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# FINAL STATEMENT OF REASONS

CALIFORNIA CODE OF REGULATIONS

TITLE 8: Chapter 4, Subchapter 7, Group 2, Article 7, New Section 3342
of the General Industry Safety Orders

## WORKPLACE VIOLENCE PREVENTION IN HEALTH CARE

## UPDATE OF INITIAL STATEMENT OF REASONS

**As authorized by Government Code Section 11346.9(d), the Board incorporates the Initial Statement of Reasons prepared in this rulemaking.**

## MODIFICATIONS AND RESPONSE TO COMMENTS RESULTING FROM THE 45-DAY PUBLIC COMMENT PERIOD (October 30, 2015 – December 17, 2015)

Following the initial 45-Day public comment period from October 30, 2015, to December 17, 2015, the following substantive modifications were made that are the result of public comments and/or Board staff evaluation.

Subsection (a) Scope and Application.

A modification is proposed to clarify that the section applies to work conducted in the health care settings identified within subsection (a)(1).

A modification is proposed for subsection (a)(1)(D) to include "medical transport" that occurs outside of an emergency response, such as the transfer of a patient from one facility to another. Since this is not necessarily done by paramedics, the term "paramedic" is proposed to be stricken for clarity. Paramedic professionals are retained in the definition of "emergency medical services" and therefore this proposed change does not remove paramedic work from the scope of the regulation.

A further modification is proposed for subsection (a)(1) to delete category (G), "Ancillary health care operations," from the proposed standard. Although the category was included early in the advisory meeting process, several organizations stated that the operations have few recorded instances of workplace violence in comparison to the other settings addressed by the proposed standard. At this time, there is insufficient data showing that health care workers in these limited settings are at increased risk of workplace violence.

In subsection (a)(2), a modification is proposed to delete the word "All," before "employers," to be consistent with other occupational safety and health regulations. A modification is also proposed to delete subsection (C), the instructions for ancillary health care operations, since the category is proposed for deletion.

In subsection (a)(3), a modification is proposed to change "working hours" to "paid time" to better establish that health care workers have flexibility in attending training, medical services, and other activities related to the requirements of the proposed regulation.

A modification is proposed to add subsection (4) to establish an implementation schedule for employers to come into compliance with the proposed standard. Employers need time to properly assess their operation, take corrective actions, establish an effective workplace violence prevention plan with employee involvement, and provide appropriate training based on the Plan. An implementation period of one year from the effective date of the standard is proposed for subsections (c), (e) and (f) to allow time for making the initial assessments, establishing a Plan, scheduling corrective actions, setting up a system to review the Plan, and conducting training.

An exception was added to exclude from the regulation three health facilities that the California Department of Developmental Services (DDS) plans to close by the end of 2021. DDS has submitted closure plans to the Legislature for these facilities in accordance with Welfare and Institutions Code sections 4474.1 and 4474.11. Closure of these facilities is underway, with residents being transferred to community programs, and compliance with Section 3203 is sufficient for these facilities during the closure process.

Subsection (b) Definitions.

A modification is proposed to the definition of "Acute psychiatric hospital" to correct an error in the citation of source by changing it to: "meeting the definition provided in Health and Safety Code Section 1250(b) or California Code of Regulations, Title 22, Section 71005." The examples of operations provided at the end of the sentence are deleted as unnecessary in that services provided are listed in the referenced sections in the Health and Safety Code and Title 22.

In subsection (b), it is proposed to delete the definition for ancillary health care operation from the proposed standard for the reasons stated above.

A modification is proposed for the definition of "engineering controls" to say that the list of control measures that employers are to consider would be "as applicable" to the specific needs of the employer. This is necessary to clarify that an employer would not have to implement the use of a control measure that is not appropriate for that establishment.

In response to several comments, a modification is proposed for the definition of "General acute care" hospital to correct the citation to "as such meeting the definition provided in Health and Safety Code Section 1250(a) or California Code of Regulations, Title 22, Section 70005, and all services within the hospital's license." The examples of operations provided at the end of the sentence are deleted as unnecessary in that services provided are listed in the referenced sections in the Health and Safety Code and Title 22.

A modification is proposed to delete the definition of "Individually identifiable medical information." This definition had been intended to be applied to subsections (d) and (g) but proposed modifications to those subsections do not use this terminology.

A modification is also proposed for the definition of "Outpatient medical offices and clinics" to add "outpatient medical services to the incarcerated in correctional and detention settings" in response to comments that correctional facilities such as jails and other detention facilities must provide medical services. These medical units are not under the license of a hospital and provide care for inmates that does not require transferring the inmate to a hospital.

A modification is proposed for the definition of "Patient classification system" in response to a comment from the California Hospital Association that the definition cites Title 22 without the specific section numbers. Sections 70053.2 and 70217 of Title 22 are added to the definition.

A modification is proposed to the definition of "Patient specific risk factors" to say that these are factors "that may increase the likelihood or severity of a workplace violence incident" by moving this phrase from the end of the paragraph. Also, the modification qualifies the factor, "psychiatric condition or diagnosis" by adding the phrase "associated with increased risk of violence," in response to Patient Rights advocates who commented that the original phrase unfairly identifies a personal condition as inherently dangerous when in fact, it can apply to many nonviolent states, thus posing discriminatory terminology.

A modification is proposed for the definition of "Work practice controls" to clarify that what will comprise a "work practice control" may vary with the circumstances. This is needed to acknowledge that not every work practice in the definition would necessarily be useful to address all situations.

A modification is proposed for the definition of Workplace violence, (C)2 regarding individuals who are not customers, clients, patients, students, inmates, to add "visitors or other individuals accompanying a patient, and delete "any others for whom an organization provides services" for clarity.

<u>Subsection (c) Workplace Violence Prevention Plan.</u>

A modification is proposed for subsection (c) to add "the" before employer and remove the qualifiers, "every" and "covered by this section," to be consistent with other occupational safety and health regulations.

A modification is proposed for subsection (c)(2) to exclude the security personnel at a facility from required involvement in developing and implementing the Plan. This is necessary because several stakeholders have pointed out that this can conflict with existing contracts and duty statements.

Modifications are proposed for subsection (c)(3) to clarify that this applies to situations where there are multiple employers in the "same" facility and to replace the phrase "have a role" to

"understand their respective roles as provided" in the Plan to clarify that when there are employees in a health care facility who are employed by different employers, each group of employees knows what their responsibilities are to carry out the Plan and coordinate activities with other employer's workers. In the same sentence, the word "implementing" is deleted since "implementation" is used at the beginning. A further modification clarifies that all employees in a facility are to be trained in accordance with subsection (f), in lieu of "other employers and temporary employees." It also proposes to clarify that violent incidents involving "any employee" instead of "those employees" working in a facility are to be reported, investigated, and recorded. This change is proposed in response to several comments that the subsection was unclear. Under Labor Code sections 6400 and 6401.7 and case law interpreting the obligations of employers in dual-employer situations, multi-employer worksites, and traditional employment relationships, all employers are responsible for the safety and health of their employees regardless of the nature of the employment relationships.

A modification is proposed to subsection (c)(4) to require the employer to establish a procedure for contacting the appropriate law enforcement agency for assistance and not retaliate against employees who call for emergency assistance when necessary. This procedure may be a central coordination process. The modifications are necessary to ensure that an employer has implemented an effective procedure for contacting law enforcement agencies when an emergency occurs and prevent retaliation against employees who contact law enforcement if the procedure is not working in a timely manner.

A new subsection (c)(5) is proposed to establish a procedure for the employer to accept and respond to workplace violence concerns that are reported by employees, including incidents between employees, and prohibit retaliation against the employee making the report.

A modification is proposed to renumber subsections (c)(5) through (c)(11) to be (c)(6) through (c)(12.)

A modification is proposed to renumbered subsection (c)(8) to clarify that although employees and their representatives must be allowed to participate in the training process, they are not required to actually deliver the training.

A modification is proposed to renumbered subsection (c)(9)(A)2 to clarify that the environmental risk factors of poor illumination or blocked visibility can hide the presence of someone who intends to assault an employee who enters or passes through that area. This is in response to several comments that the passage needed clarification. This change is needed to identify the threat associated with the condition.

A modification is proposed to renumbered subsection (c)(9)(D) to delete "paramedic and other" and add "and medical transport" in order to make this heading consistent with subsection (a)(1)(D). This does not exclude paramedics who are defined as part of "emergency medical services" in subsection (b). This is in response to several comments that transporting patients or clients may be due to that person's violent behavior, necessitating a transfer to a more suitable treatment facility. Since this activity is performed by some of the same employers who provide emergency medical services, it is necessary to add this activity to this group of employers.

A modification is proposed to delete renumbered subsection (c)(9)(E). This is necessary to be consistent with the removal of these operations as noted above.

A modification is proposed to renumbered subsection (c)(10) to include "or other persons who are not employees" along with "visitors" as needing assessment procedures for those who display disruptive or violent behavior, or "demonstrate" a risk of committing workplace violence. The term "demonstrate" replaces the word "pose" to provide an active basis for making this determination, and provides clarity. This is needed to assure that there is a process for generally evaluating people who are not employees for their potential to commit violence which may not be limited to Type 1 violence. A further modification is proposed to clarify that the risk factors applied in an assessment are the ones that would be "applicable" to the individual. This is needed to clarify that an assessment does not need to include unnecessary risk factors.

A modification is proposed to renumbered subsection (c)(11) to clarify that the serious hazards that need to be addressed by protective measures for employees within seven days are hazards "where there is a realistic possibility that death or serious physical harm could result from the hazard." This language is based on the definition of "serious violation" in Labor Code section 6432.

A modification is proposed to renumbered subsection (c)(11)(G) to add the phrase "implementing, and maintaining the use of" after the word, "Installing," to instruct employers that if they install an alarm system, they must implement and maintain it, in order for employees to use it. This is in response to comments that some employers have alarm systems but do not require employees to use them. This is necessary to assure that an important safeguard is actually deployed and ready to use.

A modification is proposed to renumbered subsection (c)(11)(I) to require the response plan to also establish a procedure for mass casualty threats such as an active shooter. This is necessary to assure that these contingencies are addressed in planning. The modification also includes a clarification to the instruction that employees designated to respond to an alarm would be assisting other employees during a violent incident.

A modification is proposed to renumbered subsection (c)(11)(J) to replace the word "minimum" with the word "sufficient," to clarify that the intent is not to require minimum numbers of staff but to require the employer to assign sufficient numbers of staff as a control measure, as applicable and to the extent feasible.

A modification is proposed to renumbered subsection (c)(12)(C) to replace the word "Providing" with the phrase "Making available." This is necessary to be consistent with other standards that address the need for employees to have medical assistance readily available without requiring an employee to use the assistance.

Subsection (d) Violent Incident Log.

A modification is proposed for subsection (d) to require the employer to record information based on information solicited from the employee(s) who experienced the violent act(s), and to omit or remove from the Violent Incident Log (Log) any personal identifying information that would allow identification of the individuals involved in the incident.

A modification is proposed to delete previous subsection (d)(2) that required the employer to allow each employee who experienced a workplace violence incident to complete a section with information about the incident directly into the Log or by recounting the information to a supervisor. This is necessary to ensure that personal identifying information is not inadvertently included in the Log.

Proposed modifications revise the levels and numbering in renumbered subsections (d)(2) through (d)(8). Subsection (3) is deleted and what were subsections (2)(A) to (C) and (3)(A) to (B) are non-substantively elevated a level and renumbered (2) through (6).

A modification is proposed in renumbered subsection (d)(7)(D) to replace "time taken off" with "lost time from." This is to preclude instances where an employee is taking other types of leave.

A modification is proposed in renumbered subsection (d)(8) to change the recorder's "title" to "job title," and to remove the Note about medical information, because the information to be omitted has been expanded to include all personal identifying information, as discussed above.

Subsection (e) Review of the Workplace Violence Prevention Plan.

A modification is proposed to subsection (e) to delete "Annual" from the title because the proposed modifications include new subsection (e)(5) to require the Plan be reviewed whenever certain events or conditions arise, which may occur more frequently than annually. Another modification is proposed to add the phrase "for the overall facility or operation" before the phrase "at least annually" to add the concept that a review of the Plan may be needed in response to certain changes that alter the way the Plan can be implemented either for the entire facility or if the changes only affect a particular operation. It is also necessary to state that the problems found during the review need to be corrected in accordance with renumbered subsection (c)(11). To explain the conditions that would require a more immediate review, new subsection (e)(5) is proposed. Subsection (e)(5)(E) informs the employer that problems with the Plan for part of a facility or operation may be reviewed for the affected areas or operations and with the affected employees without requiring a review of the Plan as a whole.

The change is necessary to enable the employer to address problems in a specific area without involving the entire staff of the facility, or waiting for the next annual review of the entire facility. It is also necessary to ensure that a review that is needed is not delayed until the next annual review date.

Subsection (f) Training.

The first paragraph in subsection (f) is proposed to be modified to require the employer to provide training that addresses the workplace violence risks that the particular employees are reasonably anticipated to encounter in their jobs.

Subsection (f) is proposed to be modified by deleting two sentences in the first paragraph of subsection (f) and deleting subsection (f)(4), to clarify that training must be provided to all employees, without reference to whether the employees are in traditional employment relationships, contract employees, temporary employees, or part-time employees. Under Labor Code sections 6400 and 6401.7 and case law interpreting the obligations of employers in dual-employer situations, multi-employer worksites, and traditional employment relationships, all employers are responsible for the safety and health of their employees regardless of the nature of the employment relationships.

A modification is proposed in the first paragraph in subsection (f) to replace "conducting" with "participating in" training sessions, referring to employee involvement. This is necessary to avoid unintentionally imposing work duties on health care workers, such as conducting all or parts of the training, while allowing them to have active involvement in the training for workplace violence in an appropriate manner.

A modification is proposed to subsection (f)(1) to delete the requirement for the facility employer to train private security personnel since this is already included in subsection (f).

A modification is proposed to subsection (f)(1)(A) to require that initial training address the workplace violence hazards identified in the facility, unit, service, or operation and the corrective measures the employer has implemented. This is necessary to ensure that the training is relevant to the needs of the employees.

A modification is proposed to add subsection (f)(1)(A)4 to specify that training shall instruct employees to recognize warning alerts or alarms that an emergency condition such as a mass casualty threat exists, and the escape routes or sheltering locations that are available to them.

A modification is proposed to add subsection (f)(1)(A)5 to explain the role of security personnel in the establishments where they are present. This is needed to ensure that general staff at a facility know the limits of assistance to expect from the security personnel who are there, and conversely, to ensure that security personnel know what their responsibilities are. This is necessary also to address the intended effect of the passage deleted from subsection (f)(1). Comments stated that, as written, the deleted text requiring that all security personnel attend general staff training could violate existing contractual agreements with the security providers.

Further modifications to subsection (f)(1) are proposed to renumber subsections (A)4 to (A)6; (A)5 to (A)7; and (A)6 to (A)8. This is necessary because of the addition of subsections (f)(1)(A)4 and (f)(1)(A)5.

A modification is proposed to add new subsection (f)(1)(C) to clarify that the initial training is not necessarily required to be given in person, as long as the training covers all the subject matter specified in subsection (f)(1) and provides for interactive questions to be answered within 24 hours by a person knowledgeable about the employer's Plan.

A modification is proposed for subsection (f)(2) to clarify that the training topics in the refresher training should be applicable to the work the employees do. This is needed to ensure that employees receive training that actually applies to their types of workplace exposure. The subsection is further clarified with a requirement that if the refresher training is not given by trainers in person, the training is required to cover all the subject matter specified in subsection (f)(2) as well as provide for interactive questions to be answered within 24 hours by a person knowledgeable about the employer's workplace violence prevention plan.

Further, a modification is proposed for subsection (f)(3)(E) to add verbal intervention and de-escalation techniques as a topic of additional training.

A modification is proposed for subsection (f)(3)(G) to add the phrase "appropriate and inappropriate use of" to "restraining techniques." This is in response to comments from patients' rights advocates and is necessary to clarify that the use of restraining devices should not be done indiscriminately but under clear protocols that are established within Title 22.

A modification is proposed for subsection (f)(3)(H) to add the phrase "and inappropriate" to "use of medications." This is in response to comments from patients' rights advocates and is necessary to clarify that the use of medications should not be done indiscriminately but under clear protocols that are established within Title 22.

A modification is proposed to remove subsection (f)(4), since the proposed subsections (f) and (f)(1) establish training needs for employees of employers other than the facility employer, as discussed above.

<u>Subsection (g) Reporting Requirements for General Acute Care Hospitals, Acute Psychiatric Hospitals, and Special Hospitals.</u>

A modification is proposed to subsection (g)(1)(A) to clarify that the violent act against any employee working at the hospital must be reported by the hospital. This is needed to be consistent with subsection (a).

A modification is proposed to move the Note that had been placed in subsection (g)(4)(H) to follow subsection (g)(1)(B) that reminds employers that the report filed immediately to comply with Section 342 is a separate item. This change is needed to emphasize this important distinction.

