911 and figure out their relationship with the Oakland police department. What really helped was having a relationship with their Area Commander, what their Emergency Management Coordinator was able to do for them. So they understood that if the hospital would call and say "this is the psychiatry department," then this is what's going on and we need you to come and 5150 somebody. Rob advised folks that can't afford to hire somebody else to form a relationship with their local law enforcement.

**Gail Blanchard-Saiger** clarified her example that there are different situations across the state and it's not the lack of trying and it's not the lack of interest on the part of law enforcement, and it's not because they don't want to spend the extra \$5/hour. Everybody, whether the hospital is large or small, is not going to be in the same place. There's a tension because their law enforcement agency is so underfunded they find somebody on the street on substance abuse and is disruptive, and ask them if they want to go to jail or the ED. So law enforcement is bringing people into the ED which is problematic in 2 ways. You're bringing somebody who

really doesn't have a medical issue and then you have to at least assess them. You're bringing a potentially aggressive person into the environment which is not appropriate. Then the reality is law enforcement leaves, which is not to disrespect law enforcement because they are underfunded and have to figure out how to manage what's happening on the street. There's this tense relationship because the hospital questions why they're bringing them if they're not really patients and they should be handling it themselves.

**Surit Goldmacher** added that this doesn't just happen in small hospitals. When she visited big hospitals that have psych, they told her that the police are bringing these patients in and the nurses knew these patients were violent. "What happened was that the patient would say they were suicidal or homicidal, when the police hear that they have to take them to the hospital and they knew that the patient was full of it. The nurses knew that and now they have a violent patient on the ward, another one. And the nurses felt powerless to do anything."

**Sandra Williams**, Alameda Health System, stated that we have to take a cultural perspective that safety is everyone's business. It's not just security or law enforcement; it pertains to the entire environment. We all should have the one goal that threats should be immediately neutralized. When looking at the life cycle of an event, we tend to look at the event itself but not the total life cycle and how the patient travels across the continuum. There's the threat, the execution of the threat, the communication piece, the response piece, system recovery and sometimes a debrief. Then we come up with after actions after the fact. There's opportunity between the response and the system recovery, meaning that when we're responding and trying to neutralize it, are we developing a care plan as to how to further treat that patient as they remain in the environment and/or if they're transferred or admitted to a bed and transferred across the continuum. It's much like when we do the threat assessment, what do we do to protect the employees and the patient within the environment. What is the plan at that time – not after the event, but at that time – taking a time out to look at what do we need to do in the moment. Then come up with a plan that can be communicated to the next shift and/or to the next line of service.

**Jeannie King**, Pomona Valley Hospital Medical Center, works as a critical care nurse. She had a nurse kicked against the wall which caused her to be out 3-4 months. The patient was cognitive of what she was doing, so she encouraged the nurse to call Pomona PD because the nurse wanted to file against the patient. They called and they finally came out and the officer told Ms. King as the union rep that this was just a misdemeanor and that he could only write a report on the incident. That disheartened all the nurses because the nurse was injured and she wanted to press charges. So Ms. King spoke with the head commander of their security who kept claiming to follow up and call the PD, but it was dropped. The nurse threw up her hands and didn't want to proceed with it, but the message it's sending is that if a worker is hurt by the patient and you call Pomona PD, it's a misdemeanor.

**Cindy Conner** stated that unfortunately it shouldn't have happened. That's why 24/7, there's always a watch commander on duty at any law enforcement agency. You pick up the phone and say, "I am the victim and I'd like to make a report." She's all about throwing them under the bus if they don't do their job. It should have been reported because somebody was assaulted and somebody was injured. She belongs to an association of private hospitals and was told by a nurse that she was assaulted, went to her administrator and was threatened with a check against her if she reported the incident. If somebody breaks into your house, steals something and an officer comes and says sorry, he's not taking a report, what are you going to do? You pick up the phone, call that station and make a complaint – it's no different. Law enforcement should be on your side to help facilitate in that situation.

**Phil Hoffman** stated he's seen where nurses or physicians have been assaulted and they don't want to make a report because they're afraid someone's going to retaliate in a parking lot. That's where there has to be a commitment between the employee and the employer because when an employee doesn't want to stand up for themselves because they don't feel they have the backing, the organization needs to step in and press charges themselves or make those calls to the district attorney. Jeannie King stated she will go back with a new light. Cindy Conner stated that it was just one person that said and did something that wasn't correct and it's amazing that ripple effect has made it the perception.

**Jorge Cabrera**, Southern California Coalition for Occupational Safety and Health, adjunct faculty at Cal State Dominguez Hills, stated the comment that was made that the responsibility of safety falling on everybody is part of the culture that needs to be changed. It needs to be realistic about the fact that healthcare professionals are there to provide healthcare services, not security services or law enforcement services. While he agrees there needs to be collaboration and training, at the end of the day it should be law enforcement and people in charge of that who are trained and took an oath to uphold the policies. He also commented on the funding levels for law enforcement and LA County Sheriff's, that there's been at least 7 billion dollars allocated at the last budget out of 27 billion of the entire LA County budget, so there doesn't seem to be a shortage of funding. He questioned how do we work together to make sure that money goes to protecting healthcare workers. Also, if there's friction between hospitals and law enforcement how do we mediate that because there is a crisis on workplace violence that needs to be fixed?

**Rob Newells** stated that safety and security are not one in the same. Security is a piece of safety, but safety is more than just security and law enforcement's role. That's the piece that safety is part of everyone's job.

**Tim O'Connell** stated that they can't always be there, but the registration clerk that watches the person pacing back and forth that never stands in line and the employee that notices the hair on the back of his neck standing up, those are all clues that something bad is coming. That's when you call the professionals, security, sheriff's office, and they intervene.

**Dennis King**, retired respiratory therapist, worked at Pomona Hospital ER. They have a large gang problem and there were many times when he was involved with shootings and there have been patients' families coming into the ER and threaten his life if anything happens to their family member. When he'd report the threat to his supervisor, the first thing he was asked was "what did you do?" or "what did you say to cause him to react like that?" There was another incident where people were shot and they treated the patient and he was going to be rolled back into the waiting room. By that time, the rival gang arrived and saw him in the wheelchair and piled on him and beat the nurse, who was hospitalized for 4 months. He's sure that the Pomona Police Dept. was busy out with other gang shootings, but they needed them at the hospital.

**Tim O'Connell** stated they lock down the emergency department especially at Highland Hospital for multiple gunshot victims because they don't know nor does the city of Oakland who's involved. Many of the times arch rivals are already shooting each other, and family and friends are coming to the emergency department. They don't let visitors come back into the ED even if they're working on them. It's too volatile and evolving at that time.

**Cindy Conner** stated that one of her locations during the summer averages 3 gunshot victims per day. They have low and high tech security. They have camera systems in place that capture every vehicle's license plate that comes through one particular parking lot and gang

members know that and it's a deterrent. When gunshot victims come in, they automatically have a plan in place communicating with ambulances and paramedics to when that victim is brought in, what physical presence they'll have between their Securitas guards and their immediate presence in the ED, so that there's controlled access and the presence. They've seen a drop in retaliating gangs coming to their location since they've had the camera systems. She spoke about hospitals in San Gabriel valley dealing with some of the smaller police departments that pick up the psych patient and dump them off and she's told the hospitals what they need to speak to the agency about to help resolve the problem that they're not aware of. There needs to be leadership and communication on both sides.

