State of California
Department of Industrial Relations

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OCCUPATIONAL SAFETY AND HEALTH
STANDARDS BOARD

Memorandum

To: Marley Hart, Executive Officer
Occupational Safety and Health Standards Board
2520 Venture Oaks Way, Suite 350
Sacramento, CA 95833

Date: April 10, 2014

From: Juliann Sum, Acting Chief
Division of Occupational Safety and Health

Subject: Division Evaluation of Petition 538[1] dated February 10, 2014 submitted by Richard Negri, Health and Safety Director, Service Employees International Union (SEIU) and Katherine Hughes, Liaison for SEIU Nurse Alliance of California.

This memorandum is written in response to your request for a Division review of Petition 538 dated February 10, 2014 submitted by Richard Negri, Health and Safety Director, Service Employees International Union (SEIU) and Katherine Hughes, Liaison for SEIU Nurse Alliance of California that requests the Board to amend the General Industry Safety Orders by adopting a new standard to provide health care workers with specific protections against work place violence.

Labor Code Section 142.2 permits interested persons to propose new or revised standards concerning occupational safety and health, and requires the Board to consider such proposals, and render a decision no later than six months following receipt. Further, as required by Labor Code Section 147, any proposed occupational safety or health standard received by the Board from a source other than the Division must be referred to the Division for evaluation, and the Division has 60 days after receipt to submit a report on the proposal.

Actions Requested by the Petitioner

SEIU proposes the adoption of a new standard to reduce the risk of exposure of health care workers, to workplace violence (WPV) as defined by the Occupational Safety and Health Administration (OSHA[2]). The petition cites the deaths in October 2010 of a psychiatric technician, strangled by a patient at Napa State Hospital, and a Registered Nurse working at the Contra Costa County jail in Martinez as a result of an inmate assault, as having raised the visibility of the issue of workplace violence as a serious hazard for healthcare workers. The deaths of theses healthcare workers demonstrate the need for better security measures, procedures, and practices. SEIU cites information that is found within the contents of the OSHA Workplace Violence website that provides resources and information on the subject of workplace violence. The petition references the OSHA Directive on Workplace Violence[3], which identifies health care and social service settings as being a high-risk industry for workplace violence. The document states that this includes workers "who provide healthcare and social services in psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment clinics, pharmacies, community-care facilities, residential facilities and long-term care facilities. Workers in these fields

[1] A second petition (Petition 539) on a similar topic was received by the Board on February 20 from Bonnie Castillo, Director of Government Relations for the California Nurses Association. This petition will be the subject of a separate evaluation.
[2] Occupational Safety and Health Administration, Workplace Violence. https://www.osha.gov/SLTC/workplaceviolence/
[3] Occupational Safety and Health Administration, U.S. Department of Labor, "Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents," Directive Number CPL 02-01-052, September 8, 2011.

include physicians, registered nurses, pharmacists, nurse practitioners, physicians' assistants, nurses' aides, therapists, technicians, public health nurses, home healthcare workers, social and welfare workers, security personnel, maintenance personnel and emergency medical care personnel."
The petitioner references OSHA's definition of workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide."[4]

There is currently no Cal/OSHA standard that specifically addresses workplace violence hazards in health care. The petitioner requests the promulgation of a new workplace violence prevention standard built upon a framework that includes subsections for:

- Scope and application to cover all workers employed in all health care settings.
- Definitions
- Management commitment and employee and union involvement
- Worksite analysis,
- A written WPV prevention plan
- Hazard prevention and control
- Information and training
- Recordkeeping and program evaluation
- Compliance
- Employee and union rights.

The petitioner referred to the Process Safety Management Standard[5] as an example of a regulation regarding employee involvement in the worksite analysis and written plan, and the Bloodborne Pathogens and Aerosol Transmissible Diseases Standards[6] as examples of regulations regarding training requirements.

The petitioner requests that a standard be developed through an advisory committee process which would involve the petitioner and other stakeholders.

Regulations, Laws and Other Standards

Existing Title 8 Regulations

There is no Title 8 regulation that comprehensively or specifically addresses workplace violence hazards. The Division has applied the following Title 8 regulations during investigations of workplace violence:

- Section 342(a) requires all employers to immediately[7] report to the local district office of the Division of Occupational Safety and Health any serious injury or illness, as defined in Section 330(h).