A modification is proposed to subsection (g)(2) to clarify incidents that must be reported to the Division within 24 hours. Subsection (A) is proposed to clarify fatalities and certain serious injuries must be reported to the Division within 24 hours. This definition is consistent with the definition that triggers a report to the Division under Section 342 except that it would not

exclude injuries resulting from a Penal Code violation. Other injuries would be reported within 72 hours. Subsection (B) is proposed to establish for reporting purposes that urgent and emergent threats are defined as incidents in which a law enforcement agency provided assistance in response to a 911 emergency request, and are to be reported within 24 hours. These modifications are needed to respond to stakeholder questions to clarify what must be reported within 24 hours, and what constitutes an urgent or emergent threat.

A modification is proposed to subsection (g)(4)(C) to identify and simplify what is required as a brief description of the incident. This will be done by the employer entering into an online data collection system, specific elements and the contributing factors that had a role in the incident, which include, but are not limited to, the type of area where the incident happened, the type of assault, if an employee was working alone, and other specific items derived from subsection (d) which already requires the information to be recorded. The factors selected for reporting are based in part on the factors known to have contributed to the fatalities that initiated this rulemaking process. The entries will be mostly checking appropriate response options to provide employers with a simplified, brief data entry process. The data elements will also allow compilation of aggregate numbers for each data element to allow for an analysis of the information by categories. This will enable the Division to comply with Labor Code Section 6401.8(c), which requires the Division to post annual reports that include "recommendations of the division on the prevention of violent incidents at hospitals." The information being specified for reporting is required to make any meaningful recommendations regarding the factors that contribute to violent incidents.

A modification is proposed for subsection (g)(4)(E) to delete "what agencies responded" and add "how security or law enforcement assisted the employee(s)." This information is necessary to comply with the directive of Senate Bill (SB) 1299 for the Division to provide recommendations about reducing workplace violence incidents.

A modification is proposed for subsection (g)(4)(F) to determine if engineering control modifications or work practice modifications are being applied as corrective measures. This information is necessary to comply with the directive of SB1299 for the Division to provide recommendations about reducing workplace violence incidents.

A modification is proposed to remove the Note following subsection (g)(4)(H) and move it to subsection (g)(1) as noted above.

A modification is proposed for subsection (g)(5) to allow employers 24 hours instead of 4 hours to respond to a request from the Division for supplemental information. This is needed to allow an employer sufficient time to respond.

Subsection (h) Recordkeeping.

A modification is proposed for subsection (h)(1) to clarify that the records of workplace violence hazard identification, evaluation, and correction are to be in accordance with Section 3203(b)(1), except that the Exception to Section 3203(b)(1) does not apply. This is necessary to ensure all employers including those with less than 10 employees maintain inspection records.

A modification is proposed for subsection (h)(2) to clarify that the training records are to be collected as stated but Section 3203(b)(2) Exception No. 1 does not apply. This is necessary to ensure all employers including those with less than 10 employees maintain records of training.

A modification is proposed for subsection (h)(3) to refer to subsection (c)(12), formerly numbered subsection (c)(11).

## Summary and Response to Written and Oral Comments Resulting from the 45 day Comment Period:

I. Written Comments

Gail M. Blanchard-Saiger, Vice-President, Labor & Employment, California Hospital Association by written comments sent December 14, 2015.

NOTE: The commenter provided background information on the topic of workplace violence from the perspective of hospitals. The Board thanks the commenter for this background information.

Comment GBS#1:
Health care employers are concerned about how their workplace violence prevention plan's effectiveness will be measured. While some incidents of workplace violence may be prevented, many others simply cannot. Thus, the mere fact that an incident occurred should not result in a finding that the workplace violence prevention plan, or an element thereof, was not effective. Rather, the regulations should clarify that the focus is on having an effective process to evaluate and implement corrective action, taking into account feasibility, foreseeable threats posed, available options, the likelihood of reoccurrence and other relevant factors.

This concern arises as there have been few studies to evaluate what techniques and strategies are effective in reducing the incidence of workplace violence. Within the health care safety and security community there is often debate about what techniques and strategies are effective to reduce workplace violence. This may derive, in part, from the diverse backgrounds of those involved in the issue. While some individuals have a clinical background, others have a military or law enforcement perspective.

Response:
The Board believes that the proposed regulation does focus on having an effective process to evaluate and implement corrective action, taking into account feasibility, foreseeable threats posed, available options, the likelihood of reoccurrence and other relevant factors. The regulation does not dictate specific techniques for reducing workplace violence.

Comment GBS#2:
Throughout the proposed regulations, there are references suggesting a requirement that employers use dedicated security personnel or a particular staffing level. To the extent Cal/OSHA intends to require a particular staffing mix, CHA strongly disagrees with this attempt,

as there is no such authority granted to the agency. Rather, such decisions are wholly within the discretion of the employer.

Response:
The intent of the proposed regulation is not to mandate use of dedicated security personnel or particular staffing levels, but to require that employers include such measures in their Plans, as applicable and feasible. Modifications have therefore been made in renumbered subsections (c)(11)(J) and (f)(1)(A)5.

Comment GBS#3:
While some hospitals utilize security staff (either their employees or contracted), others use specially trained clinical and non-clinical staff. The reasoning behind clinical or other patient care staff managing patient behavior interventions and conditions is that it emphasizes verbal de-escalation and safe restraint techniques as a method of interacting with a potentially violent or self-injurious patient and to determine specific behavior management procedures that can and cannot be used to comply with The Joint Commission, Centers for Medicare & Medicaid Services and the State of California standards. These individuals are provided the knowledge and tools needed to assess and intervene effectively and safely with the least restrictive methods. CHA propose the following definition be added and utilized as discussed below:

> "Designated response personnel" means an employee responsible for responding to workplace violence incidents. Designated response personnel may perform other duties as assigned during their shifts and may or may not be security personnel.

Response:
The Board believes that the proposed regulation does not preclude an employer from using specifically trained personnel in the manner described, and believes that this definition is not necessary. Please also see the response to Comment GBS#2.

Comment GBS#4:
While section (a)(3) is boilerplate language from existing standards, the current work environment, particularly in hospitals, warrants updating this language. While some training occurs during an employee's regular working hours, other training occurs outside an employee's regular working hours but is nonetheless paid time. Given this reality, we recommend the following:

> The employer shall provide all safeguards required by this section, including provision of personal protective equipment, training, and medical services, at no cost to the employee, at a reasonable time and place for the employee, and during the employee's ~~working hours~~ *paid time*.

Response:
The Board concurs and has modified the proposed regulation accordingly.

Comment GBS#5:
The reference contained within the definition of "Acute psychiatric hospital" is not correct. The reference should be "in accordance with *Health and Safety Code* section 1250(b) *and* Title 22, California Code of Regulations."

Response:
The Board thanks CHA for pointing this out and has modified the proposal accordingly.

Comment GBS#6:
The definition of "Patient classification system" is an incomplete and, thus, inaccurate paraphrase from 22 C.C.R. 70053.2. For accuracy, the regulations should either contain the entire provision or limit it as follows: "'Patient classification system' means a method for establishing staffing requirements by unit, patient and shift as specified in Title 22 section 70053.2."

Response:
The Board acknowledges that the definition of patient classification system is incomplete. However, the Board has determined that incorporating the entire definition from Title 22 section 70053.2 or changing the definition as recommended would make no material difference in the regulation or in the meaning of subsection (e)(1), the only location in the regulation where the term 'patient classification system' is used:

> (e) Review of the Workplace Violence Prevention Plan…
> * * * * *
> (1) Staffing, including staffing patterns and patient classification systems that contribute to, or are insufficient to address, the risk of violence.

Subsection (e)(1) requires employers to evaluate the sufficiency of existing staffing levels specific to the prevention of workplace violence. The inclusion of 'patient classification system' is a reference to other requirements concerning staffing levels, but does not add or diminish to the employers' responsibility as required by the subsection. Therefore the Board has decided not to change the regulation since the change would have no effect.

Comment GBS#7:
We have concerns about the broad definition of "dangerous weapon," particularly because of how it is later used in the proposed standard. For example, the current definition of workplace violence includes "an incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury." If dangerous weapon is interpreted to mean anything that could be used as a weapon, including a pencil, what is the employer's obligation in this regard? Would any threatening use of a pencil be recordable? And for hospitals, would it be reportable within 24 hours?

To provide more guidance and clarity, we request that the definition of "dangerous weapon" be revised as follows:

"Dangerous weapon" means an instrument designed to be capable of inflicting death or serious bodily injury, such as a firearm or knife.

Response:
The Board is aware that this issue was discussed extensively in the advisory meetings. The proposed definition acknowledges the fact that the issue is not whether a designed weapon was utilized but whether an object would have enabled someone to inflict serious harm on someone else. The Board believes that the term designed might be interpreted too narrowly; for example, it could be argued that a large kitchen knife or box cutter was not designed to inflict death or serious bodily injury, even if used the way a tactical knife would be. The intention to commit harm should not depend on the object, but on the manner in which the object is used. The Board therefore declines to make the recommended modification.

Comment GBS#8:
As noted earlier, the issues each hospital faces are unique and may even vary among a hospital's departments. Moreover, while a variety of engineering controls may be considered, some might not be appropriate. For example, some have suggested that metal detectors be used. Some hospitals have, however, elected other approaches because they are legitimately concerned that using metal detectors will result in a large cache of guns accumulated near the entrance to the hospital as visitors discard them before entering the hospital, or have considered other legitimate reasons supporting their decision not to use metal detectors. Given all of the complicated factors contributing to workplace violence, hospitals must have the flexibility to choose the engineering control(s) that make sense in light of their Plan. As such, it is important to clarify that the engineering controls are options that may be appropriate to mitigate a hazard depending on specific circumstances. To ensure clarity, we recommend the following language to subsection (b):

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

Response:
The intent of the proposed regulation is not to impose a requirement on all employers to use all the control methods listed in the definition of "engineering controls," but to provide options to be considered and used as applicable and feasible. The definition has therefore been modified to include the phrase, "as applicable." See also renumbered subsection (c)(11), which requires that corrective measures be used as applicable and feasible.

Comment GBS#9:
As noted earlier, whether a hospital decides to utilize dedicated safety personnel is a complex decision and one that should be left to the hospital. As such, we do not believe it is appropriate to include "provision of dedicated safety personnel (i.e. security guards)" in the list of "work practice controls." Rather, we recommend using the phrase "designated response personnel." However, if the list of "work practice controls" is illustrative, we would not object to including the phrase "dedicated safety personnel" so long as the sentence is clarified in that respect. A possible change is "work practice controls *may* include, but are not limited to…"

Response:
The intent of the proposed regulation is not to impose a requirement on all employers to use all the control methods listed in the definition of "work practice controls," but to provide options to be considered and used as applicable and feasible. The definition has therefore been modified to include the phrase, "as applicable." See also renumbered subsection (c)(11), which requires that corrective measures be used as applicable and feasible.

Comment GBS#10:
We appreciate the work Cal/OSHA has undertaken in an effort to develop an objective and enforceable definition of "workplace violence." CHA seeks only a limited modification related to the definition of "dangerous weapon." As noted above, the reference to "common objects as weapons" is extremely amorphous. Given that anything from a pencil to a stethoscope could fit within this definition, hospitals believe it would be an impossible task to mitigate the risks associated with all of the objects found in the workplace, particularly where there has not been any history of violence using those objects. While we recognize that such objects can be used as weapons, we believe the need to mitigate potential risks in this regard should be undertaken as part of the overall prevention plan, taking into account history and trends.

Response:
Please see the response to Comment GBS#7. The Board appreciates that it would be very difficult to predict when an individual might suddenly become violent and utilize some convenient object as a weapon and agrees that the Plan must mitigate the potential risks by training employees to assess an individual and recognize the potential for violence. In the advisory process, some employers have described procedures they use to have rooms with minimal furnishings ready for potentially violent individuals, and have provided training for employees enabling them to recognize individuals and assign them to these rooms. The Board believes that this is one effective approach to this problem.

Comment GBS#11:
In subsection (c)(2), we appreciate Cal/OSHA's goal in specifying that employers must obtain the "active involvement of employees and their representatives in various aspects of the workplace violence prevention plan." Given that development of an effective Plan — including its policies, procedures and training — is the responsibility of management, we would appreciate clarity that the employer retains discretion on how to obtain employee involvement. Some employers may utilize existing safety committees, while others might choose to hold town hall meetings or interview individuals in the various units.

Response:
The Board believes that the proposed regulation does not specify how employers are to obtain the active involvement of employees and their representatives, as long as the employer's procedures are effective.

Comment GBS#12:
CHA does not believe it is intended, or appropriate, for Cal/OSHA to require that hospitals or other employers utilize dedicated security personnel. Thus, the second sentence should indicate that the employer must include the involvement of employed or contracted security personnel, *if utilized*. Alternatively, the regulations could require the involvement of "designated response personnel" if you choose to include that definition as requested above.

Response:
The Board concurs and has deleted the second sentence in subsection (c)(2) regarding security personnel, and has addressed this issue through other modifications to the proposal.

Comment GBS#13:
Subsection (c)(3) appears to be too broadly written. It requires the employer to coordinate with other employers to "ensure that those employers and employees have a role in implementing the Plan." As noted earlier, the facility employer has the obligation to develop and implement the Plan. Thus, it is inappropriate to require the facility employer to give a third-party employer a role in implementing the Plan. Rather, the third-party employer and its employees working at the facility should be trained on the Plan and any duties they would have under the Plan. As such, we request the following change:

> Methods the employer will use to coordinate implementation of the Plan with other employers whose employees work in the health care facility, service or operation, to ensure ~~that those employers and employees have a role in implementing~~ ~~the Plan. These methods shall ensure that~~ employees of other employers and temporary employees are provided the training required by subsection (f) and shall ensure that workplace violence incidents involving those employees are reported, investigated and recorded.

Response:
The intent of this subsection is to have facility employers ensure that other employers and employees within the facility understand their respective roles as provided in the facility Plan. The Board has modified subsection (c)(3) accordingly.

Comment GBS#14:
While we appreciate the intent of subsection (c)(4) and the fact that much of it is required by SB1299, we request another sentence be added to clarify that while an employer cannot prohibit an employee from calling law enforcement, an employer can maintain a policy directing employees to call designated hospital personnel first, where appropriate. In many cases such a policy allows for a faster response by trained personnel who are familiar with the health care environment. Prohibiting an employer from maintaining such a policy may result in delayed response. Several people testified during the Advisory Committee process that their attempts to involve local law enforcement were ineffective, as many will not intervene unless physical injury

is imminent. In other situations, local law enforcement has not prioritized response to hospital 911 calls.

Response:
The Board concurs that subsection (c)(4) needs clarification to allow for facilities that need to have law enforcement contacts coordinated so that they can be directed to the right location or entry point while allowing employees to contact law enforcement on their own when they cannot utilize the system in place, or have some other circumstance that would impede a response. The Board proposes to require employers to have an effective procedure for obtaining law enforcement assistance which includes a policy that does not disallow or punish employees from making contact with law enforcement when a violent incident occurs.

Comment GBS#15:
Concerns with subsection (c)(7) are similar to those identified above. As the employer has the obligation to provide effective training, it is unclear why employees and their representatives shall be allowed to participate in developing and delivering the training. An employer may reasonably decide to utilize staff with expertise in training or contract with a training provider. As such, we request that subsection (7) be struck.

Response:
Employee participation in developing the Plan is required by Labor Code section 6401.8(4). Since the Plan includes training, the Board believes that it is appropriate for employees to participate in developing the training content since they can identify pertinent training issues and relate their experiences. The Board also believes that the individuals most qualified to be knowledgeable about the employer's violence prevention plan would most likely be an employee or administrator of the facility. Therefore the Board declines to strike renumbered subsection (c)(8). However, the Board concurs that it is not appropriate to require that these employees "deliver" the training and has deleted the requirement in the revised text.

Comment GBS#16:
Subsection (c)(9) raises concerns. The literature is mixed on how to predict any one patient may be at increased risk for violence. This uncertainty suggests that the premise for the obligation to assess patients may be faulty and should be based on their history, rather than their mental status, medication status, etc. Thus, we recommend striking subsections (A) and (B). Alternatively, we recommend changing the introductory sentence as follows:

> Patient-specific risk factors *may* ~~shall~~ include but not necessarily be limited to the following…

Response:
The Board acknowledges that behavioral science has not developed a conclusive or infallible process for predicting when an individual will behave violently. However, it is unlikely that the emergency medical service personnel would have access to the history of every individual in a timely manner to inform receiving facilities that the person might be prone to violence. Renumbered subsections (c)(10)(A) and (B) describe conditions that the emergency responder is likely to learn from the nature of the incident that required their assistance, or the knowledge of

the witnesses who summoned them, or the dispatcher report. Nonetheless, the Board agrees that the conditions may not apply to all patients and has revised the last sentence of renumbered subsection (c)(10) to: "…Patient-specific risk factors shall include, as applicable, but not necessarily limited to the following:."

Comment GBS#17:
Also with regard to subsection (c)(9), the reference to both patients and visitors in this section is likely to cause confusion because those are two very different populations. Thus, the provision related to "assessing visitors" should be placed in its own subsection. Furthermore, employers have very little information about visitors, and there is significant concern that the obligation to conduct assessments could lead to claims of discrimination. Thus, we believe it is appropriate to tie the assessment to an actual history of violence, rather than the more vague standard of those "who pose a risk of committing Type 1 workplace violence." Potential language is as follows:

> (new subsection) Procedures to identify visitors or other third parties who demonstrate disruptive behavior or who have threatened an employee or other person at the workplace.