**Gail Blanchard-Saiger** stated that increasing criminal penalties for violence against healthcare workers deserves further consideration.

**Christina Garcia** works as a doctor and she was attacked. The sheriff took the report and sent her to jail, but the felony was reduced to a misdemeanor and she was released within 24 hours. She came back to the ER and was readmitted and other residents and physicians were put in harm's way. She wants the advisory committee to look into changing that. **Cindy Conner** referred to that situation as a wobbler and it depends on whether there's physical trauma versus being smacked and there's nothing visible. They're dealing with AB 109 and the realignment from the prisons to the jails, with a lot of the early releases having mental illnesses. Also Prop 47; they issued a citation to someone for a vehicle burglary who should've gone to jail and 2 days later they caught him after abducting a 13 year old. Cindy supported Gail and is amazed that someone hasn't taken up the cause that it's a felony to assault a healthcare provider.

**Christina Garcia** stated it's a felony to attack a parking enforcement officer.

**Richard Negri** stated in New York state, if a public healthcare worker is assaulted it's a felony and minimum of 5 years in prison.

**Tim O'Connell** stated that they notice that sometimes doctors are the only ones who put red flags in people's files. With some new systems, some nurses don't even get to see that good history that would help prevent nurses, residents and doctors from being injured.

**Dorne Johnson**, Supervising Special Investigator II with CA Dept. of State Hospitals, followed up on Phil Hoffman's discussion about training and law enforcement. You're not sure what kind of training the officer is going to have when they respond to a facility. Some of the more progressive, better funded police departments have Psychiatric Emergency Response Teams (PERT). You're going to get a much different response from an officer trained under that program than your general law enforcement officer when it involves the mentally ill or crisis-type intervention. He encourages everyone to advocate in their own cities, counties and jurisdictions for their local law enforcement to spend the money to get specialized units where there will be a better, more appropriate response.

**Cindy Conner** stated there are a lot of grants out there to address that training.

**Tim O'Connell** stated that peace officer training mandates a 4 hour block every year for mentally ill contacts.

**Adam Weinberg**, Security Manager at UCSF Benioff Children's Hospital Oakland, works closely with Sgt. O'Connell and Rob Newells. He stated that at their hospital they do a really good job of implementing the philosophy that everyone is part of the safety culture right away. He trains twice a month at the new employee orientation that is cross-disciplined with doctors,

nurse, all hospital staff on personal safety and just being aware and observant on what's going on. That's the best responsibility that he'd recommend. As far as security and what to do in case of a crisis, he agrees that it's more of a security and police function at the facilities. But certainly everyone can all share in that culture and responsibility of at least observing and if you see something report it right away so that they can respond. Getting that culture and training early on will help to improve the culture.

**Deborah Gold** asked if it's true that generally speaking in a lot of the facilities, if someone gets attacked the only person available is another healthcare worker, and that the security people are typically few and far between anyplace but maybe the entrance to the ED. Stakeholders agreed with her. Deborah stated that she feels that's the concern people are raising – that people who become nurses, CNAs, LVNs, psych techs, etc. aren't trained except that people at psych hospitals are trained to do takedowns practice monthly like at John George. They're still healthcare workers and they're not security people and they don't have the authority of wearing the uniform. That issue of the interface between what's expected of the healthcare worker who is the one that's going to be assaulted and who is likely to be in proximity of the assault as well and then the role of facility security and how we can improve response within a facility (i.e. hospitals). She wants to understand more how the experts see doing that. When she thinks about workplace violence, she thinks about Dr. Ursua at John George who was assaulted by someone and killed, who probably had no clue where she was. **Surit Goldmacher** stated they knew the patient was violent when they brought her in. **Deborah Gold** commented that no one raised the question whether the patient had criminal intent. Surit mentioned that the patient had attacked her family and that's why they brought her in. Deborah stated that when Cal/OSHA issued the citations, we said that the doctor should never have been alone with that patient and the patient was between the alarm button and her and that's why she was able to strangle the doctor. Even though the patient is legitimately a psychiatric patient they can still do a lot of damage and, how can security help with that?

**Rob Newells** stated that a big piece of that is recognizing and reporting and that's the role that non-security personnel can play. Security is not going to be at every visit with patient care personnel but if you know the patient has a history you can call security to be on the lookout and give them a heads up. What they've been able to do with electronic medical records is they can't flag the patient to carry with them throughout their medical record, but they have been able to flag a person's stay so everyone knows what precautions to take with this patient. The recognition and reporting on behalf of all staff is going to be the biggest piece that's going to help security respond to things in a more efficient manner.

**Cindy Conner** looks at preventable and non-preventable and they do a lot of training, for example, personal protection in high risk areas. You're working at a psych ward and you're going into an area and you're locking the door behind you, that's when your mindset needs to change. That door's locked behind you for a particular reason. She hears all the physical things that can be put in place to help the staff member be safer, but they're applying law enforcement tactics like a safe way to round a corner so that no one's going to blind side you. Do you wear your ID with a tether tied around your neck or wear your stethoscope around your neck so that someone can turn around and choke you? If you hear noise, something bad, pause for a moment and look. These are things they teach in law enforcement and they deal with all high risk individuals. They have nothing but their training, their skills, their communication and demeanor to keep them safe, which is no different than the healthcare provider but amplified at a different level. They have different tier training depending on where you work – high risk training, those who just have contact verbally or when they're checking in patients. She spoke about the importance of debriefing and discussing what happened

**Elizabeth Billberry**, UC San Diego Health System, commented on what Deborah wanted to focus on whether safety and security is security's job or whether it's the responsibility of the security staff and law enforcement versus the healthcare workers. There are several reasons why UCSD have an interdisciplinary training department managed by the security department. They have representatives from Psych, ED, and various people who bring all their expertise to the group. They also provide the training and tell the nurses, physicians, and techs that it's also their responsibility because it's their safety. Security is not everywhere. Between their 2 hospitals they have 700 beds. On one campus, they have 3-4 security agents which isn't much. One is stationed at the emergency department, but things are happening within minutes of one another and you can't move that quickly. Of course, you're going to have nurses in the room themselves and they're going to be assaulted or battered by a patient. If you don't provide them with the resources, tools, techniques or tips on how to keep themselves safe then you haven't done your due diligence as an organization. And to continue to say that it just resides on security is not doing your staff any good.

**Rob Newells** stated that is also administration's responsibility for safety. There are facility improvements, access control, policy improvements that could be made. It's administration and staff and security and law enforcement.

**Sandra Williams** stated that healthcare is very diverse and violence occurs in clinics, long term care facilities and hospitals. Each environment is staffed and equipped differently, and has different resources and that needs to be considered. Healthcare can be compared to education in that teachers were hired to teach, but because of the changes in the environment and human behavior, they've had to acquire a different skill set to ensure their safety as well as others in the environment. Healthcare is evolving to that where clinicians are hired to treat, care for the patients and they've had to look at the way they provide healthcare differently as behavioral patients are entering the environment. Training should not only be for clinicians, also from the front desk to the back. Training should cover behavioral clues, protection strategies for themselves, how to respond until additional assistance can arrive, and recognize that events potentially scale to violence and how to detect that early on. She heard someone say that the Joint Commission restricts or there's a barrier to law enforcement within their environment and she challenges that because the Joint Commission requires them to identify, mitigate, report and communicate their risks and train when necessary. Law enforcement also requires that, when they have consultants or contractors in the environment, they have to treat them as their employees when they're doing their training. They become collaborative when they respond to safety or security events and look at intervention immediately and the risk plan in real time as the patient matriculates across the continuum. Reporting comes from different areas within the environment, for example an employee verbally reports to the supervisor, there's an occurrence report, there are potentially reports for employee health, workers' comp, safety and risk management. She wants to know how to reconcile all those reports in order to assess the situation, to categorize the risk and to develop strategies to eliminate that from happening. Reconciliation of the information is a challenge because sometimes the information isn't readily available and sometimes it isn't shared. When they miss the opportunity to collectively review, share, discuss and come up with plans for action then they have events occurring again. There must be some method to flag a chart that should travel with the patient in terms of the potential for violence or known violence. There needs to be processes and protocols put in place for psychiatric emergency response training. CPI training is used by some hospitals but training should be elevated to include more around behavioral strategies for safety which is everyone's business.