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[4] Occupational Safety and Health Administration, Workplace Violence. https://www.osha.gov/SLTC/workplaceviolence/
[5] 8 CCR 5189
[6] 8 CCR 5193, Bloodborne Pathogens and 8 CCR 5199, Aerosol Transmissible Diseases
[7] 8 CCR 342 states, "Immediately means as soon as practically possible but not longer than 8 hours after the employer knows or with diligent inquiry would have known of the death or serious injury or illness. If the employer can demonstrate that exigent circumstances exist, the time frame for the report may be made no longer than 24 hours after the incident." The definition of serious injury in section 330(h) excludes accidents on public highways or streets and penal code violations.

- Section 3203 Injury and Illness Prevention Plan requires employers to identify and evaluate workplace hazards, to investigate occupational injuries and illnesses, to implement corrective measures in a timely manner, to provide employee and supervisor training, to develop a system for ensuring compliance with workplace health and safety measures, and to establish a system of communication with employees regarding safety and health matters.
- Section 3220 Emergency Action Plan establishes general requirements for the elements that need to be in an emergency action plan.
- Section 6184 Employee Alarm Systems establishes general requirements for maintaining alarm systems.
- Chapter 7, Subchapter 1, Occupational Injury or Illness Reports and Records (Sections 14300 et seq) requires employers to record workplace injuries and illnesses and file reports with the Department of Industrial Relations.

Labor Code[8]

Labor Code Section 6332, adopted in 2000 (SB 1272), and amended in 2012 (SB 1038, Chapter 46 section 107), requires every employer of health care workers who provide health care related services to clients in home settings to keep a record of any violence committed against such a worker and file a copy of the report with the Department of Industrial Relations.

Health and Safety Code (HSC)
HSC Section 1257.7 (amended 2009 AB 1083) requires certain hospitals to establish a security plan with measures to protect personnel, patients, and visitors from aggressive or violent behavior. The security and safety assessment requires covered hospitals to examine trends of aggressive or violent behavior at the facility. Hospitals are required to track incidents of aggressive or violent behavior as part of the quality assessment and improvement program and for the purposes of developing a security plan to deter and manage further aggressive or violent acts of a similar nature. The plan is required to include security considerations relating to all of the following: (1) Physical layout. (2) Staffing. (3) Security personnel availability. (4) Policy and training related to appropriate responses to violent acts. (5) Efforts to cooperate with local law enforcement regarding violent acts in the facility. Covered hospitals are required to have sufficient personnel to provide security pursuant to the security plan. Persons regularly assigned to provide security in a hospital setting are to be trained regarding the role of security in hospital operations, including the identification of aggressive and violent predicting factors and management of violent disturbances. Any act of assault that results in injury or involves the use of a firearm or other dangerous weapon, against any on- duty hospital personnel is to be reported to the local law enforcement agency within 72 hours of the incident.

The requirements of the 2009 amendments have been addressed by the California Department of Public Health (CDPH) Center for Health Care Quality by directive in an All Facilities Letter, (AFL) 09-49 addressed to all state general acute care hospitals, acute psychiatric care hospitals, and special hospitals dated November 19, 2009.[9]

HSC Section 1257.8 establishes training requirements for emergency department personnel and personnel of

[8] A current bill, SB 1299 (Padilla) would address workplace violence hazards in certain hospitals.
[9] AFL 09-49 Hospital Security Plans Kathleen Billingsley, R.N. Deputy Director Center for Health Care Quality, letter November 19, 2009

other departments covered by the safety and security plan, for hospitals covered by HSC Section 1257.7. The AFL and HSC 1257.7 and 1257.8 are consistent with guidelines published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Welfare and Institutions Code

In 2012, Section 4141 was added to the Welfare and Institutions Code to address employee safety in California's state mental hospitals. The law requires the hospitals to update their injury and illness prevention programs at least annually. The programs are required to address the following: control of physical access throughout the hospital and grounds, alarm systems, presence of security personnel, training, buddy systems, and communication and emergency responses. In addition, the state hospitals are required to establish and injury and illness prevention committee comprised of management and non-management personnel, and to establish an incident reporting procedure.

Federal OSHA Regulations and Other Standards

There is no Federal (OSHA) specific regulation that applies to workplace violence.

Other Guidelines and Relevant Documents

Workplace Violence OSHA Safety and Health Topics https://www.osha.gov/SLTC/workplaceviolence/

Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers
U.S. Department of Labor Occupational Safety and Health Administration OSHA 3148-01R 2004

OSHA Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents CPL 02-01-052 09/08/2011.