Response:
The Board believes that renumbered subsection (c)(10) is intended to require a process to assess any individuals who do not work at a facility for indicators of potential violent behavior and proposes to have "visitors or other persons who are not employees" included in the subsection. In addition, the proposal has been modified to require assessment of visitors and other persons who demonstrate, not just pose, a risk of workplace violence (and not just Type 2 violence).

Comment GBS#18:
Subsection (c)(10) raises several concerns. The overarching concern is the implication that employers have the ability to "eliminate hazards" and "protect employees from identified imminent hazards immediately." As noted above, while some aspects of workplace violence can be prevented, much of it simply cannot. Patients with a neurological (brain, spinal cord, nerves) or cognitive disorder that results in acute/chronic cognitive impairment or lack of impulse control (i.e. stroke, tumor, seizure, encephalitis, meningitis, dementia, Alzheimer Disease, Autism Spectrum Disorder, Intellectual Disability, traumatic brain injury) could grab, pinch and kick their caregivers without warning. Visitors in the emergency department may get angry about how long the wait is or how their friend or family member is being treated. Hospitals strive to minimize potential exposure to such incidents, but they are part of this stressful and complex work environment.

Additionally, while the risks vary from hospital to hospital and department to department, the likelihood of the risk also varies. For example, we now know there is a risk that any patient or visitor could pick up a pencil and use it as a weapon. However, it is not reasonable to require health care employers to ensure that all pencils are kept locked in a drawer. Similarly, there is a risk that any patient could get angry and use a chair as a weapon. That should not mean that all health care employers must secure all chairs to the floor. Rather, as noted above, the focus should be on the process for evaluating and implementing corrective measures, depending on a realistic threat assessment, and other relevant factors.

Specific changes requested include:

a. Modify the first sentence as follows: Procedures to *address* ~~correct~~ workplace violence hazards in a timely manner in accordance with Section 3203(a)(6).
~~b.~~ Delete the third sentence in the introductory paragraph: "~~The employer shall take measures to protect employees from imminent hazards immediately, and shall take measures to protect employees from identified serious hazards with in seven days of the discovery of the hazard. When an identified corrective measure cannot be implemented within this timeframe, the employer shall take interim measures to abate the imminent or serious nature of the hazard while completing the permanent control measures.~~"
c. Change the last sentence of the introductory paragraph to state: "Corrective measures *may* ~~shall~~ include…"

Response:
The Board agrees that not all hazards can be eliminated, which is why the subsection includes the language "eliminate or minimize employee exposure to the identified hazards to the extent feasible." The Board agrees that not all possible protective measures are feasible. For example, eliminating uncontrolled movement by a patient is not feasible, but removing a lock blocking an emergency escape route when there is an active shooter situation is feasible. Renumbered subsection (c)(11) is intended to ensure that an employer takes a necessary action to rectify a problematic situation within an appropriate timeframe that will not expose employees to that hazard longer than necessary. The Board believes that a seven day period allows an employer to assess imminent hazards and determine if the problem can be solved within that timeframe or if temporary measures that protect employees need to be implemented. With respect to the use of the term "may," the Board believes that the word implies that the process of making corrections to problematic situations is optional, when it is not. The process specifies corrective measures "as applicable" and "to the extent feasible." This should provide an employer with the flexibility to find an effective way to address a hazard. The Board therefore declines to make the proposed modifications.

Comment GBS#19:
CHA recommends changing subsection (c)(10)(A) as follows: "Ensuring that sufficient ~~numbers of~~ staff are trained and available to *mitigate* ~~prevent~~ and immediately respond to workplace violence incidents during each shift."

Response:
The Board believes that "mitigate" suggests that having sufficient staffing is intended only to respond to an incident. The intent of the proposed language is to ensure sufficient numbers of staff to prevent workplace violence as one possible corrective measure. The language in renumbered subsection (c)(11) already includes the concept of feasibility. The Board therefore declines to make the requested change.

Comment GBS#20:
CHA recommends changing subsection (c)(10)(D) as follows: "~~Removing, fastening or controlling furnishings and other~~ *Minimizing, to the extent possible,* objects that may be used as improvised weapons . . ."

Response:
The intent of the proposed language is to include removing, fastening, or controlling furnishings and other objects as one possible control measure. The language in renumbered subsection (c)(11) already includes the concept of feasibility. The Board therefore declines to make the requested modification.

Comment GBS#21:
CHA recommends changing subsection (c)(10)(E) as follows: "Creating a security plan to *mitigate* ~~prevent~~ the transport of ~~unauthorized~~ firearms . . ." "This *may* ~~shall~~ include monitoring…."

Response:
The Board believes that the recommended modification is vague and the use of the term "may" makes the requirements unenforceable. The intent of the control method is to prevent firearms from being brought into a facility by people who are not authorized to carry firearms. The Board declines to make the suggested modification.

Comment GBS#22:
CHA recommends a change to subsection (c)(10)(F) as follows: "Maintaining *reasonable* ~~sufficient~~ staffing, including *designated response personnel*, who can ~~maintain order in the facility and~~ respond to workplace violence incidents in a timely manner."

Response:
The Board believes that "reasonable" in this context is vague, unenforceable and might be construed to take into consideration many other issues regarding staffing. As noted in the response to Comment GBS#19, testimony at the advisory meetings showed that having sufficient staff in some situations can prevent the occurrence of violence. The initial and annual review assessment of incidents and issues is intended to identify these situations and plan staffing accordingly. The Board has also declined to use the concept of "designated response personnel" (see the responses to Comments GBS#2 and GBS#3).

Comment GBS#23:
CHA recommends a change to subsection (c)(10)(G) as follows: "~~Installing~~ *Utilizing* an alarm system or other effective means by which employees can summon *designated response personnel* ~~security and~~ *or* other aid to defuse or respond to an actual or potential workplace violence emergency."

Response:
The Board believes that the use of the term "utilizing" might be interpreted as using an alarm system that is already present, even if it is inadequate for the present needs of the unit rather than installing a new one that better addresses the actual needs of the system. Renumbered subsection (c)(11)(G) has been modified to include "implementing and maintaining the use of an alarm," in addition to installing alarms. Regarding the concept of "designated response personnel," please see the responses to Comments GBS#2, GBS#3, and GBS#24.

Comment GBS#24:
Change subsection (c)(10)(I) as follows: "Establishing an effective response plan for actual or potential workplace violence emergencies that includes obtaining help from *designated response personnel* ~~facility security~~ or law enforcement agencies as appropriate. *Employers must have a process to ensure that designated response personnel can respond immediately to an alarm as well as protocols for when to involve law enforcement.* ~~Employees designated to respond to emergencies must not have other assignments that would prevent them from responding immediately to an alarm.~~"

Response:
As noted above, in response to Comment GBS#22, the Board has declined to use the term, "designated response personnel." The response plan must include contacting the facility security personnel, if the facility has such personnel, or law enforcement agencies, or both, as appropriate. The phrase proposed to be stricken is derived from Section 5120, and establishes that health care workers that are trained and assigned to have the duty to respond and assist during a workplace violence emergency are able to do so immediately. Therefore, the Board declines to make the recommended changes. Note: Renumbered subsection (c)(11)(I) includes a new sentence about procedures for responding to mass casualty threats.

Comment GBS#25:
CHA recommends deleting subsection (c)(10)(J). As noted above, there is no standard for what constitutes "minimum numbers of staff" to reduce patient-specific Type 2 workplace violence hazards.

Response:
The Board has modified the renumbered subsection (c)(11)(J) from minimum to "sufficient" number of staff, to address this comment and previous comments.

Comment GBS#26:
We are also extremely concerned about how this section would interact with proposed changes to 8 CCR 334(d), which would expand the definition of "repeat violation." That proposed regulation would define "repeat violation" to include "a substantially similar violation, hazard or condition." As discussed throughout this comment letter, many factors contributing to workplace violence are outside of the employer's control, and some simply cannot be prevented as patients and visitors can be unpredictable and physical. While health care employers will do their best to minimize incidents, it is generally accepted that they cannot completely eliminate them. Establishing unreasonable expectations with respect to hazard correction and continuously penalizing employers for incidents outside of their sphere of influence will not achieve the goal of prevention. Thus, we request clarification on how the various provisions will apply in the context of health care workplace violence prevention.

Response:
The Board agrees that not all workplace violence incidents can be eliminated. See the response to Comment YC#7. Regarding repeat violations, an employer would not be cited for a repeat violation if the incident was not caused by any violation on the part of the employer or if the

incident was not caused by a violation of a substantially similar regulatory requirement involving substantially similar conditions or hazards as the earlier incident.

Comment GBS#27:
With regard to Section (d) Violent Incident Log, during the Cal/OSHA Advisory Committee process, the stakeholders had numerous conversations regarding the violent incident log. As a result of these discussions, CHA and stakeholders, led by SEIU121RN, jointly proposed changes that address most of CHA's concerns. These concerns primarily centered on patient and employee privacy.

Cal/OSHA accepted the joint changes. The only remaining issue CHA has with the proposed violent incident log is the newly inserted requirement that the employee be allowed to complete the section containing the detailed description of the incident and two other elements. With respect to the proposed language that requires the employer to allow the employee to complete the "detailed description of the incident," we remain concerned that the narrative provided by an employee could contain private patient or employee information. While some hospital staff are sensitive to patient and employee privacy laws, others are not. While the proposed regulations specify that "medical information" shall not be included in the log, that admonishment is not broad enough to address all privacy concerns.

Recognizing the desire to ensure that the employee involved in the incident is also involved in completing that portion of the log, we propose subsection (d)(2) be revised as follows:

> A section *to be completed by the employer with direct participation by* ~~that~~ each employee who experienced workplace violence ~~shall be allowed to complete~~"

Response:
To protect employee and patient privacy, subsection (d) has been modified to require the employer to omit this information from the Violent Incident Log (Log), and the requirement to have the affected employee(s) directly enter the information has been removed. Please also see the responses to Comments KH#16 and KH#17. The requirement to allow the employee to complete portions of the violent incident log has been deleted in the revised text of the regulation.

Comment GBS#28:
With regard to Section (e) Annual Review of the Workplace, although much of subsection (e) is taken directly from Labor Code 6401.8, we are concerned that the second sentence, which supplements the Labor Code 6401.8 provisions, imposes an unrealistic standard and believe it should be deleted. As discussed above, it is unrealistic to adopt a standard that requires health care employers to correct all problems, as many problems are out of the control of the employer and/or would require complete redesign of facilities or the manner in which patient care is provided. Thus, the introductory paragraph would read as follows:

> "The employer shall establish and implement a system to review the effectiveness of the Plan at least annually, in conjunction with employees regarding their respective work areas, services and operations. ~~Problems found during the review shall be corrected in accordance with subsection (c)(10).~~ The review shall include evaluation of the following:"

Response:
The Board believes that the review is intended to assist the employer in discovering deficiencies in the Plan and correcting the deficiencies. Renumbered subsection (c)(11) requires that the corrective actions be implemented "to the extent feasible," which should not impose unrealistic demands on employers. The review required by subsection (e) is similar to existing requirements in Section 3203 that require employers to identify and evaluate hazards and to correct the hazards in a timely manner. Deleting the requirement to correct deficiencies found during the review would defeat the purpose of the review. Therefore, the Board declines to strike the reference to renumbered subsection (c)(11).

Comment GBS#29:
With regard to Section (f) Training, one area of confusion for many employers is the extent to which the training obligation encompasses employees of other employers who may be on the premises. This population ranges from contracted employees who work at the facility on a long-term basis to traveling staff who may work occasionally, medical equipment representatives who may be present for one surgery involving that equipment, and the individual who restocks vending machines. While we recognize that temporary staff working in nursing or other similar units should be trained, we question the need to train individuals who have no patient care contact and are present on a sporadic and occasional basis. To assist with providing this clarity, we recommend moving subsection (4) to the front of this section and to revise it as follows:

> (1) ~~(4)~~ All *employer* personnel *working* ~~present~~ in health care facilities, services, and operations shall be trained on the employer's Plan and what to do in the event of an alarm or other notification of emergency. Non-employee personnel who are reasonably anticipated to participate in implementation of the Plan shall be provided with the training required for their specific assignment.

Response:
In response to this comment, subsection (f) has been modified to require the employer to provide only the training that addresses the workplace violence risks that the particular employees are reasonably anticipated to encounter in their jobs. Subsection (f) has also been reorganized to cover training of employees generally, without reference to whether the employees are in traditional employment relationships, contract employees, temporary employees, or part-time employees. The responsibilities of employers in multi-employer and dual-employer settings are set forth in Labor Code sections 6400 and 6401.7; California Code of Regulations, Title 8, sections 336.10 and 3203; and case law interpreting and applying these statutes and regulations. All employers are responsible for the safety and health of their employees regardless of the nature of the employment relationships. Please see also the response to Comment CHA#1 provided during the second 15-day comment period.

Comment GBS#30:
For consistency, we also recommend revising current subsection (f)(1), which would be relabeled subsection (2) as follows:

> All *employer personnel* ~~employees~~ working in the facility, unit, service or operation. . .

Response:
Please see the response to Comment GBS#29.

Comment GBS#31:
With regard to subsections (f)(1)(A)6. and (f)(2), which require that the training provide "an opportunity for interactive questions and answers with a person knowledgeable about the employer's workplace violence prevention plan," it is not clear whether this section precludes an employer from using e-learning options. We believe e-learning tools can be equally as effective as in-person education, particularly with respect to the awareness training. When using e-learning tools, the employer can still comply with the obligation set forth above by ensuring that the employee's question is answered in a timely manner. We request a clarification that this section permits the employer to utilize effective e-learning tools.

Response:
The requirement to provide an opportunity for interactive questions and answers with a person knowledgeable about the employer's Plan is not intended to preclude the use of appropriate e-learning options. Language has been added in subsections (f)(1)(C) and (f)(2) to clarify that training not given in person is allowed, but also to confirm that training must provide for interactive questions to be answered within one business day by a knowledgeable person.

Comment GBS#32:
Subsection (f)(1)(B), is somewhat confusing because it requires new training when a new or previously unrecognized workplace violence hazard has been identified. What type of training must be provided?

Response:
Subsection (f)(1)(B) requires the employer to provide effective training that addresses the new or previously unrecognized workplace violence hazard. The type of training is not specified as long as it is effective and provides for interactive questions to be answered within one business day by a knowledgeable person.

Comment GBS#33:
Subsection (f)(2) requires the employer to include "the results of the annual review required in subsection (e)" in refresher training. We believe such training should only include the results of the annual review for the employee's work location and need not include the results across the employer's operations.

Response:
The Board concurs and has modified subsection (f)(2) to include only those portions of the annual review applicable to the employees being trained.

Comment GBS#34:
Hospitals currently provide training to many employees on the topics covered in this subsection. To ensure that hospitals do not have to retrain employees who have already been trained, we request the following provisions:

EXCEPTION to subsection (f)(1): For employees who have been provided initial training, only training on the elements that were not included in the training need be provided.

EXCEPTION to subsection (f)(2) and (3): For employees who have received training required by this section in the year preceding the effective date of the standard, only training on the elements that were not included in the training need be provided.

Response:
The Board believes that much of the initial training is to be based on the assessment of the facility that includes the participation of the affected employees in that unit. This assessment is likely to affect the procedures that require training, especially in subsection (f)(1)(A)1 specific to the employer's workplace violence prevention plan. Training conducted in advance of adoption of the actual requirements might be contradicted as the Plan is developed. The Board believes the training should be based on careful consideration of the assessment and implementation of the Plan. Please also see the response to Comment GBS#35 below.

Comment GBS#35:
As discussed during the Advisory Committee process, the training required by this proposed standard cannot be effectively developed until the employer (i) undertakes a risk assessment; and (ii) implements initial corrective action developed as a result of the employer's Plan. As such, health care employers should be given a reasonable period of time to undertake this activity and then provide the required training. As currently written, employers would have approximately three months from the time the regulations are final to the October 1 effective date to 1) develop a workplace violence prevention plan; 2) conduct the initial risk assessment; 3) take the identified correction action; and 4) train employees. CHA proposes:

(f)(5) Employers have twelve months from the effective date of the regulations to meet the training requirements of this section.

Response:
The Board concurs that the training must be based on the risk assessment of the facility and the initial implementation of the Plan. This provides adequate time for hospital administrators to ensure that there is an implementation method for all the contract employees and other employment categories within the hospital so that each unit receives appropriate training. The initial training must be conducted for all affected employees within twelve months of the effective date of the regulation, as specified in revised subsection (a)(4).

Comment GBS#36:
Pursuant to subsection (g)(1)(A), and consistent with SB1299, hospitals must report incidents involving "the use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury." However, hospitals need further guidance as to how the hospital is to evaluate "stress."

Response:
The Board believes that, based on the language of SB1299, a hospital must file a report of an incident of workplace violence if the incident involving the use of physical force caused the employee to experience stress, as reported by the employee.