**Richard Negri** stated that we need to be aware of the Occupational Safety and Health Act where the employer has a duty to provide a safe and healthful work environment. He referenced T8 CCR 3203, Injury and Illness Prevention Program, that goes above and beyond the General Duty Clause and that requires the employer to provide a safe and healthful work environment. When we think about safety being everyone's concern, the onus is on the employer of the business. **Sandra Williams** agreed and stated she's not trying to move away from that or suggest that it's just the employees' responsibility. At the end of the day, the employer is responsible for the patients, the staff, and the visitors and ensuring that it is a safe environment. Collectively it takes all of us to execute that.

**Katherine Hughes** stated there's been a lot of discussion about safety being everyone's job and what SEIU meant is that "security" isn't everyone's job. She's a nurse and not a security officer. Her workplace violence prevention training was a ridiculous 15 minute video that focused on if her husband comes in with a gun, etc. If she worked in other areas like forensic psych or in a locked psych facility, she would be trained in takedowns and rightfully so because she would probably be an immediate responder. In the vast majority of healthcare, except for those few places, nurses are healthcare providers and she doesn't want her patient to be threatened by her or afraid of her. She doesn't want them to think that she's the one that wrestles them to the ground because they need to be able to trust her and she's already going to hurt them by caring for them whether treating them while they're in pain or doing a dressing change or medical nursing intervention that is going to result in pain. She's noted what has been said that could be put in the standard and is realistic – specific training and education based on where you work, describing what security personnel do so that workers can distinguish between a security guard, security officer and sworn officer of the law, using a multi-disciplinary approach for committees, communication and reporting, officers training approach for everyday training, for example how to step around the corner. She asked other stakeholders to give them some tangible ideas on what could be in the standard. If healthcare workers are going to be immediate responders, then they can't be disciplined. If healthcare workers are going to be required to report, then they can't be dissuaded to report or retaliated against for reporting. And they can't be retaliated against if they need to file criminal charges because hospitals don't want bad PR because that's the stuff that's really happening.

**Cindy Conner** stated that our environment is changing and you have to treat your workplace like you would your home. Your work environment is your neighborhood watch as well. Her deputies tell her about nurses and doctors propping a door open so they can smoke. There are a lot of things that can be done better, and it starts with the top leadership but also the leadership by charge nurses on floors, the commitment from those people to get their troops to fall in line. They have clear shields that they use with behavioral response teams so they can go in and be protected against the patient with the cup of urine that's ready to gas them with, and other safe techniques so everyone goes home safe at the end of the day. Their behavioral response team is made up of tiny women that call themselves the mod squad because they're so trained and skilled that she takes them on her team as opposed to a big, beefy guy who doesn't have half their finesse. Some of her female deputies are better than her male deputies because they're communicators and not ready to jump in there. Everybody has to take responsibility. It starts at the top, but it's at all levels.

**Rob Newells** responded to Katherine Hughes' request stated that someone must be named to be responsible for the workplace violence prevention program, just like someone is named to be responsible for the injury and illness prevention program because security can't hold it together. One of the challenges that they had in relying on security to identify all the risks in their facility for the Joint Commission standard was that security's categories didn't quite match up with what

they needed. Everything was pretty much an assault and it took time to work out with them that if there was an employee involved, put it under workplace violence category because incidents were only identified as an assault or a threat and didn't call out that employees were involved. With regards to training, Rob likes Katherine's suggestion of different levels of training for different work responsibilities and the standard has to be flexible enough to allow for that. Some people only may need training on recognition and reporting, some need to be trained in defensive measures, and some need to be trained in takedown. Everybody doesn't need the same level of training and if everybody gets 8 hours of training per year, they're not going to be able to do that. If some people need an hour of training, some with 4, some with 8, they can manage that.

**Katherine Hughes** added healthcare workers need to be able to request training. She referred to the training in safe patient handling regulation that provides initial training, annual renewal, new employees, when there's a new threat or hazard recognized, or any time an employee asks for it.

**Cindy Conner** commented that another component of training is after an incident, it's critical to have a debriefing and discuss it, as is done in law enforcement for any major incident. Even if everything turned out great, it's important to look at what they did well and what could they build on, and have the follow-up dialogue after an incident. They also put out a quarterly briefing on incidents so that everyone can learn from it.

**Katherine Hughes** stated the standard should also include post-care whether it be physical or psychological post-care because they have a lot of members with PTSD, people afraid to go to work but don't have a choice because it's their livelihood.

**Cindy Conner** stated that her department is teaching at UCLA's nursing school now and they train during new employee orientation. They consider training perishable skills and try to do it in 15 minute increments where they're rotating through different shifts because it's tough to pull someone out for 4 or 8 hours, but there are things you can do that are feasible in the middle of a busy day such as cover hot topics.

**Jollene Levid**, SEIU 721, is a social worker mostly based out of Harbor UCLA Medical Center had a question about best practices for security measures and security staffing in psych areas. She heard a few examples from Mr. Hoffman regarding security staff watching patients as opposed to just any aides and ambulance point system. At Harbor UCLA, the nursing staff expressed they don't like using the riot shield because it makes them feel even more unsafe. Nurses call her all the time because they're bit, kicked, punched in the face and black out. She's interested in other practices outside of LA County and what is done in psych areas.

**Cindy Conner** stated she keeps track of the shield that's used (not a riot shield) and since training 2 months ago, it's been used 15 times in psych and 8 west. She doesn't have any stats that reflect biting or knockouts. They've had zero incidents.

**Jollene Levid** stated that the union keeps their own stats because there's a lot of intimidation and they can compare notes. She wants to know of other practices because even though they have to use them, the nursing staffs feel unsafe and if the patient hits the shield and they don't have a helmet on, it can hit their face. There are a lot of safety issues and she's sure there are other practices across the state that they can implement throughout the LA County facilities outside of militarizing their psych facilities even further.



**Surit Goldmacher** referred to the handout, Executive Summary Evaluation of Safety and Security Programs to Reduce Violence in Health Care Settings. There is 1 ½ pages of recommendations from the study she was involved in that talks about safety and security training programs, where they should be site specific. They incorporate 5-10 minute training reviews in monthly staff meetings because staff didn't remember a lot of things because they only had it once a year. Another issue was that staff hired in September just missed the new orientation training and didn't get it for 6 months. Training should be site specific and based on the incidents that occurred in their facility, which is not done so staff don't really know how many incidents happened in the ER, etc. She was assaulted not in the ED, not in a psych unit, but just on a floor. It happens all over the hospital. Everywhere is high risk nowadays and you're dealing with a highly stressed out population.