Workplace Violence Prevention for Nurses, CDC Course No. WB1865 - NIOSH Pub. No. 2013-155

Discussion

As noted above, the petitioners propose using the OSHA definition of workplace violence which includes "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide." The source of violence is not limited to patients, however, a 2010 study found that nearly 60 percent of all nonfatal assaults and violent acts by persons occurred in the health care and social assistance industry, and nearly three-quarters of these violent acts were assaults by residents of a health care facility[10]. Currently, researchers use four general categories of violent acts, defined in terms of the relationship of the perpetrator of the act to the victim, to classify an act of violence, and this is used in the OSHA compliance directive CPL 02-01-052:

- Type 1—Criminal Intent: Violent acts by people who enter the workplace to commit a robbery or other crime—or current or former employees who enter the workplace with the intent to commit a crime.
- Type 2—Customer/Client/Patients: Violence directed at employees by customers, clients, patients, students, inmates or any others to whom the employer provides a service.

[10] Janocha JA and Smith RT. Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003-07. Bureau of Labor Statistics. August 30, 2010, p. 9-10.

- Type 3—Co-worker: Violence against co-workers, supervisors, or managers by a current or former employee, supervisor, or manager.
- Type 4—Personal: Violence in the workplace by someone who does not work there, but who is known to, or has a personal relationship with, an employee.

According to federal OSHA[11], "The Bureau of Labor Statistics (BLS) reports that there were 69 homicides in the health services from 1996 to 2000. Although workplace homicides may attract more attention, the vast majority of workplace violence consists of non-fatal assaults. BLS data shows that in 2000, 48 percent of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. Most of these occurred in hospitals, nursing and personal care facilities, and residential care services. Nurses, aides, orderlies and attendants suffered the most non-fatal assaults resulting in injury.

"Injury rates also reveal that health care and social service workers are at high risk of violent assault at work. BLS rates measure the number of events per 10,000 full-time workers—in this case, assaults resulting in injury. In 2000, health service workers overall had an incidence rate of 9.3 for injuries resulting from assaults and violent acts. The rate for social service workers was 15, and for nursing and personal care facility workers, 25. This compares to an overall private sector injury rate of 2.

"The Department of Justice's (DOJ) National Crime Victimization Survey for 1993 to 1999 lists average annual rates of non-fatal violent crime by occupation. The average annual rate for non-fatal violent crime for all occupations is 12.6 per 1,000 workers. The average annual rate for physicians is 16.2; for nurses, 21.9; for mental health professionals, 68.2; and for mental health custodial workers, 69. (*Note:* These data do not compare directly to the BLS figures because DOJ presents violent incidents per 1,000 workers and BLS displays injuries involving days away from work per 10,000 workers. Both sources, however, reveal the same high risk for health care and social service workers.)"

A survey conducted under a NIOSH grant in 2007, "Evaluation of Safety and Security Programs to Reduce Violence in Health Care Settings" January 2007[12] provides WPV data on a representative sample of general acute care hospitals (GACHs), emergency departments, psychiatric units, and psychiatric facilities. The data shows that California has a significant rate of WPV. For example in emergency departments, 92% of employees reported verbal abuse, threats were reported by 49%, over one-third reported being assaulted in the previous year, and 72% of those who were assaulted verbally or physically did not report the event.

For an indication of the current extent of WPV injuries in various health care settings in California, the Division requested the DIR's Research Unit to extract the total numbers of reported workplace violence related workers' compensation claims for the years from 2010 through 2012. Data were extracted from the Workers' Compensation Information System. [13]Since there is no specific classification for these events in the reporting forms, the researchers extracted the events by

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[11] Occupational Safety and Health Administration. Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers. https://www.osha.gov/Publications/OSHA3148/osha3148.html

[12] Evaluation of Safety and Security Programs to Reduce Violence in Health Care Settings Final Report, Peek-Asa, Corinne, et al January 2007 NIOSH Contract 200-2001-08014 and NIOSH R01-OH007934

[13] California Labor Code section 138.6

searching for key words in the injury description such as "violent, violence, assault, strangled strangling, agitated, aggressive, combative, threaten, abuse, or abusive" and other key phrases, including "crime". A total of 4,884 claims were identified for health care workers. The search excluded state hospitals and state prisons, including prison health care operations. The table below summarizes the results of this extraction.