Comment GBS#37:
Given that some hospitals may not have security staff, subsection (4)(E)'s inclusion of that reference does not appear appropriate. Further, gathering that data does not appear necessary. Rather, the data to be collected should be limited to whether law enforcement was contacted and what agencies responded.

Response:
Because subsection (g)(4)(E) refers to security or law enforcement, the Board declines to make the requested change.

Comment GBS#38:
The timeframe included in subsection (g)(5) is unrealistically short. The supplemental information may not be available and/or the employer may need to consult with counsel before release of information. As hospitals are 24/7 operations, the appropriate person to respond may not be available if an incident occurs at 3 a.m. on a Saturday morning. We propose the following language instead:

> The employer shall respond to requests for supplemental information to the Division regarding an incident within 24 hours of any request.

Response:
The Board concurs that 24 hours is a more suitable timeframe, and subsection (g)(5) has been modified to address that concern.

Comment GBS#39:
In its Initial Statement of Reasons, the Board's economic impact analysis concludes that the regulation should not impose any substantial additional costs because health care employers should already have health care workplace violence prevention plans in place that include all of the components that will be required by the proposed regulation. While the premise is accurate that California hospitals have existing workplace violence prevention plans in place and conduct workplace violence prevention training, the statement that Labor Code Section 3203 obligated all health care employers, including hospitals, to have a Plan that mirrors the proposed regulation is confusing. If that were true, then it would appear there would be no need for the proposed regulation. In order to achieve an effective regulation, it is critical to acknowledge that the proposed regulation goes well beyond existing obligations and would impose substantial additional costs on the employer. At a minimum, hospitals will have to adjust their current training protocols, modify their security tracking software to add newly required components and create a method for increased reporting. Without acknowledgement of the costs, an accurate analysis cannot be undertaken.

Response:
The Board acknowledges that the methods employers use to comply with the proposed regulation may entail upgrades and revisions to existing systems and has adjusted its analysis accordingly. The Board has revised its cost estimates to account for the additional requirements of the proposed regulation as compared to Section 3203. The updated costs are explained in detail in the Final Statement of Reasons.

Barbara Hewitt Jones, Regulatory Analyst for Tenet Healthcare, by electronic mail sent December 16, 2015.

NOTE: The commenter provided background information on the topic of workplace violence from the perspective of Tenet hospitals in California. The Board thanks the commenter for this background information.

Comment BJ#1:
The lack of available psychiatric services has led to hospital emergency rooms becoming a safety-net for mental health and substance abuse patients—whether the facility provides psychiatric services or not. Holding involuntary commitment patients (5150s) until psychiatric space becomes available and transfers are arranged is directly correlated to increased incidence of violence in hospitals. Law enforcement drop patients off at the emergency room, in many counties, which is akin to patient dumping. The patients brought in by law enforcement to hospital emergency rooms, not designated as psychiatric facilities, should remain under the supervision of law enforcement to ensure safety for patients, staff and visitors to the hospital.

As per Centers for Medicare and Medicaid Services guidance, hospitals are responsible for providing safe appropriate care to patients. Law enforcement partners should be maintaining oversight and security when a potentially volatile or violent patient is brought to a hospital. Centers for Medicare and Medicaid Services Interpretive Guideline Section 482.13 (e) states:

> The law enforcement officers who maintain custody and direct supervision of their prisoner (the hospital's patient) are responsible for the use, application and monitoring of these restrictive devices [handcuffs, manacles, shackles, other chain-type restraint devices or other restrictive devices] in accordance with federal and state law. However, the hospital is still responsible for an appropriate patient assessment and the provision of safe, appropriate care to its patient (the law enforcement officer's prisoner).

Regardless of hospital security, security officers are restricted in their role in subduing patients in a volatile situation. Centers for Medicare and Medicaid Services interpretive guidelines point to law enforcement as the only appropriate personnel to use weapons to subdue a patient for the purposes to restrain or seclude and "if a weapon is used by security or law enforcement personnel on a person in a hospital (patient, staff or visitor) to protect people or hospital property from harm, we would expect the situation to be handled as a criminal activity and the perpetrator be placed in the custody of local law enforcement."

Tenet believes that it is important to collect data on law enforcement interaction with violent patients. An accurate depiction of law enforcement engagement with facilities and patients is critical to be able to troubleshoot best practices for patient management.

Recommendation: Explicit expectations, roles and responsibilities of law enforcement should be included in the violence prevention plan regulations, beyond prohibition from disallowing an employee from seeking assistance and intervention from emergency services or law enforcement.

Add:

3342(g)(1)(C) An incident where law enforcement was called to respond.

Edit:

(g)(4) (E) Whether security or law enforcement was contacted, and what agencies responded;

Add new:

(F) Whether law enforcement had interaction with the incident, and what agency, including:
(1) Transported the patient to the facility.
(2) Patient was in law enforcement custody
(3) If law enforcement was called to respond to act of violence.

Reletter (F through I)

Response:
Subsection (g)(4)(E) has been modified to describe how law enforcement assisted the employees. In addition, a law enforcement agency transporting a patient to a hospital would be considered a medical transport employer, and the proposed regulation requires medical transport employers to communicate patient risk factors to hospitals. The Board believes that the other recommended language imposes an inappropriate burden on hospitals and therefore declines to make those modifications.

Comment BJ#2:
Department of Public Health, Health and Safety Code requirements that are analogous to the violence prevention plan -- Health and Safety Code sections 1257.7, 1257.8, 1279.6 --should be cross-referenced to avoid conflicting jurisdiction.

(c)(2) Effective procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing the Plan, including their participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating workplace violence incidents. This process shall also include the involvement of security personnel who are employees of the facility, or representatives of employees who provide security services to the employer. Hospital safety assessments shall be consistent with Health and Safety code 1257.7(b).

Response:
The Board acknowledges that Health and Safety Code section 1257.7 et seq. preceded this proposed regulation. However, the Board has already determined that the petitions requesting

this rulemaking have done so with the belief that the existing codes lack features that are in the proposed regulation. HSC 1257.7 provides for incorporating Cal/OSHA guidance or regulations into its Plan in subsection (a):

> "In developing this Plan, the hospital shall consider guidelines or standards on violence in health care facilities issued by the department, the Division of Occupational Safety and Health, and the federal Occupational Safety and Health Administration."

In this regard, the Board believes that the proposed regulation is consistent with existing codes but also provides additional requirements and procedures. The Board therefore respectfully declines to make the recommended change.

Comment BJ#3:
Subsection (c)(4), A policy prohibiting the employer from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs. The Plan shall also include effective procedures to accept and respond to reports of workplace violence, including Type 3 violence, and to prohibit retaliation against an employee who makes such a report. Plan for hospitals shall be consistent with Health and Safety code 1257.7(d).

Response:
Please see the response to Comment BJ#2.

Comment BJ#4:
Subsection (c)(8), Assessment procedures to identify and evaluate environmental risk factors, including community-based risk factors, for each facility, unit, service, or operation. This shall include a review of all workplace violence incidents that occurred in the facility, service, or operation within the previous year, whether or not an injury occurred. Hospital safety assessments shall be consistent with Health and Safety code 1257.7(a)

Response:
Please see the response to Comment BJ#2.

Comment BJ#5:
Subsection (e)(5), Hospital Plans shall be managed consistent with Health and Safety Code 1257.7 and 1279.6.

Response:
Please see the response to Comment BJ#2.

Comment BJ#6:
Subsection (f)(5), Training of staff in a hospital emergency department shall be consistent with Health and Safety code 1257.8.

Response:
Please see the response to Comment BJ#2.

Comment BJ#7:

(g) Reporting Requirements for General Acute Care Hospitals, Acute Psychiatric Hospitals, and Special Hospitals.
(1) Every general acute care hospital, acute psychiatric hospital, and special hospital shall report to the Division any incident involving either of the following:
(A)The use of physical force against a hospital employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
(B)An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.
(C) Reporting by hospitals may be a copy of reports required under Health and Safety code 1257.7(d).

Response:

The proposed regulation requires hospitals to report incidents electronically to the Division of Occupational Safety and Health (Division) database system. It is unclear if the suggestion is to allow paper copies to be mailed or delivered in some other format, but these other reporting mechanisms will not allow the Division to organize, analyze, and post information online about violent incidents at hospitals, as required in Labor Code section 6401.8(c). It is also unclear from the comment if these other reports contain the essential elements specified in Labor Code section 6401.8(c). The Board appreciates the information that hospitals already have a process for collecting the information that would be reported. However, for the reasons stated above, the Board declines to make the suggested change.

Comment BJ#8:

Regarding (a)(3): Adding to investments in personal protective equipment beyond what is prudent and necessary for the clinical conditions is a significant financial burden and is not an employee protection. All prudent safety measures should be taken. But prudent means backed by science and consistent with the Federal government agencies guidance. When resources are allocated to compliance with no benefit in clinical outcomes, safety or other prudent operational benefit, it is an excess cost on the facility-- resources are redirected from other services. Safety equipment and use should follow federal guidelines.

Recommendation:

Section 3342 (a)(3) The employer shall provide all safeguards required by this section, including provisions of personal protective equipment, training, and medical services, as applicable to patient care or workplace duties, at no cost to the employee, at a reasonable time and place for the employee, and during the employee's working hours.

Response:

The Board notes that the recommended language refers to conducting patient care or workplace duties, which might restrict the application of these protective measures only to patient care and not to worker protection. Therefore, the Board declines to make the suggested change.

Comment BJ#9:
Regarding the definition of "general acute care hospital" in subsection (b), the definition should be in accordance with Section 1250 and Title 22 and not expound beyond licensed services. Outpatient observation is not a licensed service in California.

Recommendation:

"General acute care hospital" (GACH) means a hospital, licensed by the California Department of Public Health as such in accordance with Section 1250(a), Title 22, California Code of Regulations and all supplemental services in accordance with Section 1253.5(a), and program flexibility granted by the Department of Public Health in accordance with 22 CCR 70129, inclusive of each physical plant location maintained and operated on separate premises as provided in Section 1250.8. ~~services within the hospital's license including, but not limited to: emergency, outpatient observation, outpatient clinics, physical therapy and ambulatory surgery services located at the hospital facility, and all off-site operations included within the hospital's license.~~

Response:
The Board concurs regarding non-licensed services and proposes the following definition:

"General acute care hospital" (GACH) means a hospital, licensed by the California Department of Public Health as such ~~in accordance with~~ meeting the definition provided in Health and Safety Code Section 1250(a)~~, Title 22,~~ or California Code of Regulations, Title 22, Section 70005, and all services within the hospital's license ~~including, but not limited to: emergency, outpatient observation, outpatient clinics, physical therapy and ambulatory surgery services located at the hospital facility, and all off-site operations included within the hospital's license~~.

Comment BJ#10:
Staff that is provided through temporary services or contracted staffing or security contracts should be orientated to the facility and safety procedures, but the facility cannot be required to provide all training to the equivalent level of regular employed staff. The contractor should provide general training along the lines specified in subsection f(3) and if the contractor provides staffing to health facilities, the contract employer should be able to provide assurances of training. Further temporary or contract employees should not be part of the regular process review cycle or annual training. Contract and temporary employees need to be addressed in a separate training regulation than the facility employees.

Recommendation:

f(1) All employees working in the facility, unit, service, or operation shall be provided initial training as described in subsection (f)(1)(A) when the Plan is first established and when an employee is newly hired or newly assigned to perform duties for which the training required in this subsection was not previously provided, and shall also be provided additional training as described in subsection (f)(1)(B). Training of security personnel in hospitals shall be consistent with Health and Safety Code 1257.7(c). ~~An employer that employs proprietary private security officers, contracts with a private patrol operator or other security service to provide security guards, or hires or contracts for the services of peace officers, shall arrange for those personnel to participate in the training provided to the employer's employees.~~

Response:
Please see the response to Comment GBS#29.

Comment BJ#11:
Add f(5)

(5) An employer that employs proprietary private security officers, contracts with a private patrol operator or other security service to provide security guards, or hires or contracts for the services of peace officers, or hires temporary staff, shall arrange for those personnel to be orientated to facility Plan as applicable to areas of assignment as required under (f)(4).
(A) If contract employee is regularly assigned to employer or is directly contracted with the employer, employer may include contractor in training under (f)(1)
(B) A contract employee is exempt from training if the contractor provides attestation of training described in subsection (f)(1)(A)(2), (3), (4) and/or (f)(3).
(C) Training of contract security staff at hospitals shall be consistent with Health and Safety Code 1257.7(c).

Response:
The Board notes that a significant problem identified in the advisory meeting process was that the health care staff did not know what role security personnel played in responding to violent incidents. Subsection (f)(1)(A) has therefore been modified to include training on the role of private security personnel, if any. Please also see the response to Comment GBS#29.

Comment BJ#12:
Specify that training is applicable to the process of identified hazards as specified in the section.

(f) Training. The employer shall provide effective training to all employees, including temporary employees, working in the facility, unit, service, or operation as specified in subsection (c)(8). The training shall address the workplace violence hazards identified in the facility, unit, service, or operation, the corrective measures the employer has implemented, and the activities that each employee is reasonably anticipated to perform under the Plan. The employer shall have an effective procedure for obtaining the active involvement of employees and their representatives in developing training curricula and training materials, conducting training sessions, and reviewing and revising the training program. Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.

Response:
Please see the response to Comment GBS#29.

Yvonne Choong, Vice-President, Center for Health Policy, California Medical Association (CMA), by electronic mail sent December 17, 2015.

Comment YC#1:
There is wide variation in the types of office-based physician practices, which can vary by number and type of employees, physical plant, geographic location, specialty, and financial

resources. While providing guidance to these physician employers regarding the need to develop a workplace violence prevention plan and the elements that could be included would be a valuable resource, establishing a regulatory mandate to develop a Plan, employee training and recordkeeping processes with highly prescriptive requirements places a substantial burden on physician practices that could impact the provision of patient care. The proposed regulations establish a "one size fits all" framework that would apply substantially the same requirements for a solo rural physician practice and the largest acute care hospitals in the state, regardless of actual needs and resources.

Response:
The proposed standard is based on Section 3203 which applies the basic principle that an employer needs to assess their workplace, identify occupational hazards, and take steps to correct the problems they identify, and train their employees in the proper procedures to avoid harm from the hazard(s) identified. This is not "one size fits all" since Section 3203 applies to essentially all workplaces (except exempted by jurisdiction) in California. This basic approach is adopted into the proposed regulation by requiring the health care employer to identify workplace violence factors in their facility or operation. This assessment can be done by the employer who may use professional assistance as needed, but must also take into account factors such as the past occurrences of violent incidents and the experiences of the employees in the work area that is being evaluated. This is intended to allow the employer to identify problems specific to their workplace and establish the necessary applicable workplace controls. For example, subsection (c) lists weapon detection devices but does not require all health facilities or practices to have one. The employer is required to determine with employee involvement if there is a need for it, and if it is feasible to have it at the facility. Therefore, the Board believes that the standard does provide employers with flexibility to implement suitable and appropriate control measures in a manner consistent with Section 3203.

Comment YC#2:
Below, we outline our concerns regarding the proposed regulations and the potential negative impact it may have on office-based physician practices.

Broad definition of "workplace violence" could result in significant administrative response and record-keeping burdens. The proposed regulations define "workplace violence" in Section 3342 (b) as: "… any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following: (A) The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury…"

This definition is broad and could be interpreted, in conjunction with the definition of Type 3 (employee-employee violence), to include actions that are more appropriately categorized as conflict between co-workers and are more appropriately addressed through existing human resource policies and procedures. For example, an employee could claim that another employee threatened violence and that it caused stress. Regardless of whether the claim is substantiated, it would still have to be logged as a violent incident. Having a logged but unsubstantiated "violent

incident" is troubling in and of itself and will increase the employer's exposure to harassment claims and other potential forms of liability.

Response:
Conflict between coworkers must involve a reasonable possibility that an employee might be physically injured, as provided in the definition of "threat of violence," to be within the scope of the proposed regulation. The Board therefore believes that the definition of workplace violence is appropriately limited. Type 3 violence is an unfortunate occurrence that has been acknowledged by various commenters to the proposed regulation and by professional organizations. Mandates from professional organizations, as well as existing laws protecting individuals from various forms of discrimination, have established a framework that employers can apply to the issue of Type 3 threats to determine what is a threat of violence in their workplace that must be addressed under the proposed regulation. The Board recognizes that this is not a simple process but believes that this issue needs to be addressed to diminish a long-standing problem in health care.

Comment YC#3:
The proposed regulations also require that the employer record, in a "violent incident" log, information about every incident, post-incident response and workplace violence injury investigation. Based on the definition of "workplace violence," the employer could be required to record in the violent incident log all patient verbal outbursts and threats, regardless of whether an actual injury resulted. In some settings, such as practices specializing in behavioral health or in emergency departments, these types of outbursts can be common. Regardless of whether these outbursts pose an actual threat to patients or employees, these regulations would require each incident to be logged and investigated, resulting in significant administrative burden.

We recommend that the Board consider revising the definition of workplace violence or the violent incident reporting requirements to specify that certain types of incidents do not need to be reported and logged as a workplace violence incident.