**Elizabeth Bilberry** commented that if they took staff and put them in an auditorium for 8 hours, they really didn't pick it up. However, if they did the book stuff in the auditorium or a conference room, and took them into their environment for a simulation where the room was set up just like the environment they work in, you would see them position themselves correctly in the room, with the door to their back.

LUNCH

**Deborah Gold** reconvened the meeting. She stated that stakeholders spoke of the need for hospital security plans to be integrated between the security personnel and the medical/nursing staff. She asked if anyone wanted to comment further on agenda item 3A, Facility security roles: In hospitals (i.e. GACHs and Acute Psych), security plans, intervention and limitations. She stated it's interesting that Children's Hospital has gone to having onsite law enforcement personnel as well as the security people. **Rob Newells** stated they wouldn't have if they didn't have an incident.

**Sgt. Tim O'Connell** stated the sheriff's department noticed the high probability of gunshot victims dropped off at Highland Hospital because it's the major trauma center for Oakland. **Surit Goldmacher** added that Kaiser Richmond has had that for years.

**Cindy Conner** stated that if they were to run people dropped off into the county healthcare system, they'd probably have a lot of warrants or are arrestable. There's the environment of wanting to ensure that all patients feel welcome and safe so they don't make a practice of it unless someone brings cause for them to focus attention on them, then they're a patient. She also mentioned that weapons screening has been a wonderful deterrent. They've had incidents where someone walks up and they get them on the camera and they see the screening mechanism and U-turn and walk the other way.

**Rob Newells** learned from their experience with Cal/OSHA to pay more attention to what's going on outside of the hospital, staff park 2 blocks away from hospital so make sure to pay attention to that part of the community as well.

**Jorge Cabrera** reiterated that healthcare professionals should not be security guards, be mindful of demographics, immigrants are afraid of law enforcement because there has been a link from law enforcement to deportation.

**Rob Newells** added that reinforces why the safety program can't just be law enforcement and law enforcement has to check in with the nursing supervisor before going on to a floor to question someone because they don't want law enforcement to be the first experience someone

sees while they're in the hospital. He doesn't want staff to be playing hero; he tells staff to stay away from a code gray if they're not responding. They have to have the active role of recognizing a threat or emerging threat and reporting, which is one of their biggest gaps. One of the reasons staff don't report is that they don't think someone's going to do anything. If they don't hear about it, they can't do anything about it.

**Meleah Hall**, special education teacher, stated that the patients with autism or other disabilities that are in clinics are in their classrooms every day so teachers, physical therapists, occupational therapists are exposed 6 hours per day. Paraprofessionals perform tube feeding, for example, and like healthcare are exposed to high levels of violence. The standard should address what to do when there is a staff shortage and delineate job duties, for example security guards should be at the front gate. Silent victims (unintentional vs. intentional), the non-desirous report, violence walkthrough, working with the community and law enforcement also needs to be looked at.

**Rob Newells** mentioned they are doing workplace violence risk assessments separate from their security risk assessment and they're hiring for a position as an Injury and Illness Prevention coordinator to help with the Safe Patient Handling Act as well as workplace violence, but it took a Cal/OSHA experience to get administration on board.

**Deborah Gold** inquired about security for non-hospitals. At the last advisory meeting someone from home health said they instruct employees to call 911 if there's an incident. **Surit Goldmacher** said that one of the other studies she did was on home health and hospice. Some agencies had private security, but it took forever for security to get there and they got behind on seeing their patients. Most of the nurses she spoke to said they felt pretty safe because the families protected them and there were occasions where they didn't. Another solution could be that 2 people go in at the same time (e.g., nurse and nurse's aide). Some did security assessments – ask about guns, knives, drug use in home. It's not uniform.

**Cindy Conner** said that home health is their Achilles heel, and that not many incidents are reported. She's been told of sketchy areas where deputies would not be sent alone and she's not sure what the solution is and is putting the issue on the table for discussion. A few agencies use vector which is a locator for the cell phone, but a lot of them don't want it because they don't want to be tracked. She's heard excuses that if a nurse isn't comfortable in the house, they want to get out of the house or that they want to stop and shop along the way. There's truth in the middle. Law enforcement is tracked everywhere they go and there's beacon in their car. She wants to hear what kind of training home health care providers are getting. She also recommended obtaining crime maps showing what crime have occurred from crime analysts at local police stations. **Deborah Gold** mentioned that sometimes home health services are delivered to psychiatric patients, some of whom may have stopped their treatment protocol without telling anybody and sometimes they're specifically avoiding the home health nurse and vice versa. **Vicky Wells**, City and County of San Francisco, Dept. of Public Health stated she is not aware of any problems with their home health services.

**Adam Weinberg**, Children's Hospital Oakland, stated there are some good training resources and a lot of their home health employees are in their training sessions. He sees concerned looks on their faces about things that might happen. International Association for Healthcare Security and Safety (IAHSS), a hospital safety and security organization, has resources on this topic as well as CPI training. But that's training and putting the responsibility on the individual employee again which would still be of help to the employee. He advocates communication

devices, like a cell phone with a GPS function. **Sgt. Tim O'Connell** added that someone should check on them when they're on a visit to make sure they're alright like a phone call.

**Anthony Roman**, Director of Security Scripps, emphasized training in situational awareness. He feels that early intervention is key to interacting with someone exhibiting behaviors that could potentially lead to violence and that could be considered in the home health environments as well.

**Rob Newells** stated their psych nurse worked with trauma services emergency department staff to develop specific training for emergency department staff that is not the same training that everyone else might get during new employee orientation. The employee and the department involvement in the creation of training that works for them is part of that site-specific, specialty-specific training that needs to happen.

**Katherine Hughes** stated that with regard to tracking devices members should not be shopping on work time, but she's heard that nurses have a workload they're expected to do and if they spend too much time in a household they could be disciplined. She supports a check-in/check-out system with an employer-provided phone equipped with a tracking mechanism that's only used while doing home health visits. As far as employee/employer involvement, ask home health nurses what they need and then find out if that's feasible. They've heard suggestions to have a placard on the car that identifies them and others have said absolutely not

**Richard Negri** stated that when we talk about the role of security, we're also talking about preventive mechanisms and not just reactionary. Working alone is a common issue he hears about from home health and if they could solve that problem, it would be a great preventive mechanism.

**Deborah Gold** stated we need to know what is being done with security in non-hospital environments, such as medical office buildings and ambulatory care clinics, hospital-run outpatient offsite and onsite facilities, which are subject to violence.

**Dr. Christina Garcia** stated that in private sector you can choose to have your own personal security and in psychiatry you can choose to have panic buttons or security cameras in your private office, but it goes against HIPAA if anyone else got a hold of it. In terms of the public sector and their outpatient settings, the panic buttons that are in each office at LA USC don't work. She's read studies on where to place panic buttons, such as the offices of the providers, triage areas where nurses might be, definitely where the secretary or front desk person being the main source of watchfulness for agitation. Then we need standards to follow up on who's alerted when the panic button gets pushed. Quite often you can have a provider push the button in room #1 but providers in room #10 don't know something's happening. And if an active shooter comes in, the entire clinic is not always aware so if panic buttons are going to be put in place it has to be a system where the entire clinic is alerted, including other patients and other staff.