Industry for Reported Claims of Workplace Violence among Health Care Workers, 2010-2012[14].

Category	Frequency	Percent
Hospitals	1629	33.35
Skilled Nursing and Intermediate Care Facilities	866	17.73
Government[15]	583	11.94
Residential and Intellectual Development Disability Facilities	303	6.2
Residential Care Facility - Elderly	276	5.65
Psychiatric and Substance abuse and Specialty Hospitals	200	4.1
Home Health Services	188	3.85
Child and Youth Services	162	3.32
Ambulance and Ambulatory Care Services	154	3.15
Physician Offices	129	2.64
Schools	60	1.23
Outpatient Care Centers	59	1.21
Other Individual and Family Services	46	0.94
Social Services	25	0.51
Medical Laboratories	16	0.33
Services for Elderly and Persons with Disability	3	0.06
Temp Shelters	2	0.04
UNKNOWN	183	3.75

It should be noted that these numbers are not likely to reflect the actual total number of violent incidents since these are claims that were made for injuries meeting the criteria established under workers' compensation and reported by claims administrators. The number of similar incidents causing less severe injuries that do not rise to the threshold of this category is likely to be significant. Many sources report that it is part of the "professional culture" of health care workers to think that incidents of violence from patients is part of the job, and they have no incentive to report them, and there is probably no employer process for recording them. The apparent under-reporting

[14] The search excluded state mental hospitals and prisons, including prison health from this search

[15] Due to the nature of data collected through the Workers Compensation Information System, the category "government" could not be further broken down into type of facility.

is supported by the California survey showing that 72% of emergency department staff who were verbally or physically assaulted did not report the event, as noted above[16].

The SEIU is also conducting a survey among its membership about personal experiences with WPV. As of February 2014 there were 128 responses. Eighty-six percent reported seeing or experiencing violence at work and 52% responded that fear of retaliation is an important factor they consider when deciding whether or not to report an incident. Thirty-two percent thought their employer had a successful program to prevent work place violence[17]

Division's Experience

In 1993, the Division published one of the first guidelines in the nation to address workplace violence, "Guidelines for Security and Safety of Health Care and Community Service Workers," which was prepared by Joyce Simonowitz of the Cal/OSHA Medical Unit. This publication, as updated in 1995 is still available on the DOSH website. As resources permitted, the Division maintained a workplace violence task force throughout the 1990s, and held meetings and reviewed enforcement cases on this issue in many different environments.

In recent years, the Division has conducted inspections in response to complaints and reports of serious injuries (including fatalities) in hospitals, long-term care facilities, jails, and psychiatric facilities. The Division's review of the employers' injury records and interviews with managers and staff indicate that there are a number of hazard identification, evaluation, and correction measures that are not implemented that could reduce the number and severity of injuries to employees. The Division has found that employers may not have effective procedures for identifying and evaluating workplace violence hazards, both in terms of facilities and patients, may not have procedures correcting those hazards, may not have effective procedures for alerting other employees to the need for assistance, may not have effective procedures for responding to alarms, and may not have effective procedures for post-incident follow-up. Employees who are exposed to workplace violence hazards, or who are expected to respond, may not have had adequate training. The Division has also found serious workplace violence injuries that were not reported to the Division.

Without a specific regulation, the Division has applied the sections noted above to require employers to develop and implement procedures to prevent or minimize the severity of workplace violence incidents. However, Section 3203 provides limited guidance for how employers can address the specific hazards of workplace violence. Other sections do not specifically address the use of employee alarm systems or emergency action plans for response to workplace violence incidents, although some general provisions have been cited in these investigations. For almost 20 years, the Division has issued special orders to establish specific requirements in certain facilities, most recently in the Department of State Hospitals (formerly the psychiatric hospitals of the Department of Mental Health). However, special orders address only single establishments, and are not an effective means for proactively addressing industry-wide hazards. The process of developing these special orders, in collaboration with the Cal/OSHA Medical Unit, employers, employees, occupational safety and health professionals, and researchers has provided a useful background for the Division in evaluating this petition and the Division believes will be helpful in developing a regulation.