Response:
Threats of violence must involve a reasonable possibility that an employee might be physically injured. If the threat is made by a patient who is not actually in a coherent state, or who habitually makes threatening statements as a manifestation of the patient's condition, the threat may not be recordable and need not be put in the Log.

Comment YC#4:
The Initial Statement of Reasons underestimates the costs to physician offices.

Response:
Please see the response to Comment YC#6.

Comment YC#5:
Title 8 section 3203 provides a partial exemption to recordkeeping for employers with less than 10 employees and the proposed regulation does not have these exemptions. CMA recommends that Cal/OSHA develop simplified requirements to allow physician small businesses to discharge their responsibility to train employees on workplace violence.

Response:
Please see the response to Comment YC#6 regarding the impact of the regulation on physician businesses.

Subsection 3203(b)(2) Exception 1 allows employers with less than 10 employees to maintain a log of instructions provided to employees for each hazard unique to the employees' job assignment, rather than maintaining employee training records.

The proposed regulation requires initial training be provided to all exposed employees, annual training provided to employees with patient contact activities, and initial and annual training to employees who respond to violent incidents. Section 3203 does not specify training topics and does not require annual refresher training. Due to the different types of training and the increased frequency of training of the current proposal compared to Section 3203, the Board believes it is easier for employers with less than 10 employees to maintain training records for employees rather than maintain logs of instructions given to employees. Therefore, the Board believes that the exception in subsection 3203(b)(2) does not provide any benefit to small employers and declines to include it in the current proposal. At the time the exception was written, training records were frequently kept as written documents. With current technology, most training records are stored digitally, eliminating the advantage of maintaining logs compared to maintaining individual training records.

The exception to subsection 3203(b)(1) permits employers with fewer than 10 employees to maintain records of inspections to identify and evaluate hazards only until the hazard is corrected. In the current proposal, records of inspections to identify and evaluate hazards are used during, and are of critical importance to, the review of the workplace violence prevention plan required by subsection (e). Without records of inspections to identify and evaluate hazards, the employer will not be able to comply with subsection (e). The Board declines to include the exception similar the exception in subsection 3203(b)(1) in the current proposal as the records are necessary and there is little or no additional cost to keeping the records compared to disposing of the records.

Comment YC#6:
Proposed regulations could significantly increase costs for small employers. Compliance with these proposed regulations potentially requires significant staff and financial resources as well as access to specialized expertise on workplace violence and security issues. While this may not present a significant challenge for hospitals and other licensed health facilities who have the financial resources and organizational capacity to develop the Plan (and indeed may already have a workplace violence prevention plan in place as a licensing or accreditation requirement), physicians and other health care providers practicing in small or solo practices and operating as very small businesses may be challenged to comply with the proposed new requirements.

Requiring physicians who employ only a few employees and who may not have the practice management infrastructure to develop extensive workplace violence prevention plans and training processes would place a substantial financial burden on the practice, as well as yield minimal benefit as there is no evidence that there is a high likelihood of violence in these

settings. Efforts to comply could result in the practice closing down for a few days to develop the Plan and provide the training to employees. Patient access to care could also be limited as staff resources are diverted to develop the Plan and provide employee training.

Response:
The Board concurs that the regulation could place a disproportionate burden on office-based physician practices. The proposed regulation has therefore been modified to remove from the scope of the proposed regulation all outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings.

Comment YC#7:
In order for there to be meaningful compliance with these regulations, additional information is needed about how compliance will be assessed and the nature of the expected outcomes. If the intent is to develop workplace violence policies which result in zero workplace violence incidents of any kind, this is likely to be an unattainable objective for some health care settings. For example, hospital emergency departments and behavioral health settings, by the nature of the care provided, regularly have patients that are unruly or verbally threaten violence. The existence of a robust workplace violence prevention policy is unlikely to alter the number of incidents that are recorded.

Based on discussions with Cal/OSHA staff, the department does not intend to proactively audit or inspect workplaces to determine if compliance with the regulations has been achieved. Any inspections will be initiated by complaints regarding the workplace. This could expose employers to frivolous complaints from disgruntled employees or patients regarding failure to comply with a provision of these regulations, resulting in increased legal and administrative costs. An employer could make a good faith effort to comply with these regulations, but if audited, could be found to be deficient for having failed to include every possible security precaution identified in the regulations. For example, while an alarm system might improve security, the employer may not be able to implement such a security measure due to cost, facility constraints or possible impact on patient care. It is unclear if this type of deficiency would constitute a violation.

We recommend that the Board consider moving prescriptive specifications regarding risk factors and possible security measures out of the proposed regulations and into an external guidelines document that can be adopted as appropriate to the health care setting, as well as more easily updated as needed. This would provide guidance to health facilities and help to clarify elements that are intended to be legal requirements versus suggested considerations.

Response:
Complete elimination of all workplace violence incidents is not required by the proposed regulation. Although standards may not achieve complete elimination of specific hazards from California, they are designed to establish methods so that employers will reduce the likelihood of the hazard causing injuries and illnesses in their workplace. Employers are expected to follow the approach that has been developed for Section 3203, which is to assess their operation, identify existing problems and hazards, and take steps to correct those problems to the extent

feasible. Factors for deciding whether controls are feasible can include the physical layout of a facility or existing laws or regulations that preclude a specific type of work practice or installation of engineering controls, for example. The employer must evaluate and mitigate problems to the extent feasible, and should document the process to show compliance. Within the proposed regulation, the active involvement of the affected employees will provide for added confirmation that the employer complied with these requirements.

The Division conducts inspections when complaints are lodged. There is no evidence that the proposed regulation will result in greater numbers of frivolous complaints than other regulations. This regulation does not require employers to install every security precaution and device possible. Please see the response to Comment YC#1.

The experience of the Division has been that external guidelines usually do not provide enough incentive for employers to widely address the existing hazards within their places of employment. For example, external guidelines for workplace violence issues in health care have been issued by Cal/OSHA since 1993 and several times by federal OSHA and the National Institute for Occupational Safety and Health, but have apparently had only limited utilization by employers. The Board believes that this would be the same outcome if the recommended change was to be applied here and declines to make that modification.

Comment YC#8:
Additional time needed to implement regulations. Physician employers will need sufficient time to achieve compliance with the regulations due to the following factors:

- Unlike licensed health facilities, which may already have some type of workplace violence prevention plan in place and an infrastructure for providing employee training and recordkeeping, many physician offices will have to establish completely new policies and procedures to comply with these regulations.
- Physician offices often lease their facilities and may not have the flexibility to quickly make necessary changes to the physical configuration of their offices.
- The proposed regulations specify that employees are to be engaged in the development of training materials and the violence prevention plan, which might not happen until physical plant improvements have been made. Patient schedules may also need to be rearranged to create time to allow all staff to design and participate in the training.
- Employers may also need to retain outside assistance to comply with the regulations including consultants to develop plans and conduct trainings, and legal counsel to ensure that their Plan is in compliance with the regulations. This may include substantial technical assistance from Cal/OSHA, including model violence prevention plans, guidelines for facilitating employee training, violent incident tracking log forms, and policies and procedures. Without this type of support, there is unlikely to be meaningful compliance from many small employers.

We recommend that the deadline for full implementation of the regulations be established no earlier than one year after approval by the Office of Administrative Law and the effective date of the regulations.

Response:
The Board agrees that allowing more time for implementation of the regulation will allow employers to develop more effective Plans and training. The Board proposes to require that the implementation of certain portions of the regulation be done within one year after the effective date of the regulation.

Braden Oparowski, Director of Policy, Advocacy and Public Affairs, California Association for Health Services at Home (CAHSAH), by written comments sent December 11, 2015.

Comment BO#1:
CAHSAH is very concerned that the proposed regulations were developed with a "one size fits all" approach that fails to take into account for the disparities in entity types within the health care community. Specifically, subsections (c), (d), (e), (f) and (h) are applied to all facilities including hospitals, provider offices, home health, home care and hospice, to name a few. It is important to note that some of the proposed options for assessing and maintaining safety are simply unrealistic in a home setting.

Response:
The Board recognizes the variability in health care settings and has developed the framework for this proposed standard based on Title 8, Section 3203, Injury and Illness Prevention Program (IIPP), which applies to all employers regardless of size or industry. The proposed Section 3342 affords employers the flexibility to safeguard its workplaces with applicable engineering and work practice controls where necessary and feasible. Also please see the response to Comment YC#1.

Comment BO#2:
While CAHSAH sincerely agrees with the need to have strong, active workplace safety regulations, it is vital that the regulations fall within the confines of the home setting. According to OSHA, reported claims of health settings workplace violence for the period of 2010 to 2012, the percentage of instances of workplace safety and violence in hospice and home health has been reported at 1%. This is significantly less than facility based entities.

Response:
Workplace violence is a significant risk for home health care workers. According to the National Institute of Occupational Safety and Health, in 2006, nonfatal assaults on home health care workers, resulting in injuries with day away from work, occurred at more than twice the rate for all U.S. workers. In a survey of over 1,200 home health care workers, twenty-one percent of the workers reported that they had been threatened with violence in the past year and fourteen percent of the workers reported that within the past year they had been kicked, bitten, hit with a fist, pushed, grabbed, shoved, slapped or someone had tried to hit them, but failed. See the following articles:

- Department Of Health And Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. NIOSH Hazard Review Occupational Hazards in Home Healthcare, Publication No. 2010–125, January 2010
- G. C. Hanson, N. A. Perrin, H. Moss, N. Laharnar, and N. Glass. Workplace violence

against homecare workers and its relationship with workers health outcomes: a cross-sectional study, BMC Public Health, vol. 15, no. 11 (2015): 1-13

Comment BO#3:
The approach to developing regulations should include an analysis of the risk for each entity type and a feasibility study for implementing such safety measures for each specific entity type based on a risk analysis. The regulations should then be developed to maximize their effectiveness for each entity type.

Response:
Please see the response to Comment YC#1.

Comment BO#4:
Federal Regulations Title 42: Public Health Part 418 for Hospice Care Section 418.26(3) allows a hospice agency to discharge a patient if their behavior is disruptive, abusive or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The ability to discharge a home health patient is also allowed in federal law and is specified in Centers for Medicare and Medicaid Service Guidance 100, Chapter 7, Section 10.10. All home health and hospice agencies already apply these discharge policies when the safety of the worker is at risk. Implementing the proposed safety precautions, instead of discharging unsafe patients could actually put home health and hospice workers at a greater risk.

Response:
The proposed regulation does not prevent the discharging of an abusive patient as allowed under other regulations. The Board recognizes that other agencies and organizations with oversight roles in health care have regulations or requirements that home health and hospice agencies must follow, but does not believe that the proposed regulation is in conflict with them. The Board encourages home health and hospice agencies to utilize all appropriate control measures to safeguard their employees and other patients, including discharging unsafe patients as allowed by federal law.

Comment BO#5:
Subdivision (c)(8)(C) requires home health, hospice and home care to develop procedures to identify and evaluate environmental risk factors such as the presence of weapons, evidence of substance abuse, and the presence of uncooperative cohabitants. Additionally, these procedures must be implemented during intake, at the time of the initial visits, for continued visits, and where there is a change in the patient's conditions. CAHSAH has numerous concerns relative to the feasibility of accurately acquiring the information at those specific intervals to make a determination about the safety of a worker who is caring for a patient that is receiving care in a private residence. It also appears that home health and hospice are the only entity type that has been singled out to incorporate safety assessment and implementation of safety precautions at specific timed intervals.

Response:
The proposed regulation, in renumbered subsection (c)(9)(C), requires evaluation of environmental risk factors at different stages only when there has been a change in these factors.

(The term "changes in conditions" refers to changes in environmental risk factors.) Employers can establish procedures for evaluating environmental risk factors at home health settings through observation and questioning of patients and family, neither of which is infeasible. For very high risk environments, the employer may consider additional evaluation methods, which will vary on a case by case basis and be determined by the employer.

Comment BO#6:
Requiring a home health agency or hospice to accurately identify whether a neighborhood is an area where violence would more likely occur is problematic and would require some type of crime statistical analysis for the area.

Response:
At the November 13, 2014, and November 19, 2014, meetings focusing on workplace violence prevention in non-hospital health care facilities, and facility security and law enforcement, numerous suggestions were made on how to readily obtain crime data through no-cost/low-cost measures such as crime apps, and how to obtain crime maps from crime analysts at local police stations.

Comment BO#7:
Subdivision (c)(F) [SIC] which specifies that the provider, "Maintain sufficient staffing, including security personnel, who can maintain order in the facility and respond to workplace violence incidents in a timely manner" is not feasible for home settings. Having a security guard accompany home health clinicians into a private home is not practical like it is for a facility location. Maintaining sufficient staffing in home health is problematic as well because federal regulations dictate whether multiple health care providers can be in the home at the same time based on the patient's medical needs. The reimbursement structure is cost based and unless two workers were authorized in the approved care plan, an agency would not be reimbursed for two workers; nor, are there reimbursement provisions for security guards on home visits.

Response:
Renumbered subsection (c)(11)(F) is listed as one of the corrective measures that an employer shall include, as applicable and to the extent feasible. This does not mandate employers to hire security personnel.

Comment BO#8:
The requirement that staff be trained every 90 days to review safety defense training is not possible with a home based provider because of the very nature of how home care is staffed.

Response:
Although the Board sees the importance and encourages practicing maneuvers and techniques at regular intervals, it recognizes the 90-day frequency may be challenging for employers. The requirement has since been removed from discussion draft presented at the April 1, 2015, advisory meetings and in the Board's current proposal.

Comment BO#9:
CAHSAH firmly believes that all staff should complete workplace violence training; however, a more appropriate method of training for private settings would be training at initial hire and every year thereafter with on-line training being an option.

Response:
The training frequency in the current proposal is for training at initial hire, additional training when new equipment or work practices are introduced or when a new or previously unrecognized workplace violence hazard has been identified, and refresher training annually. The Board recognizes that on-line training can help employers provide timely and useful information and does not exclude this mode of training, as long as the employer provides employees with an opportunity for interactive questions and answers with a person knowledgeable about the employer's workplace violence prevention plan.

Comment BO#10:
Clarification is also needed on subdivision (c)(10)(A) which specifies: "Ensuring that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. A staff person is not considered to be available if other assignments prevent the person from immediately responding to an alarm or other notification of a violent incident." It is unclear what criteria are used to determine "sufficient number of staff." Current statute does not require specific staffing ratios for home health, hospice and home care. This is another example where home and community based entities cannot be lumped into the same requirements as all heath workplace settings.

Response:
Renumbered subsection (c)(11)(A) is listed as one of the corrective measures that an employer shall include, as applicable. The Board recognizes that small employers may not have more than one employee at a home setting, but expects employers to have procedures that protect the workers at the moment these incidents occur, including effective procedures for responding to these incidents.

Comment BO#11:
We are also concerned that the following requirements are not feasible in a home setting because individuals have legal rights which protect them under the law from being required to alter their residence. Yet, these requirements are included for home health, hospice and home care:

- Removing, fastening, or controlling furnishings and other objects that may be used as improvised weapons in areas where patients who have been identified as having a potential for workplace Type 2 violence are reasonably anticipated to be present.
- Installing an alarm system or other effective means by which employees can summon security and other aid to defuse or respond to an actual or potential workplace violence emergency.
- Providing line of sight or other immediate communication in all areas where patients or members of the public may be present. This may include removal of sight barriers, provision of surveillance systems or other sight aids such as mirrors, use of a buddy system, improving illumination, or other effective means. Where patient privacy or physical layout prevents line

of sight, alarm systems or other effective means shall be provided for an employee who needs to enter the area.
- Configuring facility spaces, including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms, so that employee access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.

Response:
The Board recognizes that patients in home settings have numerous protections and rights as afforded by law. Renumbered subsection (c)(11) only requires applicable and feasible corrective measures to be used. Not all corrective measure listed in renumbered subsection (c)(11) would necessarily be applicable in all health care settings, and the listing of possible corrective measures does not preclude the use of other effective measures. Since it may not be feasible nor applicable to alter a resident's home, the requirements regarding reconfiguring the workplace may not be applicable to the home setting. Employers must consider applicable means to safeguard their employees in these settings to the extent feasible. One such measure may be to ensure that staff has access to cell phones to obtain instructions in situations where risk is apparent or anticipated.

Comment BO#12:
We believe that through proper education and staff training, the percentage of workforce violence will decrease in home settings. Home and community based patients are referred by other health care providers where the screening process assists in identifying any safety risks. Federal regulations allow for home setting providers to call 911, vacate the premises, and discharge patients if there is risk to the workers. Consideration must be given to the unique circumstances that home and community based providers face when determining specific safety prevention protocols.

Response:
The Board concurs that home and community based workers will benefit from receiving effective training specific to the hazards and corrective measures in their workplaces. The Board acknowledges that patient screening, notifying authorities, vacating premises, and discharging unsafe patients can be effective measure to prevent workplace violence in home and community based settings.

Jedd Hampton, Director of Policy, Health Services, LeadingAge California, by electronic mail sent December 16, 2015.