**Deborah Gold** asked if the panic button were to work, who gets alerted? **Dr. Garcia** replied that the sheriff's department is supposed to respond. The employees are supposed to know, if they put in a phone call to the sheriff's department, where their office is located and how they can direct people to come and assist them. Also consider placing panic buttons in bathrooms or dark corners, down hallways, etc.

**Rob Newells** stated you have to engage the non-healthcare folks, such as the administrative support staff. When he was in the office in the psychiatry clinic, their panic buttons didn't work and he only discovered that when he decided to press one. Nobody ever checked them, security is a block away but never came to their building. He asked for security to come over once in a while to walk through the clinic, and to check and test the panic buttons daily. It's a children's hospital but you have children with psychiatric issues that have parents with psychiatric issues. The front desk staff is challenged by irate parents on a regular basis, so the security manager gave them CPI training. It's not always patient care folks or senior management. Clerical staff also needs to be involved.

**Dr. Christina Garcia** added that mental illness doesn't always lead to violent assaults. What they see is mental illness with substance abuse increases violence by tenfold. Secondly, they do their job to treat the patient but a lot of their patients, when they're violent, appear from a medical standpoint that it's more of a violent behavior that belongs in jail where they're better equipped to handle. Even if the patient has a diagnosis of depression, if it's the anti-social part of it going on, the doctor can't give them enough drugs to get rid of it because there's no medication that actually treats that. So when they're arguing with the patients or their family members, it's not something that they can treat medically and they turn to law enforcement to assist them in the hospital, the clinic setting, or at home health visits because their hands are tied.

**Adam Weinberg** proposed that security's role in a clinic environment or a medical building or any ancillary areas largely boils down to the security workplace violence assessment that should be done where you take in multiple factors. It needs to be multi-disciplinary and include staffs that work in that environment and needs to look at the crime profile within the area, and the level of incidents within the building. We're talking about a range of communities with a range of needs. If the assessment is done properly, it will address a lot of those concerns and will determine security's role at this address, in this location, in this community with the patient population that we serve.

**Deborah Gold** stated that not all ambulatory care clinics or community based clinics come up under the Health and Safety Code regulation's requirement to have a security assessment. She understands that those that fall under a general acute care hospital's license would have to do that. **Adam Weinberg** agreed and said that having the same approach to those not covered under a hospital's license would have to be looked at.

**Cindy Conner** mentioned they have four sites in probably the most crime-ridden area in Los Angeles and the administrators outreached to all the churches and that was effective in the community. One particular clinic, probably with the highest level of homicides, is sacred ground because of the outreach within the community to the churches, schools, and various things they engage and host at the clinic that provides to the kids in the community. Their presence is very positive and a deputy will drop by there once a shift. Their presence there is primarily private security and sheriff's security officers. They did a low level security assessment and they controlled access, identified areas of risk and have had a high level of success there.

**Gail Blanchard-Saiger** stated that we haven't really talked about the patient here today. At the hospital, you just can't discharge a patient because they're not being cooperative, so there's that a tension we can't lose sight of. And there's an overlap between patient care and employee safety and she's not saying that one is more important than the other, just that we can't forget about patient care. Whether clinics are licensed by a hospital or whether they're a community clinic, they would seem to be similarly situated so she doesn't see a distinction between the two.

**Rob Newells** mentioned that their threat management team includes a patient advocate and others that try to keep patient issues at the front so that collaboration is important.

**Vickie Wells** said they have a whole range of outpatient clinics, some of which are licensed under the hospital and some aren't. She opined that some kind of security assessment would be needed in all of the clinics to determine what their needs and risks are. Some outpatient clinics have higher risk, not only based on where the clinic is located but based on the types of patients they're seeing. Over time, they'll see security risks for any given clinic change if the types of patients they're seeing change significantly. Some of their clinics have very high risk for workplace violence behaviors because they treat the homeless with substance abuse problems or alcohol problems. Regardless of whether clinics are licensed under a hospital, a security assessment that looks at the type of patients that are treated, what the past history of incidents has been, and where they're located would be appropriate. **Deborah Gold** asked what type of security they provide at the clinics with high numbers of incidents. **Vickie Wells** replied that they have sheriffs staffed at the high risk clinics.

**Michael Musser**, CTA, mentioned public schools are other workplaces where healthcare workers, such as nurses, nurses' aides and paraprofessionals, are exposed to workplace violence. They have a variety of campuses – those that have actual law enforcement, those that have security personnel that are district employees. What they don't have is some type of consistent system to deal with workplace violence that supports the employees (healthcare workers and others), students, and members of the public that are on their campuses.

**Rob Newells** stated they run a couple of clinics at high schools. They have a great workplace violence prevention program and a sheriff's deputy 24/7 at the hospital, but he can't force the high school where his clinic staff is working to have their same workplace violence prevention policy. He asked how he protects his staff without sending another armed officer over there.

**Deborah Gold** stated that Rob Newells raised the issue of the host employer and this issue came up last week where there are healthcare employees working at corrections and working for a different employer than the correctional officers are working for, the correctional officers were not taking the protection of the healthcare worker as much of their responsibility as they would the protection of another deputy. So nurses might actually work alone in a situation where a deputy would always be with another deputy.

**Cindy Conner** clarified that the nurses at the LA County are employees of the Sheriff's Dept. She discussed it with the chief of the custody division and they do have deployed deputies that work with those healthcare providers at least in the LA County jail system. She thinks the level of camaraderie is different between healthcare providers and deputies.

**Katherine Hughes** stated she thinks that happens at some correctional facilities in detention where the nurses often do work alone. Obviously there are times when you're going to walk into a patient's room or in the clinic and you might be alone in the room, but then you'll have a risk assessment where you're able to say you don't feel comfortable being in the room by yourself and have someone say okay let's find you someone else to pair up with.

**Jorge Cabrera** stated that it's great that we're talking about correctional facilities because SB 1299 doesn't go far enough because it excludes them and we need to keep them in mind. He asked if there were going to be additional meetings on the subject because there have been a lot of questions asked that we don't have answers to. **Deborah Gold** replied that there will be

another advisory meeting in January or February, then another in March or April. Anyone who has information should send it to her or Bob Nakamura. We'll be having this discussion in the context of what should the regulation include. Although 1299 doesn't specifically address local corrections or even state, it doesn't say we can't and the decision from the Board was to address healthcare as a whole.

**Sandra Williams** talked about the roles and responsibilities of security and what that looks like in healthcare. We should consider what goes in contractual language for security companies in terms of some of the expectations. If it's a proposal then there's specific deliverables and companies are selected based on the proposals and need to meet the deliverables. It's important to have some type of integrated piece within the contract so they can better understand the environment and work collaboratively to respond to certain issues. We also talked about panic buttons and specifically about hard-wired panic buttons. There are other panic buttons as well to consider. It's okay to conduct risk assessments, but you need to be able to implement recommendations, and a timeframe to implement deliverables based on categories of risks. If clinics also have to do assessments, we should consider what environment the clinic rests in and use data from law enforcement's CAP index.

**Deborah Gold** asked if there are facilities that are contracting for security, it would be helpful for the Division to see the documents, such as the request for proposals or scope of services, that define what facility security is going to do. **Gail Blanchard-Saiger**, expressed concern over the state getting involved in contracts. Deborah Gold clarified that Cal/OSHA will not be specifying contract language but wants to understand how hospitals and others contracting out facility security, are defining that role. What is the description that's being put out to a security company about the role that the security company is going to play in the facility security plan.