Components of the Standard Proposed by the Petitioner

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[16] Evaluation of Safety and Security Programs to Reduce Violence in Health Care Settings Final Report, Peek-Asa, Corinne, et al January 2007 NIOSH Contract 200-2001-08014 and NIOSH R01-OH007934, p. 19.
[17] Cal/OSHA Standards Board Petition File No. 538 Appendix B: Survey on Workplace Violence

The Division believes that the components incorporated by the petition are appropriate for consideration in an advisory process. The Division has found that complex issues such as workplace violence require employee involvement and management commitment, specific hazard identification and correction procedures, written programs, training, and regular review including review by employees and their representatives. In addition, provisions would need to be included to encourage reporting of injuries, near misses, and warning signals of workplace violence. Similarly, accurate recordkeeping that includes critical information such as the location and type of incident, precipitating factors and type and effectiveness of response, is necessary to evaluate and improve the effectiveness of the program.

Specifically in regards to scope, the petition proposes that the standard should address workplace violence hazards to all workers in all health care settings. The information reviewed to date indicates that workplace violence is a hazard in many different types of healthcare environments. The Division believes that the advisory process should develop information regarding workplace violence hazards and their control in various settings, recognizing that control measures in an outpatient or homecare environment may be different than those in an acute care or long-term care setting.

The petitioner has cited the definition of workplace violence used in the OSHA advisory publications. The Division believes that as the advisory process progresses, it is likely to be necessary to not only define workplace violence in a manner that does not rely on intent or lawfulness, but to develop other definitions specific to provisions in any proposed regulation.

Effect of existing Health and Safety Code Provisions

As noted above, HSC Section 1257.7 and 1257.8 require certain hospitals to establish a safety and security plan with measures to protect personnel, patients, and visitors from aggressive or violent behavior in certain areas, and to provide training to identified personnel. Expanded provisions of Section 1257.7 took effect in 2010. The application of provisions of these laws is evaluated by the Licensing and Certification Unit of CDPH during their regular audits. Further, hospitals are required to report adverse events through a confidential reporting system.

The Division has conducted several investigations regarding workplace violence in general acute care hospitals and acute psychiatric hospitals that fall within the scope of these laws. The Division has in many cases found that employee protection has not been sufficiently addressed, and the data obtained by the DIR Research Unit reflects a continuing risk of recordable injuries[18] in the facilities addressed by the Health and Safety Code provisions. The Division does not have the authority to enforce the provisions of the Health and Safety Code to protect employees from WPV incidents.

Under Labor Code Section 142.3 the Board is the only state agency with the authority to adopt occupational safety and health standards. In the Division's experience, notably in the area of bloodborne pathogens and aerosol transmissible diseases, it is necessary to have occupational health and safety standards to protect employees in health care settings. These regulations may be more specific to occupational risks than the general mandates of the Health and Safety Code, and contain those provisions that are necessary for the protection of employees. Adoption of an enforceable regulation by the Board will provide an additional tool

[18] The extract for "hospitals" found 560 cases in 2010, 485 cases in 2011, and 584 cases in 2012. This data does not necessarily include all public hospitals and does not include state and prison hospitals.

for employers, employees, and the Division to increase employee safety in those environments covered by the Health and Safety Code, and in the many other health care environments addressed by the petition. There are, however, other agencies which regulate some health care facilities, services and operations, and the Division believes that the advisory process must take into account these other laws and regulations in order to avoid a conflict in the codes, and in order to provide consistency for the regulated public[19].

Conclusion

The Division believes that a regulation that specifically addresses workplace violence hazards in health care environments would improve employee protection and can reduce the incidence and severity of injuries. There are many stakeholders and experts who could participate in an advisory process that also reviewed guidelines and recommendations issued by employer and employee organizations, OSHA, NIOSH, JCAHO, CDPH, and various research publications.

Therefore the Division recommends that the Board adopt the petition to the extent of requesting the Division to convene an advisory committee to consider regulations to address workplace violence hazards in health care settings. The committee should consist of employers, employees, and their organizations, as well as occupational safety and health professionals, researchers, and Board staff. The Division would then provide periodic updates to the Board on the process.

cc: Deborah Gold
Glenn Shor
Steve Smith
Robert Nakamura

[19] It is not unusual to have different agencies regulating a specific operation or industry, for example, paint spray booths are regulated by the Fire Code as well as by Title 8, hazardous waste operations are regulated by Title 22 as well as Title 8, asbestos removal operations are regulated under various environmental regulations a well as title 8, and as mentioned above exposures to infectious agents are regulated by Title 17 and Title 22, as well as Title 8.