Comment JH#1:
In its Initial Statement of Reasons, the Board's economic impact analysis concludes that the proposed standards would not impose significant additional costs because the health care employers should already have health care workplace violence prevention plans in place that similarly reflect those outlined in the proposed standards. While many of our skilled nursing facilities do have workplace violence prevention programs already in place, it appears that facilities will now be required to adopt the Plan outlined in the proposed standards. The burden of complying with all of the various elements of proposed standards, which encompass newly-created staffing, training and reporting requirements, go far beyond what is typically included in

a workplace violence prevention policy and will likely impose a substantial cost to our skilled nursing facility members.

Response:
The Board acknowledges that the proposed regulation contains important requirements not contained in existing regulations. Please see the response to Comment SEIU#3 provided during the second 15-day comment period. Please see also the final statement of reasons for details on the estimated costs and benefits of the proposed regulation.

Comment JH#2:
It should be noted LeadingAge California members operate not-for-profit skilled nursing facilities, and currently, any additional surplus income generated by these facilities is invested back into the community to improve or expand the quality and services they provide. If our facilities were faced with the potentially higher costs associated with coming into compliance with the proposed standards, then it could lead to less capital being invested back into the community and improving the quality and services for its residents.

Response:
While there may be additional initial costs borne by providing training and implementing control measures, these costs would in part be balanced by avoiding or minimizing the costs inherent in workers' compensation claims, lost work time, and productivity losses caused by workplace violence deaths and injuries to employees.

Comment JH#3:
We have concerns about the references in the proposed standards that suggest that health facilities must employ both a particular staffing level and security personnel. Specifically, proposed 8 CCR 3342(c)(10)(F) suggests that a facility must maintain "sufficient staffing, including security personnel…" within their facilities.

Response:
Please see the responses to Comments JH#1 and BO#7.

Comment JH#4:
Furthermore, proposed 8 CCR 3342(c)(10)(J) suggests that facilities must "assign or place minimum numbers of staff to reduce patient-specific Type 2 workplace violence hazards." We strongly disagree with the notion that Cal/OSHA has the authority to mandate staffing decisions for a facility, and maintain that these decisions rest with the employer.

Response:
Renumbered subsection (c)(11)(J) has been modified to refer to "sufficient" numbers of staff instead of "minimum" numbers of staff. Please also see the responses to Comments JH#1 and BO#7.

Comment JH#5:
We have concerns encompassing the various training requirements included in the proposed standards. Specifically, proposed 8 CCR 3342(f)(1) indicates that all employees working in a

facility must undergo training as required by the proposed standards. While we understand that temporary and contracted employees, particularly those engaged in direct care contact should be trained, we believe that requiring all employees on the premises to be trained is likely unnecessary.

Response:
A modification was made to subsection (f) to clarify that employees are to receive training that addresses the workplace violence risks that they are reasonably anticipated to encounter in their job so that training is specific to employee exposure and hazards. All employees must receive at least some form of instruction commensurate with their risk, such as how to recognize emergency signals and procedures for evacuating or sheltering in place.

Comment JH#6:
Furthermore, we have concerns with proposed 8 CCR 3342(f)(1)(B), which indicates that "additional training shall be provided when new equipment or work practices are introduced or when a new or previously unrecognized workplace hazard has been identified." We believe that this section is overly broad and unclear in how "new work equipment or work practices" are measured. We would also suggest that it is unclear as to what kind of training would be required once a "previously unrecognized workplace hazard" has been identified. Would this training be separate from the initial workplace violence trainings or would it be a re-training? We believe that proposed 8 CCR 3342(f)(1)(B) needs more clarification to prevent employer confusion on what triggers the need for additional training.

Response:
This language is consistent with additional training requirements in Section 3203, IIPP, and Section 5120, Health Care Worker Back and Musculoskeletal Injury Prevention. If new equipment, such as an alarm, is installed then employers would be required to train employees on its proper use and maintenance. This would be a separate training if not covered in the initial training.

Comment JH#7:
We have concerns about how a facility's workplace violence prevention plan will be assessed and measured. Our concerns arise out of the fact that it is entirely plausible for a health care employer to have a strategic and comprehensive workplace violence prevention plan in place, and yet for various reasons, an incident may still occur.

Response:
The proposed standard is based on Section 3203, which applies the basic principle that an employer must assess their workplace, identify occupational hazards, and take steps to correct the problems they identify, and train their employees in the proper procedures to avoid harm from the hazard(s) identified. The Division will evaluate an employer's Workplace Violence Prevention Plan similarly to how employers' injury and illness prevention programs under section 3203 are evaluated. The Board believes that developing and implementing a Plan will prevent workplace violence incidents from occurring, but also acknowledges that some incidents may not be preventable. Also see the response to Comment YC#7.

Comment JH#8:
Skilled nursing facilities in particular, whom tend to care for patients with one or more acute medical, behavior or cognitive impairments, face a significant risk in workplace violence incidents based solely upon the resident that they serve. We would suggest that merely because an isolated incident takes place, it is not necessarily indicative that the workplace violence prevention plan was ineffective. Simply put, a workplace violence incident may be extremely difficult to predict or anticipate.

Response:
Please see the response to Comment JH#7.

Sandra J. Haskins, Executive Director, Gold Country Retirement Community, by electronic mail sent December 15, 2015.

NOTE: Ms. Haskins made identical comments as LeadingAge using a form letter. Please see the responses to Comments JH#1-JH#8. Below are responses to her specific comments.

Comment SH#1:
We have "security" personnel on our campus however their function is to respond to resident incidents and do maintenance and janitorial work. They are not trained in any way to be "security" guards. The security they are to provide is to our residents when they have an emergency in their unit.

Response:
The Board notes that the functions of personnel described in this comment do not meet the criteria in renumbered subsections (c)(11)(F) and (c)(11)(I). However, those subsections only give examples of control measures that are to be used as applicable and to the extent feasible.

Comment SH#2:
We have concerns encompassing the various training requirements included in the proposed standards. We already face numerous regulations that direct our staff training; to add overbroad requirements on workplace violence and recognizing hazards could take away from training that is more focused for the profession we are in.

Response:
The Board acknowledges and appreciates the professional work of health care workers, such as those employed in skilled nursing facilities and congregate living health facilities. However, the Board also notes these same workers are at an increased risk of workplace violence and therefore must be trained on the employer's Plan to prevent or minimize these incidents. The Board further notes that training on workplace violence prevention may be incorporated into other existing training programs. Subsection (f) has been modified to clarify that the required training need only address the risk that employees are reasonably anticipated to encounter in their jobs.

Lisa Hall, Director of Regulatory Affairs, California Association of Healthcare Facilities (CAHF), by written comments sent December 17, 2015.

NOTE: The commenter provided background information on the topic of workplace violence from the perspective of long term care facilities. The Board thanks the commenter for this background information.

Comment LH#1:
The Intermediate Care Facilities for the Developmentally Disabled, whether the facilities are licensed as a habilitative or nursing level, are for the most part six beds homes. They care for those residents with moderate to severe developmental disabilities. CAHF would expect these to be exempt from any type of requirements that are implemented.

Response:
The Board acknowledges that smaller establishments, such as intermediate care facilities, have limited resources, however notes that resident aggression and violence occurs in these small facility settings and may require staff to intervene or separate residents who are aggressive. Therefore it is necessary for these employers to have procedures that protect the workers where these incidents occur, including how to respond to these incidents.

A survey of 6,300 randomly selected nurses found that assault rates were 2.6 times higher in nursing homes/long-term care facilities than other health care settings. Assault rates in nursing homes/long term care facilities were even higher than assault rates in psychiatric departments.

The U.S. General Accounting Office found that in 2013 the estimated rate of injuries for all private-sector workers due to violence that resulted in days away from work was 2.8 per 10,000 workers. In contrast, the estimated rate for private-sector hospital workers was 14.7 per 10,000 workers, and for nursing and residential care workers the rate was 35.3 per 10,000 workers (12 times greater violence injury rate than all private-sector workers).

See the following studies:

- Gerberich SG, Church TR, McGovern PM, Hansen HD, Nachreiner NM, Geisser MS, Ryan AD, Mongin SJ, Watt GD, Jurek A (2005) Risk Factors for Work-Related Assaults on Nurses. Epidemiology 16, 704–9
- United States Government Accountability Office. Workplace Safety And Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence, Report to Congressional Requesters (GAO-16-11). March 2016

Comment LH#2:
In talking to our members, resident-to-resident violence is more of concern and there is little resident-to-staff occurrences.

Response:
Please see the response to Comment LH#1. In a study on resident-to-resident aggression in long-term care facilities, thirty-eight percent of focus groups described having to physically intervene or separate residents who were aggressive; this included having to take away objects such as canes or walkers that were being used as weapons.

See the following study:

- Rosen, T., Lachs, M. S., Bharucha, A. J., Stevens, S. M., Teresi, J. A., Nebres, F., and Pillemer, K. (2008). Resident-to-Resident Aggression in Long-Term Care Facilities: Insights from Focus Groups of Nursing Home Residents and Staff. Journal of the American Geriatrics Society, 56(8), 1398–1408 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2755096

Comment LH#3:
All levels of Intermediate Care Facilities for the Developmentally Disabled need to be excluded from the requirements. The majority of these facilities are six bed residential homes that house medically frail as well as developmentally disabled clients. The financial hardship they would face to implement would see many no longer being able to provide services.

Response:
The Board recognizes the size variability in health care settings and has developed the framework for this proposed standard based on Title 8, Section 3203 IIPP, which applies to all employers regardless of size or industry. The proposed Section 3342 affords employers the flexibility to safeguard its workplaces with applicable engineering and work practice controls to the extent applicable and feasible. Small employers, such as intermediate care facilities, may seek assistance from safety and health professionals in Cal/OSHA Consultation Services, law enforcement, and insurance safety auditors to help develop their programs.

Lydia Missaelides, MHA, Executive Director, California Association for Adult Day Services, by electronic mail sent December 17, 2015.

Comment LMI#1:
On behalf of California's 241 adult day health centers, we are writing to offer our input on the proposed Health care Workplace Violence Prevention Regulations under consideration by the Board. We are extremely concerned that these regulations appear to extend to long-term services and supports (LTSS) provided in community-based settings, such as adult day health centers and other LTSS programs. If such programs are included it could have serious unintended negative consequences on access to care for tens of thousands of frail elderly and disabled Californians.

These are our overarching concerns:
These standards were not designed for community-based LTSS settings. They are fundamentally misaligned with the character, mission and requirements of LTSS programs. Integrated LTSS that include health care as well as social supports are not institutional in character and do not have the same workplace violence concerns, infrastructure or resources as hospitals, nursing facilities or emergency departments.

Response:
The Board notes that the requirements of the proposed regulation are meant to protect employees in health care settings from workplace violence as they work throughout a continuum of activities. The health care settings covered by the proposed regulation include institutional care in health facilities licensed by the California Department of Public Health (CDPH) as well as home health care and home-based hospice. LTSS provided in these health care settings are

covered by the proposed regulation. The Board believes that the standard provides employers in all health care settings with flexibility to implement suitable and appropriate control measures in a manner consistent with Section 3203, IIPP.

Comment LMI#2:
We have only recently learned of these proposed regulations; and it is our understanding that NO LTSS providers were part of the process of development, which is reflected in the misalignment of the regulations for these settings. In addition, the California Department of Aging, which understands the character and requirements of these programs, does not appear to have been solicited for input. The lack of fit of these standards for LTSS programs is a consequence of this lack of input from providers, stakeholders and other departments of state government that oversee these programs.

Response:
The Board notes that stakeholders such as the California Hospital Association, CAHSAH, and CAHF, were in attendance at advisory meetings that took place from September 2014 – April 2015. The CDPH Licensing and Certification Program was consulted on certain aspects of the proposed regulation. The California Department of Health Care Services, Long-Term Care Division, also contacted the Division of Occupational Safety and Health (DOSH) to obtain clarification of the application of the requirements.

Comment LMI#3:
The proposed regulations bring the culture, approaches and requirements of institutional health care settings to home and community-based LTSS programs. The intention of home and community-based programs is to be homelike, and these requirements move LTSS in the direction of institutional settings. This trend is fundamentally at odds with federal guidance and requirements on home and community-based settings. New Centers for Medicare and Medicaid Home and Community Based Settings (HCB Settings) regulations currently being implemented (Centers for Medicare and Medicaid Services, Final Regulation: 1915(i) State Plan HCBS, 5-year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and 1915(C) HCBS Waivers) and HCBS Final Regulations 42 CFR 441.301; 441.710; 441.530 will prohibit LTSS programs from receiving federal funding if their programs are deemed to be institutional in nature, including their policies and procedures. Centers for Medicare and Medicaid Services is imposing a "heightened scrutiny" standard for ANY setting that is viewed as institutional in character. An analysis of where the new federal HCBS rules and these proposed regulations conflict is urgently necessary before LTSS is included in new CalOSHA regulations. To the best of our knowledge no analysis of these factors has been conducted. Including LTSS in these regulations prior to such an assessment may well put the entire sector of LTSS programs at risk of being unable to receive federal HCBS funding. This issue is urgent and must be addressed prior to implementing the regulations for LTSS.

Response:
DOSH staff and the California Department of Health Care Services, Long-Term Care Division spoke about the new federal HCBS rules and concluded that there were not any apparent conflicts with the proposed regulation. The proposed section requires employers to determine, based on the assessment of their facility or operation, which engineering and work practice

controls are appropriate, feasible and that will effectively control workplace violence hazards. The proposed regulation does not require employers to implement controls that are in conflict with existing laws and regulations.

Comment LMI#4:
We agree with the premise that planning for and preventing violence is an important priority in all workplaces. However, LTSS settings, along with their operational and regulatory situation, must be clearly understood before approaches that result in negative unintended consequences occur. To achieve relevant and meaningful workplace violence prevention in LTSS, it is essential that providers, stakeholders and departments of state government who oversee these programs are involved in their design. Those conditions have not been met with regard to LTSS in the proposed regulations.

Response:
Please see the responses to Comments LMI#2 and LMI#3.

Comment LMI#5:
We strongly and urgently request that community-based LTSS programs including adult day health centers, be exempted from the current proposed regulations, in order for providers and stakeholders of these programs to participate in developing relevant and workable standards that balance the independence and dignity of persons participating in community settings with safety concerns and risk reduction.

Response:
The Board believes that employees of community-based LTSS programs such as adult day health care centers have occupational exposure to workplace violence and must be afforded the protection under this proposed standard. As noted in the previous responses above, the proposed standard is flexible enough to apply in all covered health care settings and operations.

Bill Taylor, CSP, Legislative and Regulatory Representative, Public Agency Safety Management Association (PASMA) - South Chapter, by electronic mail sent December 14, 2015.

Comment BT#1:
The inclusion of firefighters and paramedics who provide emergency medical services is unwarranted and will impose significant additional costs on Fire agencies while doing little to prevent incidents of workplace violence among firefighters and paramedics. PASMA does not believe that including firefighters and paramedics in this proposal which covers health care workers meets the necessity test, or that the need for including firefighters and paramedics in this particular regulation is demonstrated by substantial evidence. The Division has presented no evidence to suggest that these requirements are necessary to protect firefighters and paramedics from incidents of workplace violence.

In addition, these new requirements seem duplicative of other requirements contained in Section 3203 which among other requirements mandate that employers identify and evaluate workplace hazards, correct unsafe conditions, work practices, work procedures, and provide training and instruction. It doesn't make sense for the Division to mandate increased workplace violence

prevention plans and training requirements for one group of first responders such a firefighters, yet exclude another group such as police officers who are routinely subject to threats of workplace violence. The reality is that firefighters and paramedics work closely with police personnel and have demonstrated that they are well aware of the potential for workplace violence and are able to address the hazards without a requirement to add an additional program and the mandates contained in Section 3342.

Response:
It is necessary to include firefighters and paramedics in the proposal because they experience high rates of workplace violence. The Board believes that the additional cost to implement the program is warranted by the high risk of workplace violence. Fire departments will benefit from the proposal with reduced injuries, reduced absenteeism, reduced workers compensation costs and improved firefighter morale. The proposed regulation is intended to apply to emergency medical services and the transportation of potentially violent patients from a first-response setting or between facilities. Police departments with police officers who provide emergency medical services or transport patients to hospitals are not exempt from the regulation. Advisory meeting attendees and published research articles have reported that emergency medical service and transport personnel are exposed to the same or greater risks of workplace violence as compared to health care workers in fixed facilities. In addition, excluding transport personnel from this regulation could hinder communication between transport employees and facility employees that a patient is potentially violent. See the following articles documenting the high rates of violence experienced by emergency medical service providers:

- Franks, P., Kocher, N., and Chapman, S. January 2004. Emergency Medical Technicians and Paramedics in California. University of California, San Francisco, The Center for the Health Professions https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/9.1%20(Issue%20Brief)%202004-01_EMTs_and_Paramedics_in_California.pdf
- Kirkwood, S. May 2013. It's Time to Stop the Violence, NEMSMA launches initiative to address attacks on EMS providers. National EMS Management Association http://www.naemt.org/docs/default-source/Health-and-Safety-Documents/EMS_28_BestPractice0513.pdf
- Oliver, A. and Levine, R. 2015. Workplace Violence: A Survey of Nationally Registered Emergency Medical Services Professionals. Epidemiology Research International Vol. 2015. http://dx.doi.org/10.1155/2015/137246
- Taylor, J. A., Davis, A.L., Barnes, B., Lacovara, A. V., Patel, R. Injury risks of EMS responders: evidence from the National Fire Fighter Near-Miss Reporting System. BMJ Open 2015;5. http://bmjopen.bmj.com/content/5/6/e007562.full.pdf+html

Please also see the response to Comment GBS#1.