**Paul White**, Securitas Healthcare Division, stated he would provide Deborah with a sample request for proposal, to include scope of services. This topic has always been around and has escalated over the years, but now we're at a breaking point that we can catch the wave or miss it again. In 1993, AB 508 was created to report these incidents to law enforcement and 1995 it was implemented. It's nothing. In 2010, AB 1083 was passed and now we have SB 1299 and are in the same boat. Now we're talking about employee safety and there's a lot on patient side (Joint Commission, CMS). We really need to stay focused on employee safety. Can we not put in the regulation a check-box thing like all of the other regulations in healthcare? He gave the example of video training as a check-box item. We should use a knowledgeable person, like what SB1299 has done, where someone validates that the employee understands the training such as a safety officer, risk person, but it has to be outside of security who likes to check boxes. We also need a way to impact employee safety in regards to workplace violence. He worked for a large healthcare entity where not just nurses, but other hospital employees that changed their careers because of workplace violence.

**Deborah Gold** stated we've had a lot of discussion about law enforcement, particularly facilities that have internal law enforcement. In terms of facilities that don't have law enforcement on site, who's making the decision about how and when to summon those resources? What is that point where you say we need to call the police? Are there limitations to what private security can do? **Gail Blanchard-Saiger** said she tried to get some folks here that are in that situation that don't have law enforcement on site and they just couldn't be here. She can talk to them individually or can arrange for a conference call.

**Rob Newells** said for all of their offsites, they train staff at new employee orientation to call the emergency number for their clinic. If it's in Oakland, they call 9-911 and tell them where they're

located. He doesn't know what kind of message comes from the clinical supervisors, he wants employees to call and not worry about what it's going to cost.

**Sandra Williams** said it goes back to the event recognition and then training the employees to communicate. When there's not security within the environment, it's been her experience that they do call 911. Deborah Gold asked if each individual makes that decision and Sandra replied that each individual does. They use emergency codes and when one of them are used, it's either a direct call to 911 and some larger units that are linked to the hospital system, they have the ability to call and activate security but they have the option to call 911. It's no different than a medical emergency – you call 911. **Katherine Hughes** agreed that it's no different than a medical emergency.

**Elizabeth Billberry** stated that at UCSD, the way their phone system works staff cannot dial out to 911. The call goes directly to their PBX and the operator picks up the emergency line and asks what your emergency is. Based on the information that's provided, simultaneously someone will call 911 and the other will call security. Based on the incident, they have proprietary security agents that are onsite and they have a police department on their northern campus. The decision to call the San Diego or the university police department is assessed and decided by the security and/or the medical staff that are onsite. Security will come in and do an assessment and decide whether to call law enforcement or de-escalate and handle on it their own.

**Katherine Hughes** stated that if she felt she had to call 911, she doesn't want someone else to determine if it's an emergency or not. She's talked to some security firms where they have the personal alarms that are part of your badge so they're with you at all times. They have different levels of alerts – yellow lets people know this person is starting to escalate and might need people to stand by who are designated and trained. Then the red alert is an actual emergency where something bad is happening and automatically calls 911. You can do the same thing where code yellow gets people there so the healthcare worker is not by themselves anymore and then a different code which means to call 911 now. That has to come from the person who's seeing what's happening, not somebody like the PBX operator. If she needs to call 911 and has to wait for security to come, she could be dead by then.

**Cindy Conner** stated that if anybody calls 911, they're asked what their emergency is. All 911 calls from LA County come into law enforcement. If it's medical it's immediately transferred to fire/paramedics. It's either medical or a law enforcement matter and the caller will be barraged with questions like what do you have, is there an active shooter, what is the situation because when they're responding they're tactically preparing for whatever the situation may be. Their procedure with the panic alarm is that they will call back that area immediately. The training they provide is if they can't answer the phone because they're trying to get out of harm's way, they will come with all that they need. But if they pick up and are able to answer yes/no questions, such as is there a weapon involved, it will help them to prepare. If you ask someone to call on your behalf they will still come, but it's going to be a delay. If you have that system in place, make sure your local law enforcement agency understands that it's going to be a second party 911 call coming through so they understand the situation.

**Rob Newells** stated that for a lot of their clinics, even though they're not on the main campus, they share the phone system. If they call from a clinic that's two blocks away from the hospital, it comes through as Children's Hospital on the switchboard so everybody shows up to the main

hospital but you're two blocks away. So they had to make sure to train folks that work in offsite locations to call 911 and give them your address, so folks show up at the right place

**Elizabeth Billberry** clarified that when you dial 611 which is their emergency line for any emergency, e.g. code blue or code gray, when the PBX picks up the line and asks what's your emergency, it's immediately transferred and the caller is not asked are you sure or what's really going on. They don't do that and it's not a situation where someone is deciding for you. It's just for the purposes of the way the system is deployed, every time you make a phone call regardless of where you are on campus, the address that comes across is the hospital's address and the switchboard makes sure those communications occur. Secondly, they often have patients that call 911 to report the nurse is being mean and won't bring their food. They also have situations where there's something happening at a clinic and everyone at the hospital who could help don't know they've called 911 until they look out the window and see 5 fire trucks and 10 police cars and the people who could have helped them were across the street. That's the reason why their system is the way it is today.

**Phil Hoffman**, stated they don't have security at all of their medical offices. Some have security and some have a lot of security based on community standard, their culture and what's going on campus. If you call 911, it's going to take between 7-30 minutes so their emphasis during an incident is for personal protection and that staff should disengage themselves. They can't order their security officers to put themselves in harm's way and the way someone will respond to a situation will either be fight or flight. One thing we're all in agreement is that the employer needs to protect and provide that. Maybe the way it's spun or framed is that we have the duty to be inclusive in our plans of protection for all facilities we're responsible and have employees at. Kaiser has 700 medical office buildings and another 300 leased spaces. Some of those will have critical vulnerable areas, some will have behavioral health, some will have pharmacy operations that bring in drug-seekers and some that know they have cash on hand at those facilities. They have to address these different categories and not to be specific on what you want or what you think should be a standard, but that it's included in the plan and you're able to show that it has been addressed. What's important going forward is that you guys are going to be asked what are the crimes, what are the exposures, and what are the risks that you've had because in case law you have prior similar circumstances and foreseeability and that's the litigation side of the house. The key is that if you have a bunch of assaults, then you have to demonstrate that you're preventing that from future occurrence and not remaking it as mistakes. If you're inclusive in the plan and your plan addresses how you summon law enforcement if you don't have one on board or don't have security officers there, it has to address how you protect in the immediate sense. When it goes through the operator services, there's a point where they can call a roaming patrol to that location that might shorten the police response time. When you get down to framing how you want that to look, you can't be too constrictive because some organizations might not be able to afford that level of protection, you might not have that bandwidth or the police department might be too small to provide that. But at least you have to address it in your plan of protection on how you're going to get that back up for that police or security. It's incumbent that you at least address a process and to either disengage or have some sort of response of a higher level of protection.

**Cindy Conner** stated that 911 in urban communities, there is a threshold of 3 minutes to be there. You're calling because there is a life-threatening, imminent situation. There could be an extended estimated time of arrival in a community because you're in the high desert or a rural area. This is where we discuss contingency planning, but if you truly have an emergency and need that 911 in your contingency you have your onsite security who's at a lower level, she



would suggest first making the 911 call and that contingency plan is also being initiated for your private security.