Comment BT#2:
We believe that in house medical staff who are not part of a "workplace clinic," but that may provide consultation and treatment to their own employees should be excluded from Section 3342 and instead be covered under the employer's existing workplace violence prevention program.

Response:
The Board concurs. The regulation has been modified to remove ancillary health care operations (which include workplace clinics) from the scope of the regulation. In house medical staff, which would be classified as part of an ancillary health care operation, are also excluded from the modified regulation.

Comment BT#3:
Firefighters appear to be included in the requirement for non-employees to participate in the implementation of the Plan and to be provided with training.

Response:
Subsection (f)(4), which addressed the training of "non-employees," has been deleted. Subsection (f) has been modified to clarify that training is required for all employees, regardless of whether they are hired and directly employed by the health facility. Emergency medical services and medical transport sometimes involve prolonged proximity to a patient who has been or may become violent. Advisory meeting attendees and published research (noted in the response to Comment BT#1) affirmed that these employees have a high risk of being victims of violent behavior.

Comment BT#4:
This regulation appears to require each firefighter or paramedic to attend both the initial and annual workplace violence prevention training classes offered at each of these separate facilities, in addition to their own department's workplace violence prevention plan. Including firefighters and paramedics in Section 3342 would impose significant additional costs of at least 14 million dollars a year to Fire and EMS agencies in California.

Response:
Subsection (f) has been modified to clarify that training must address only the workplace violence risks that the particular employee is reasonably anticipated to encounter and that training is not necessarily required to be given in person. The training does not have to occur at any specific facility or at different facilities. The Board calculated the cost of training for firefighters to be much less than 14 million dollars per year. Please see the final statement of reasons for details on the costs.

Comment BT#5:
We are requesting that Section (a)(l)(D) be deleted from new Section 3342, and that firefighters and paramedics be removed from the scope and application of this regulation.

Response:
Please see the response to Comment BT#1.

Kerri Greene, Interim Assistant Risk Manager - Loss Control, Contra Costa County, by electronic mail sent December 17, 2015.

Comment KG#1:
(b) Definitions

- The phrase "Dangerous Weapon" is a redundant term and should be re-labeled "Weapon."
    - Under the definition, weapon should be defined as "an instrument capable of inflicting death or serious bodily injury" that also includes firearms, sprays (oleoresin capsicum spray or pepper spray, e.g.) and the use of common objects as weapons.
    - The use of the word weapon should be made uniform throughout the document.

Drop the use of the phrase "dangerous weapon."

Response:
The Board notes that the phrase was derived from SB1299 and declines to make the suggested change.

Comment KG#2:

- The "Threat of violence" definition is unclear when it states "*and that serves no legitimate purpose."*
    - This phrase is unclear in its meaning and seems to infer that there are legitimate reasons for threatening violence.
    - Deleting the phrase "and that serves no legitimate purpose" would make the definition more clear.

Response:
Although a threat of violence made by most people present in a health facility would not serve a legitimate purpose, if law enforcement personnel are there responding to a criminal event, for example, they may have a legitimate purpose in threatening to commit a violent act. Therefore, the Board declines to make the recommended change.

Comment KG#3:

- The "Workplace violence" definition for "Type 3 violence" should include a discussion of lateral violence, bullying, harassment, and hazing as examples.

Response:
The employer's Plan is required to have a process to curtail or discipline these actions when they involve or threaten physical harm against an employee, as set forth in subsection (A) in the definition of "workplace violence." The Board believes this follows from the other definitions and subsequent discussion and declines to make the suggested change.

Comment KG#4:
Regarding subsection (c)(9) Workplace Violence Prevention Plan, Procedures to identify and evaluate patient-specific risk factors *and assess visitors.*

- Remove the phrase *"and assess visitors."* The rest of this section refers mostly to patient risk factor assessment.

- While it is important to respond to and document incidents with visitors, it is not appropriate, effective, or feasible to start documentation or conduct risk assessments on visitors in public facilities.

Response:
The comment provides no basis for this assertion. At the five advisory meetings that were conducted for stake holder suggestions, many validated a concern about the violence that is committed by people who are present with patients or on their own behalf. They believed that an indicator such as unruly behavior should be noted by staff so that an appropriate response, as established by the Plan, can be prepared by the employees before the behavior escalates into violence. The Board believes that letting an incident occur without warning and without preparation will most often result in more frequent and serious injuries to the employees involved. On this basis, the Board declines to make the recommended change.

Comment KG#5:
Remove the reference to *Type 1 workplace violence*.

Response:
There is no basis provided for this directive. At the five advisory meetings, there was no stakeholder assertion that Type 1 violence was not a problem. The Board therefore declines to make the change.

Comment KG#6:
Regarding subsection (c)(9) "procedures for paramedic and other emergency medical services to communicate with receiving facilities."

- These procedures are already in place; field emergency responders put this information on their field assessment and relay it to the receiving facility, which then includes it on the intake form when the client's record is started.
- The concern here is the subjectivity of the information and what should be done by the receiving facility who MUST accept patients for treatment, regardless of the readiness or risk factor.

Response:
The Board believes that this comment may not necessarily be true for the entirety of stakeholders in the state that employ or contract for paramedic and emergency medical service and transport. No evidence was provided that a statewide regulation or directive from the Emergency Medical Services Authority requires a process for a facility to advise the paramedic or transporter to expect unruly or violent behavior from the individual they will be moving. The Board acknowledges that such instructions must be made without compromising laws or regulations that already apply to patient rights or privacy concerns, but believes that simple cautionary advice can prevent or minimize harm to both the transporting personnel and the patient.

Comment KG#7:
Regarding subsection (c)(10) "shall take measures to protect employees from identified *serious* hazards within seven days of the discovery of the hazard."

- Remove the word *"serious"* which is subjective and not defined.

Response:
In response to this comment, the Board has added language to renumbered subsection (c)(11) to clarify that serious hazards are where there is a realistic possibility that death or serious physical harm could result from the hazard.

Comment KG#8:
Increase the response time for corrective actions. *Seven days* is not enough time to implement corrective measures or even interim measures in a hospital or health care setting where there are multiple departments and disciplines that must review and approve changes. In addition, outside governing and accrediting entities must approve many changes and these approvals can take months. For example, California's Office of Statewide Health Planning Department may take up to 9 months to approve a single card key mechanism on one door in a surgical suite.

Response:
The Board acknowledges that some institutions are bound by regulatory procedures that require more than seven days to make a change in a facility. However, the requirement is for the employer to assess the problem and initiate a course of corrective action within seven days even if the actual completion of the corrective action takes much longer.

Comment KG#9:
Regarding subsection (c)(10) "shall take interim measures to abate the *imminent or serious nature of the* hazard while completing the permanent control measures."

- Remove the phrase, "*imminent or serious nature of the*" as this is a subjective phrase.

Response:
Please see the response to KG#7. In addition, the Board believes the term “imminent hazard” is sufficiently clear in the context of Division enforcement under Labor Code section 6325. The Board therefore declines to make the requested change.

Comment KG#10:
Regarding subsection (c)(10), the language around "Corrective measures shall include, as applicable, but shall not be limited to" lists 10 items A - J that must be implemented for hazard correction.

- Remove the language "*shall include*," and replace it with the language, "may include, but shall not be limited to" to ensure that the interpretation that the items A-J are all options that can be used to control hazards, but that all 10 are not expected to be implemented at the same time.

Response:
Renumbered subsection (c)(11) already allows the selection and implementation of control measures based on whether they are applicable and feasible. The suggested change would make

the subsection unenforceable and the use of any control method optional, and the Board therefore declines to make the requested change.

Comment KG#11:
Regarding subsection (c)(10)(A), "Ensuring that *sufficient numbers* of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. *A staff person is not considered to be available if other assignments prevent the person from immediately responding to an alarm or other notification of a violent incident.*"

- Remove the phrase sufficient number as this is a subjective number and can vary over time, census, and circumstances.

Response:
Subsection (c)(10)(A) requires the employer to determine sufficient numbers of staff to prevent and respond to workplace violence incidents. The Board concurs that sufficient numbers vary over time with the census or other circumstances, but notes that the Plan is to be developed to account for these fluctuations from the perspective of making sure that there are enough employees to safely deal with violent incidents that can be expected based on the experience that the employer and employees have had in that particular unit over time. The Plan should take into account how many employees are needed to implement a procedure to respond safely to a violent incident which provides the basis for what is a sufficient number at a given time and location. For the above reasons, the phrase in question will not be removed.

Comment KG#12:
Remove the sentence, *"A staff person is not considered to be available if other assignments prevent the person from immediately responding to an alarm or other notification of a violent incident."* All staff should be responsible for preventing and responding to incidents; providing staff with no other duties may be one option as a control measure, but is not a feasible staffing option in all circumstances or facilities.

Response:
The Plan is intended to require a sufficient number of employees to be available in an area to respond appropriately to a violent incident for each shift to the extent feasible. This does not preclude staff from having other duties. If there are not sufficient numbers of staff assigned to an area, the Plan needs to be revised accordingly to include additional control measures.

Comment KG#13:
Also please note that the regulation refers to the term employee (93 times), staff (6 times* - not to be confused with staff, which is used 8 times), worker (1 time) and nonworker (1 time); we suggest that the regulation use one term to avoid confusion.

Response:
The Board notes that the use of "employee," "staff" and "worker" is sufficiently clear in the context of use and does not require this change. The Board has removed the term "*non-employee personnel"* from the regulation to reduce confusion. The term "*nonworker*" was never used.

Comment KG#14:
Regarding subsection (c)(10)(C), edit the phrase, *"Configuring facility spaces ... "*

- Add language to the phrase that acknowledges that not all facilities can be feasibly rearranged or reconfigured, *"Where possible,* configuring facility spaces ... "

Response:
Renumbered subsection (c)(11) says, "Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible." This would apply to renumbered subsection (c)(11)(C) and the other parts of subsection (c)(11). Therefore, the requested change is not necessary.

Comment KG#15:
Regarding subsection (c)(10)(D), edit the phrase, "Removing, fastening, or controlling furnishings and other objects from public and patient areas that may be used as improvised weapons ... "

- Remove the phrase *" ... in areas where patients who have been identified as having a potential for workplace Type 2 violence are reasonably anticipated to be present."*
- Add the phrase, "in public and patient areas."
- Maintaining good housekeeping of these items in public and treatment areas improves safety for all staff, patients, and visitors.

Response:
Although securing all objects in public and patient areas might prevent a certain number of cases of someone using an improvised weapon against an employee, other worker, patient or visitor, the main areas of concern identified in the advisory meetings were the rooms of violence prone patients and the areas where they would receive care. Applying this same process to all rooms and areas where a patient might pass through was not deemed necessary and would impose significant costs. Therefore the change will not be made.

Comment KG#16:
Regarding subsection (c)(10)(E), the phrase, "Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility *in areas where visitors or arriving patients are reasonably anticipated to possess firearms or other weapons that could be used to commit Type 1 or Type 2 violence."*

- Characterizing certain persons and areas as having more likelihood of possessing a weapon is subjective and potentially biased.
- Weapons screening is a complex operation that requires training, screening and monitoring equipment, and storage locker options. This method should be an option, but not required for all facilities.

Response:
Advisory meeting participants described several instances of guns being taken into facilities by people continuing violent interactions with patients or people accompanying a patient. Facilities that have had this or similar occurrences would have an expectation that weapons could be brought to their premises. Similar facilities that also have received victims of continuing

violence, even without the actual observation of weapons, would also have an expectation that this could happen. Only corrective measures that are applicable and feasible are required by renumbered subsection (c)(11).

Comment KG#17:
Regarding subsection (c)(10)(F), the phrase, "Maintaining *sufficient* staffing," should have the subjective word *sufficient* removed.

- Alternate language could include, "Staff and/or security personnel to maintain order in the facility, prevent patient-specific Type 2 violence, and respond to incidents."

Response:
Please see the response to Comment KG#11. The Board believes that the Plan is to be developed from the perspective of making sure that there are sufficient numbers of employees to safely deal with violent incidents that can be expected based on the experience that the employer and employees have had in that particular unit over time. Therefore, the word "sufficient" will not be removed.

Comment KG#18:
Regarding subsection (c)(10)(J), the phrase, "Assigning or placing minimum numbers of staff, to reduce patient-specific Type 2 workplace violence hazards" should be eliminated.

Response:
Please see the response to Comment KG#17. The Board has modified renumbered subsection (c)(11)(J) to replace the word "minimum" with "sufficient."

Comment KG#19:
Regarding subsection (c)(11)(C), the phrase *"Providing* individual trauma counseling to all employees affected by the incident;" should have the word providing substituted with the word *"Offering."*

- As an employer, we can only offer services; it will be up to the employee to choose which counseling or treatment service they use.

Response:
The Board agrees and in renumbered subsection (c)(12)(C) has replaced the term "providing" with "making available," to clearly state that an employer is to make the post-trauma treatment and counseling available to the affected employee(s).

Comment KG#20:
Regarding subsection (c)(11)(D), the phrase "Conducting a post-incident debriefing as soon as possible after the incident *with all employees, supervisors, and security involved in the incident;"* should have the underlined phrase above removed.

- It is more important that the debriefing occur as soon as possible after the event; waiting to gather *"all"* of the affected individuals could result in a delay to the investigation and poses a staffing hardship.

- Consider language *"inviting"* all involved in the incident to attend or provide comment to a post-incident debrief meeting, as their ability or availability to attend may be variable depending on the situation.

Response:
The Board believes that it is more likely to be able to contact for debriefing all the individuals directly involved in an incident soon after its resolution than to "invite" them to return at some later date. Also, an individual's recollection of events is more likely to be clearer soon after the event. For this reason, the Board declines to make the recommended changes.

Comment KG#21:
Regarding subsection (c)(11)(F), remove the word *"adequate"* from the phrase, "such as *adequate* staffing, provision and use of alarms ... "

- The word adequate is subjective.

Response:
The word "adequate" refers to sufficient numbers of staff as called for by the Plan, and will not be removed.

Comment KG#22:
Regarding subsection (c)(11)(G), *"Soliciting from the injured employee and other personnel involved in the incident their opinions* regarding the cause of the incident, and whether any measure would have prevented the injury" should have the phrase regarding soliciting opinions removed.

- Incident investigations should include facts, not solicited opinions.
- Employees already have a mechanism through the IIPP to provide safety suggestions and report hazard concerns.

Response:
The evaluation of any investigation calls for a subjective analysis of facts and observations. This instruction calls for the subjective conclusions of an eyewitness to the incident. This may or may not be substantiated as facts are determined, but the witness account should provide avenues of investigation, if any are needed. This also may be the only witness account, and cannot be discounted categorically. Obtaining the employee's opinion is also a part of incident evaluations in other California occupational safety and health regulations and has proven to be an effective method for evaluating those incidents and identifying corrective measures.

Comment KG#23:
Regarding subsection (d), Violent Incident Log (2)(A-C). Remove the language regarding a prescribed log section that employees, *"shall be allowed to complete."*

- Adding a section of employee recordkeeping to the log requirements is too prescriptive.
- Employees who do not contribute to the log may leave the employer vulnerable to a recordkeeping violation.
- Employee descriptions and statements are already included in the incident investigation.

Response:
The Board agrees and has determined that the process of collecting the information for the Log should be more consistent with the Sharps Injury Log from Section 5193. Please see the response to Comment KH#17.

Comment KG#24:
Regarding subsection (d)(3)(B)2, the phrase "Attack with a weapon or object, *including a gun, knife, or other object;"* should be changed to "Attack with a weapon or object."

Response:
Identifying if an attack involved the use of a gun or other weapon is consistent with SB1299. For hospitals, the phrasing is consistent with the information that is required to be reported to the Division. Being able to see trends such as the increased presence and use of firearms in a health care facility provides very useful information to the employer for evaluating security needs with local law enforcement.

Comment KG#25:
Regarding subsections (d)(3)(B)5 and 6, remove *"Animal attack"* and *"Other."*

- If there is an animal bite, scratch or other injury, this would not necessarily mean that it was related to a workplace violence incident.
- If an animal is trained or used as a weapon to commit violence, this information could be captured in Item 2.

Response:
An animal that is trained or used as a weapon to commit violence matches the other types of incidents listed in renumbered subsection (d)(6). There is no basis for removing “Animal attack” and “Other.”

Comment KG#26:
Subsections (d)(4)(A) and (D) should be taken out of the language as this information is protected medical information and will be provided separately in the worker's compensation file.

Response:
The log itself does not identify the employee and providing the general information as to whether or not medical care was provided, and length of time away would provide an indication of how severe an injury had been rather than the nature of the injury. For this reason, the items will not be deleted.

Comment KG#27:
Regarding subsection (e), Annual Review of the Workplace Violence Prevention Plan, remove the phrase "in conjunction with employees" from the review language.