**Katherine Hughes** stated she thinks we should have both and she gets that PBX has the technology to announce codes throughout the facility and she doesn't. But if she sees someone walking in with a gun, she just wants to be able to call 911 and get somebody there. Then maybe someone else is doing the PBX thing so people know what's going on because her coworkers need to know there's a code silver. But for the phones to now allow you to physically do it, that's a problem for her.

**Cindy Conner** stated that in some areas, if you dial 911 on your cell phone it will not necessarily go to who you want to immediately respond. In some areas, it directly goes to CHP. They make sure their employees are given the emergency phone numbers that are customized to their location. You have to have contingency plans if you're in a rural area but in urban areas the threshold is 3 minutes or less.

**Rob Newells** said there's a difference in how you respond in a hospital setting and how you respond in a clinic setting. In a hospital they don't have employees call 911 because it's going to take 911 longer to get there than it will for their onsite deputy and onsite security to respond. If you call 911, the deputy won't hear about it until after the police show up. If you call their emergency number, the operator and security answer the phone at the same time and the operator asks the same types of questions as 911 would ask, security's calling to the deputy and 911 if necessary. If you're at an offsite that's not connected to their internal emergency number, they're told to call 911 and then call security afterwards so they know what's going on.

**Sgt. Tim O'Connell** referred to the discussion about contingency plans and emphasized that staff have the right to protect themselves. You need to get everyone's buy-in that you have the right to protect yourself and those that work with you. If that means hitting that person with a chair, so be it. You need to survive. If it's taking a long time for PBX to answer the phone or 911, you need to go home at the end of the day.

**Richard Negri** commented that a few months ago at Riverside Community Hospital, a patient acted out violently on one of their members. A colleague of the nurse who was being attacked who is also a member, came to their rescue and intervened. They were able to calm the situation down and control that hazard and SEIU applauded them. That individual was disciplined and put on suspension for intervening. They're handling that case at their local in Pasadena.

**Cindy Conner** stated they have an objectively reasonable standard. What would another person given the same circumstances do, from someone standing on the sideline. She's seen similar situations occur but she's also seen the employee go above and beyond that when the situation was quelled and they decided to get one last shot in because they allowed their emotions to take over. She's seen situations where a combative patient came in and the behavioral response team was dealing with the patient doing everything right, then all of a sudden putting a pillow on the patient's face because he's spitting as opposed to a spit mask. And now you have a patient who's gasping for air so of course they're going to fight more. It goes back to training and thinking about it.

**Deborah Gold** introduced the last topic on the agenda, "What are barriers to implementation, and how to overcome them?" She stated that we've been talking all along about barriers to implementation: security and how to call them, staffing problems. This is the time to talk about

what's making it harder to implement security planning, hospital plans, security procedures in hospitals or non-hospital environments. We didn't talk that much as we have in other meetings about issues like privacy issues when police get involved in hospitals or mental health facilities, the need to record for these interactions. Also are there barriers we haven't talked about getting effective security and law enforcement responses.

**Rob Newells** discussed that one of the barriers is policies. What policies do you or don't you have, making sure that security's role is spelled out in the policies. Security is willing to do stuff but if there's not a policy that says this is what we do, it doesn't get done. It takes him at least a year to get a new policy through – a workplace violence prevention policy, the weapons-free campus policy, still working on the use and possession of drugs and alcohol policy. Things come up where you have parents in the patient's room and you find empty alcohol bottles and you call it a disruption but don't have a policy that you can't have alcohol, then what can you do? Make sure that your policies don't have a bunch of gaps and that you have all the right stuff.

**Vickie Wells** said that one of the problems they have is the issue of patients themselves. If they have a patient who is continually acting out and being a problem they can't just deny care to that patient. They have to find some way to transfer that care and in many cases, it's hard to find anyone to transfer the care to. You can have very problematic patients who continually act out in that facility but it can be very difficult to deny care to that patient.

**David Kernazitskas**, OSHSB Board staff, asked what the costs of onsite security and law enforcement are as an obstacle. **Sgt. Tim O' Connell** replied that one deputy 24/7 costs \$180K; that includes having a patrol car, communication and training costs, time for replacing deputy when they can't be there. **Cindy Conner** stated that it's not just the deputy that you're buying the whole department that comes along with that position: detective resources, sheriff's response teams if there's a natural disaster or act of terrorism. **Elizabeth Billberry** stated UCSD is divided up into the campus and then the medical center. The campus has the police department so in order to have the police officer reside in the hospital, it's very expensive. In UCLA, it's upwards of \$450K annually for 1 police officer assigned to that facility that's attached to the security department. But it's part of the whole system because when he calls for assistance all the police officers are coming to help.

**Deborah Gold** referred to the discussion of someone reciting the history of all the many bills that have required hospitals to have safety and security plans, and asked if it's true that these are not are new costs for hospitals. Elizabeth Billberry agreed and stated they've always had security at all of their medical centers. Because of the way some of their campuses are built, they are 15 miles away from the campus they don't have UCPD on their campus. They use the local law enforcement. At some of their sister sites, they are located on campus and have UCPD right there.

**Gail Blanchard-Saiger** clarified that HSC 1257.7 and the other bills do not require private hospitals to contract with local law enforcement so that would be a new cost. Deborah stated that would be the case if it were to be required, but asked if there any urban hospitals that don't have security onsite. Gail stated they do have security but it's not necessarily a contract with local law enforcement, so they have their own internal security.

**Phil Hoffman** remarked that based on their plan, that's justifiable. Wherever there's scrutiny, then that's where you say well is really one enough, two, three, four enough so it's totally up to the hospital. **Deborah Gold** added that it's part of the Health and Safety Code so theoretically it

would be audited by CDPH Licensing. **Paul White** stated that part of it is what you say it is, though. **Deborah** asked and stakeholders confirmed that there's no staffing ratio, nothing spelled out for security. She also asked and it was agreed that it's a performance requirement within licensing to have a safety and security plan, doesn't state it has to be effective. **Paul** stated it has to be evaluated annually so the plan is designed to get better, however you can have a security plan and not have any security officers because you've delineated that practice to Environmental Services, for example. So as part of Environmental Services' hat they have to do security, here's the training, here's the auditing to do. And you've checked the box because they're security, but they're Environmental Services. So when they call for help, they drop them off, everyone shows up but they've never practiced it and they don't have the skillset of lawmen so there you have issues.

**Jeannie King** stated that one of the barriers is communication with their local law enforcement between even the security of the hospital and even nurses. She'd like to sit down with security and the Pomona PD and have a lot of communication to see what plan they can make up, start from the ground up.

**Katherine Hughes** addressed the question about hospitals required to have a plan and if it has to work. She looked past 1083. Because it falls under licensing code, part of the problem is enforcement. She's never seen this enforced or seen CDPH go out and cite a facility, asking for a plan. She's talked to members that say they've called to file a complaint with CDPH and they've been told it's not their job to protect the employee. It says the security considerations relating to efforts to cooperate with law enforcement regarding violent acts. So they're supposed to: have a plan, include employees, include the union if there is one, and evaluate it every year. When her members ask to see a plan it doesn't always exist. For a lot of their employers in general acute care hospitals, plans don't exist, there isn't anything about effectiveness, so it just has to be a plan and her 15 minute video covered that. That's why SEIU petitioned the Standards Board. They wanted to go with an agency that was actually charged with protecting employees. CDPH is not that agency; they're charged with protecting the public and protecting patients. The plan is not worth the paper it's printed on if we can't enforce it and it's unenforceable as far as they can see. That's their biggest problem with it although it's actually well written.

**Rob Newells** remarked that for hospitals that are accredited by the Joint Commission, they're looking at their security plans so they're updating it every year and evaluating it all the time. **Katherine Hughes** replied that's JCAHO and not CDPH. **Rob** added that if CDPH came to investigate something, that would send up a red flag for the Joint Commission and they would be right behind them to come look at their plans. **Katherine** said that CDPH doesn't cite.

**Rob Newells** said that one of the barriers to implementing the workplace violence prevention program is training. If the standard is specific about what type of training program there is, that could be a challenge to get the length of time getting folks scheduled to come in. There are some staff that love to go to training but there are others that don't want to go to another training. It's getting folks to the standard's type of training. Everybody uses online training for almost everything, but some staff are going to need in-person, face to face, this is how you do it training, but everyone can't be required to have the same exact training across the board so that's one of the barriers.

**Katherine Hughes** commented that the problem with online training is there's no interactive question and answer and if she has a question she needs to be able to ask somebody what that is and that's one of the barriers to online training. **Rob Newells** replied that if there's a

question, there's a number you can call for an expert in that particular training area immediately 24/7. **Katherine** asked their nurses what happens if they call that number and was told they leave a voicemail. **Rob** said during the day you'll get whoever that subject matter expert is and during off shifts, you'll probably get the nursing supervisor who if they can't answer the question, they're going to refer it to one of them in security.

**Richard Negri** stated that he's found, after talking with members about the online training modules, that they sit down and will be interrupted by a code or will be pulled away after being online for a minute and a half. According to the hospital's administration, because they're going by the check box on that module, that nurse has taken the training. **Rob Newells** replied their training is more involved than that and they have to do more than check a box.

**Cindy Conner** said there are different types of training in law enforcement. Anything that's hands on they have to do on a regular basis to be proficient at it. She's looked at some of the training that is the standard which was developed 13-15 years ago, CPI. This is a different world than when CPI was rolled out. There's a whole lot that they utilize today through adult learning concepts which is hands-on training, even if it's for 15 minutes. They've taken what they utilize in custodial environments with high risk inmates and modified it

**Sandra Williams** added for the safety and security plan, those are required and they have to produce those documents at survey time. In addition, emergency activations are required as well as an after action plan. Joint Commission makes recommendations and CDPH will cite them under unusual occurrences in Title 22. Anything that threatens the welfare of staff, patients or visitors is a reportable item. In the plans, it delineates the role and responsibilities are and how they're carrying out certain tasks to ensure the environment is safe. Regarding training, you can provide education and information but that doesn't mean you're asking someone to demonstrate competency so that is different and what we're all looking for is the competency. **Katherine Hughes** commented that the employees don't always know what the plan is. **Sandra** replied that if you're an accredited facility, you have a plan and that plan can be produced and generally, it's not kept under lock and key. For the environment, there are six plans that have to be in place if you're accredited – hazardous materials, utilities, emergency management, life safety, equipment, safety and security.

**Gail Blanchard-Saiger** stated that she tried to get CDPH involved in this conversation earlier because there is a lot of overlap. One of her concerns is that whatever we're doing is not in conflict or creating additional requirements with respect to the current health and safety laws. There is a difference in the healthcare setting between training and competency and we should focus on competency and not 2 hours of training. Depending on what the training looks like, you may or may not be competent. **Deborah Gold** commented that the Cal/OSHA term that we use is "effective" training. We want effective training so the person can actually utilize that.

**Ingela Dahlgren**, critical care nurse with SEIU Nurse Alliance of California, likes effective training and doesn't take excuses from her fellow healthcare workers that they don't have time or don't want to go to training. Just make it mandatory because it's not just about your own life, it's about mine too. So get the training that you need and if it's made mandatory, you're paid for it and you're going to be completely knowledgeable and know what to do next time something is going on.

**Jorge Cabrera** stated that domestic violence has been thoroughly discussed but given that 80% of all healthcare workers are women and 85% of all victims of workplace violence are women, there's a step over of domestic violence affecting the workplace and that is a safety

hazard. We need to be thoughtful of this and incorporate it into the standard, and make sure the training is not only for the employees but also management for their responsibility to recognize domestic violence as a workplace hazard and abate it.

**Meleah Hall** stated that she's taught in classrooms and was a teacher for home instruction. It's difficult when you have students with severe behavioral outbursts every day. It's important to specify when to report, who to report, what to report. She was in the middle of a shootout in a local neighborhood and on the job. That probably needed to be reported but that was not made clear. There's no training at all for home instruction.

**Michael Musser** stated that 2 barriers come to mind when talking about public education. The first is funding for any type of resources or personnel is coming from the state budget so there has to be adequate funding coming from the state to begin with. Then it comes down to individual priority, how do the school districts prioritize their individual budgets to make sure they're adequately providing resources to their employees, students or communities that they serve. How do they recognize what level they deal with workplace violence? Those are challenging areas in public education.

**Phil Hoffman** explained the threat management team process when observing an unsafe condition – 1) employee observes something unsafe and reports it to somebody; that needs to be outlined. 2) management needs to give feedback to the employee, i.e. please don't call 911 again, that's something we can handle internally; or thanks for bringing it to our attention, we're going to get a restraining order; or thanks for bringing it to our attention, we're going to move you out of the building for a while because of an angry spouse making threats to the workplace; or this patient is consistently misbehaving but the organization needs to address it via letter or phone call to them from member services saying please behave when you come here, this is not appropriate behavior and this is a zero threat environment. It's really the mechanism. You can have the best policy, best system, greatest orientation but if you don't have a working, demonstrable program to transact the activity then we missed the boat. That's when you go back to correct your security management plan and tweak it, i.e. more security in the parking lots or ED; or need to address the lighting situation. Regarding employee commitment and management commitment, what is the feedback going back to the employee, the union, or department. Show them the transaction, which would pump a lot of life into the program.

**Deborah Gold** commented that would be to close the loop means "effective communications" in OSHA-ease. Phil added that a lot of people don't understand that there's the plan and then the threat management team process and what that looks like.

**Richard Negri** commented that what Phil Hoffman shared speaks to the rationale for feasibility and preventability and that not everything will be prevented, especially human behavior. When you look at hierarchy of controls, elimination isn't going to come into play for that. However there's a tremendous amount of predictability and we've seen them work in some environments. We don't see them working in environments where they're not even tried.

**Deborah Gold** concluded that the meeting has been interactive and the stakeholder had a lot to say, which has been helpful to the Division. The Division will spend the next couple of months reviewing information it has accumulated to come up with a draft that discusses programmatic issues, how employees communicate and how employers communicate back to them, training issues. We have to have different tiers. There are facilities that are already covered by the Health and Safety Code and SB 1299. We have to reconcile that and reporting requirements in 1299. And we have to deal with all the different types of healthcare facilities, how to customize for the level of facility, available resources, what are all of the issues, etc. She emphasized that

the draft which should be ready mid-January is not a rulemaking proposal. We're at the point where we're trying to draft some language so you can consider it and see if it's captured what you think is important and see if it's where you were expecting it to be or left out something really important. We build our standards through processes like this, e.g. pay workers that are quarantined for ATDs, vaccinations for ATDs, etc. We don't have all of the answers and the Cal/OSHA staffs are looking to get those answers from the stakeholders and from its own research. Deborah thanked the stakeholders for their participation and adjourned the meeting.