- All employees will have access to the reviewed and improved Plan.
- Employees already have a mechanism through the IIPP to provide safety suggestions and report hazard concerns.

Response:
In order to allow an employer a flexible approach in assessing the workplace violence program needs for their operation, the proposed regulation is based on incorporating the involvement of the employees in that unit, area, or facility so that their experience and knowledge can be used to identify physical safeguards, and safer procedures to be implemented. The alternative to this approach would be to make a very prescriptive list of requirements for each setting, regardless of actual experience. Many employers have objected to this alternative in their comments and during the advisory meetings, and prefer flexibility. Reviewing the Plan would logically require that employees provide an accurate assessment of how well the Plan has worked. SB1299 also clearly mandates that in hospitals, employee involvement will be incorporated in developing the Plan.

Comment KG#28:
Regarding subsection (e)(1), change the language to, "Staffing levels, staffing patterns, and patient classification systems in place at the time of each incident;"

- This updated language is objective, allowing each incident to be evaluated based on the unique documented circumstances. It documents the conditions at the time of the incident but does not include subjective premises that could change depending on the evaluator.

Response:
The purpose of reviewing the workplace violence prevention plan is to evaluate factors that contribute to the risk of workplace violence. The Board therefore declines to make this change.

Comment KG#29:
Regarding subsection (e)(2), change the language to, "Security systems, alarms, emergency response, and security personnel involved in the incident;"

- This updated language is objective, allowing each incident to be evaluated based on the unique documented circumstances. It documents the conditions at the time of the incident but does not include subjective premises that could change depending on the evaluator.

Response:
Please see the response to Comment KG#28.

Comment KG#30:
Add language that requires the reviewer to calculate and compare the data of the recorded incidents to evaluate and interpret trends.

Response:
The Board believes that a comparison of data to identify trends is inherent in the instruction to review the effectiveness of the Plan and declines to add that instruction.

Comment KG#31:
Regarding subsection (f), Training, remove the phrase, "including temporary employees," from the training requirement and create a special section for addressing the special circumstances surrounding the training of temporary employees.

- Often, temporary employees only work assignments for a few days; the training described in the regulation is at least 2 hours for general personnel and at least 6 hours for personnel with patient contact. This is not feasible for someone that will be onsite for a few days at a time.
- Labor Code section 6401.8 specifically states that temporary employees need to be "oriented" to the facility's workplace violence prevention plan, which sets a different and more achievable standard for educating this staffing category.

Response:
The Board has modified subsection (f) to clarify the level of training that is offered to employees with different levels of occupational exposure.

Comment KG#32:
Remove the language, *"An employer that employs proprietary private security officers, contracts with a private patrol operator or other security service to provide security guards, or hires or contracts for the services of peace officers, shall arrange for those personnel to participate in the training provided to the employer's employees."*

- Employers already have a significant expense providing security coverage; paying for security personnel to participate in the training of the large numbers of employees results in unreasonable costs.
- Consider language that directs the employer to provide the workplace violence prevention plan and procedures to all security contractors, and require they train their employees prior to working onsite.

Response:
Please see the response to GBS#29. Because of existing requirements for employers in multi-employer worksites and dual-employer situations set forth in Labor Code sections 6400 and 6401.7; California Code of Regulations, Title 8, sections 336.10 and 3203; and case law interpreting and applying these statutes and regulations, subsection (f)(1) has been modified to delete the requirement for the facility employer to train private security personnel.

In addition, subsection (f)(1)(A)5 has been modified to require training on the role of security personnel, in the establishments where they are present. This is needed to ensure that general staff at a facility know the limits of assistance to expect from the security personnel who are there, and conversely, to ensure that security personnel know what their responsibilities are.

Comment KG#33:
Regarding subsection (g)(1)(B), in the phrase, "An incident involving *the use of a firearm or other dangerous weapon,* regardless of whether the employee sustains an injury," change the wording to include only the word, *"weapon."*

- (2) Remove the phrase, *"dangerous weapon,"* and refer only to the word, *"weapon."*

Response:
The phrasing in question comes from Labor Code section 6401.8 which mandates the reporting.

Comment KG#34:
Regarding subsection (g)(2), the standard for 24 hour reporting should only be implemented if a weapon is used, the employee has an injury, or there is an urgent or emergent threat to staff safety.

- Many injuries can occur while holding patient hands, administering treatments, or even through involuntary movements or reactions by patients. These types of injuries should not be reported with those related to workplace violence.
- LC Section 6401.8 limits reporting to injuries, weapons, and emergent threats and does not include "near miss" incidents.
- Reporting every potential incident could result in burdensome recordkeeping and response.

Response:
Subsection (g)(2) already contains the criteria for 24 hour reporting listed in the comment. In addition, the Board has added the following language for reports that must be made within 24 hours:

For purposes of this reporting process:
(A) "Injury" means a ~~Any~~ fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement.
(B) An "urgent or emergent threat to the welfare, health, or safety of hospital personnel" means that hospital personnel are exposed to a realistic possibility of death or serious physical harm ~~Urgent or emergent threats are incidents that involve 911assistance from a law enforcement agency~~.

Comment KG#35:
Regarding subsection (g)(3), clarify the meaning of the phrase, *"All other reports to the Division required by subsection (g)(1) shall be made within 72 hours."*

- The incidents described in Items (1) and (2) cover any circumstance of workplace violence with a weapon, injury or emergent threat.
- Examples of incident types (near misses?) that qualify for this time period should be clarified before the standard is adopted to avoid confusion and potential violations.

Response:
The incidents that must be reported within 72 hours comprise all other incidents described in subsection (g)(1) and not covered by subsection (g)(2).

Comment KG#36:
Regarding subsection (g)(5), remove the phrase, "The employer shall provide supplemental information to the Division regarding the incident within four hours of any request."

- Employers respond to Division requests through the document request form. A 4 hour turnaround on information during an open investigation is intrusive and counterproductive to the ongoing efforts toward employee safety.

Response:
The Board concurs. The timeframe was consistent with the access provided in Section 14300.30, but since that information is different in nature, the Board believes that 24 hours is appropriate for this process and has modified subsection (g)(5) accordingly.

Comment KG#37:
Include language in the regulation that refers to the Division's requirement under LC 6401.8 to publish the reported incidents, how that information will be reviewed and quality controlled, and where and for how long it will be posted.

Response:
The Board notes that the Division is developing an electronic reporting system to receive the incident reports, and is communicating with hospital stakeholders to address their concerns about data security and integrity. The Division has determined that procedures for reviewing and conducting quality control of the data will need to evolve over time to respond to the experience of reporting hospitals and the Division as well as improvements to the electronic reporting system. SB1299 did not set specific goals or procedures for producing the report, and thus the Division has some flexibility in developing a workable procedure within the limits of its resources. The Board believes that limiting by regulation the options available to the Division for processing this information would restrict the Division's ability to have a system that is flexible and responsive to the experience of reporting hospitals and to technological changes, and declines to make the suggested changes. The report will be posted to the Division website as specified in SB1299.

Comment KG#38:
Regarding subsection (h), Recordkeeping remove the phrase," ... *and job titles,"* from the training recordkeeping requirement.

- In order to use the training record standard to the IIPP and for all other training standards in the orders, remove the job title requirement to avoid confusion and potential administrative violations.

Response:
It is unclear why the listing of job titles would violate administrative rules. The requirement is intended to verify that the employees who are required to be trained actually received the training. This requirement is consistent with the corresponding recordkeeping requirement in the Aerosol Transmissible Diseases standard, Section 5199(j)(2) that also applies to health care workers. In the absence of information about specific conflicts that would occur, the Board declines to remove the phrase.

Comment KG#39:
Contra Costa County Departments affected by this regulation agree that it is an important step toward protecting employees from workplace violence. However, we encourage the Division to balance the prescriptive nature of this regulation with the limited resources that are already available for medical and security staffing at the very institutions, job tasks, and facilities described in this regulation.

Efforts to keep the 2,000 County health services workers safe are rigorous and ongoing. We encourage the Division to ensure that the adopted regulation language provides guidelines for the efforts to keep employees safe from workplace violence but avoids putting overly restrictive and prescriptive standards that only increase administrative needs with little to no payoff in real safety gains.

Response:
The proposed regulation focuses on procedures for expanding upon an employer's existing IIPP to identify appropriate control measures. It does not prescribe particular control measures.

Elizabeth Treanor, Director, Phylmar Regulatory Roundtable – OSH Forum, by written comments dated December 8, 2015.

Comment ET#1:
PRR understands and appreciates that the intended purpose of proposed Section 3342 is to address the risk of workplace violence to health care workers. PRR supports that goal. Nevertheless, several PRR members have expressed significant concern about proposed subsection (g), Ancillary Health Care Operations, as it would affect the operation of on-site occupational health clinics that several PRR members operate at their worksites.

PRR believes that an on-site occupational health clinic located at a worksite and operated by an employer for its employees, where access is controlled so that the general public cannot enter, should be excluded from the definition of "ancillary health care operation" in section (b) of the proposed standard, and thus should be removed from its scope. On-site occupational health clinics do not share the same risk factors that may be found in health care facilities that treat and allow access to the general public or other populations that may lead to the risk of violence. The Board has not demonstrated any necessity for including them within the scope of the proposed standard, and the advisory committee record does not contain sufficient evidence to support such a rule.

PRR notes that employers provide these services and facilities voluntarily and do so at considerable expense. Indeed, many employers operate such facilities in conjunction with fitness centers. There is concern that the imposition of unnecessary requirements under the proposed standard, and the attendant costs for compliance and potential liabilities associated with the new regulations, will discourage employers from providing these benefits.

Response:
The Board acknowledges there is currently a lack of data to show how the rate of workplace violence in the clinics described above compare to other practices. For this reason, the Board has modified the proposed regulation to remove from the scope of the proposed regulation ancillary health care operations and outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings. On-site occupational health clinics are thus no longer included within the scope of the regulation.

John Robinson, CEO, California Attractions and Parks Association (CAPA), by written comments dated December 15, 2015.

Comment JR#1:
We are concerned that the proposed standards would inappropriately include our park first aid workers and stations under the broad definition of "ancillary health care operation."

We feel strongly that these standards should apply to "licensed" health care facilities and not basic first aid providers. Our park workers do not face the same risk factors that health care workers in hospitals and urgent care facilities face, where the “general public” is often perpetrators or victims of violent crime.

Response:
The Board believes that places that provide solely first aid are not in the scope of the proposed standard and were not intended to be included. First aid services were not identified in the petitions or during the advisory meetings as operations exposed to significant incidence rates of violence. The Board notes that all ancillary health care operations and all outpatient medical offices and clinics that are not within the license of a “health facility” and are not outpatient medical services provided to the incarcerated in correctional and detention settings have been removed from the scope of the regulation.

Comment JR#2:
Our park first aid clinics do not serve the "general public" but only park patrons, a distinction which should be noted. Our level of care provided is not comparable to general licensed health care facilities. Any patron with an injury requiring more than immediate first aid is referred or transported to a full, licensed health care facility. We do not provide extended care or treatment.

Our parks are a very controlled environment, most with security checks and screening prior to entry. All of our large parks have full-time security. The likelihood of violence to our health care staff is extremely low and can't be compared to the risk faced by some health care workers employed in facilities frequently serving violent or unstable clientele. The intent of SB1299, the initiating 2014 legislation, was focused on "licensed health care facilities" and full urgent care. It was not intended to extend to small, first aid facilities such as those found in CAPA member parks. The safety of all of our workers and patrons is our first priority.

Response:
Please see the response to Comment JR#1.

Comment JR#3:
The standards would also require parks by January 1, 2017, to post a report on a state (DIR) public website that lists the number of violent incidents, the number of reports and the outcome of any related inspection or investigation. This will prove very difficult to provide with confidentiality. Our first aid workers and parks may not have access to the outcomes of investigations, particularly when it involves law enforcement. This section refers to "hospitals" and should not include first aid clinics at amusement parks.

Response:
The reporting requirement applies only to hospitals. Please also see the response to Comment JR#1.

Comment JR#4:
Given the broad construction of the proposed regulations, a park's medical services clinic could also fall within the definition of "paramedic and emergency services, including these services when provided by firefighters and other emergency responders."

Response:
Private and public paramedic and emergency medical services are not exempt from the proposed regulation. Please also see the response to Comment BT#1.

Comment JR#5:
We encourage the Board to focus the proposed standards where they are needed and sensible and offer a further distinction in the definition of "ancillary health care operation." We would suggest language such as defining that "ancillary health care operations do not include first aid workers and facilities at places of public entertainment such as amusement parks."

Response:
Please see the response to Comment JR#1.

Matt Antonucci, Vice President Production Affairs and Safety, Contract Services Administration Trust Fund and Melissa Patack, Vice President and Senior Counsel, Motion Picture Association of America, Inc., by electronic mail sent December 17, 2015.

Comment MA#1:
The Motion Picture Association of America, Inc. (MPAA) and the Contract Services Administration Trust Fund (CSATF) are concerned about the scope and application of proposed Section 3342 to "field operations such as mobile clinics and dispensing operations, medical outreach services, and other off site operations," and "ancillary health care operations," which has been defined to include workplace clinics. Many of the MPAA's member employers in the motion picture and television industry have first-aid medical clinics on their studio lots. Additionally, production companies are often required, pursuant to collective bargaining agreements, to employ a "set medic" on production sets. This is an individual who is appropriately trained to provide first aid, if necessary, to production personnel. Set-medics tend to treat production employees and administer basic first aid, such as ibuprofen, and provide shoulder massages for soreness.

Accordingly, MPAA respectfully seeks an express exemption for the motion picture and television industry with respect to the newly proposed Section 3342. It appears clear from the stated purpose in the ISOR, the OSHA guidelines cited in the ISOR, and the Division's evaluations of the two petitions filed by the CNA and SEIU unions that the motion picture and television industry was not intended to be covered under this standard. However, it is possible that the voluntary, first-aid/medical clinics operated by employers in the motion picture and

television industry may be incorrectly read into the scope of the law. An express exemption would rectify the ambiguity and prevent any unintended result for the industry.

Additionally, the engagement of set medics, as required under collective bargaining contracts, is beyond the purview of this regulation and that should be clearly and unambiguously stated in the regulation.

The MPAA proposes the following addition to subsection (a)(2) Application: "(D) This section does not apply to the workplace medical clinics and to set-medics or other health-care personnel used at production sets of the motion picture and television industry."

Workplace clinics are both common in California and highly effective in reducing the impact of work injuries, and are not subject to the same exposure or conditions that are the intention and subject of the petitions, SB1299, or the regulations in Section 3342. This is again illustrated by the fact that there has not been a single incident of workplace violence in any of the workplace first-aid or medical clinics on studio premises or off-site production in the past ten years.

Response:
The Board has determined that outpatient medical offices and clinics, field operations, and ancillary health care operations of the type described here will not be included in the scope of the regulation and thanks MPAA for this detailed description of this setting and its features. Subsection (a)(1)(G), Ancillary Health Care Operations, is deleted in the revised text. Please see the response to Comment ET#1.

Paul D. White, CHPA, CHSP, CHEP, CEAS, Vice President - Healthcare Division, Securitas Security Services USA, by electronic mail sent December 17, 2015.

Comment PW#1:
Because of the importance of the law and intent, I believe your organization (after it approves the final standard) should offer a couple of conferences or educational events (not online or webex) to clarify the intent and give the audience an opportunity to ask real time questions and get answers.

Response:
The Board appreciates this suggestion, but notes that the Board does not conduct training or outreach of this type. Often, with the roll-out of a new regulation, the Division's Consultation Services Branch will conduct outreach sessions to help employers with the implementation and understanding of the new regulation.

Pamila Lew, Staff Attorney, Disability Rights California, by electronic mail sent December 16, 2015.

Comment PL#1:
Subsection 3342 (b) Definitions, "Patient specific risk factors" means factors specific to a patient, such as use of drugs or alcohol, psychiatric condition or diagnosis, any condition or

disease process that would cause confusion and/or disorientation or history of violence, which may increase the likelihood or severity of a workplace violence incident.

Disability Rights California (DRC) requests that "psychiatric condition or diagnosis" be deleted as psychiatric condition or diagnosis is not a predictor of violent behavior. Researchers have found that most violent acts are not committed by people with mental health disabilities, and the link between mental illness and violence is greatly exaggerated by the media and entertainment industry. Including this language is unnecessary and stigmatizing to persons with mental health disabilities.

Response:
The Board notes that some psychiatric diagnoses are associated with violent behavior, and that these psychiatric conditions would be covered under the definition of "patient specific risk factors" as any condition or disease process that would cause confusion and/or disorientation or history of violence. The Board concurs that most people who are violent are not mentally ill, and most people who are mentally ill are not violent. For these reasons, the Board proposes to modify the factor as follows: "psychiatric condition or diagnosis associated with increased risk of violence" to make this clarification.

Comment PL#2:
"Threat of violence" means a statement or conduct that reasonably causes a person to fear for his or her safety because there is a reasonable possibility the person might be physically injured, and that serves no legitimate purpose.

DRC recommends that there be a reasonableness standard added to the individual's fear response when defining an alleged threat of violence. Research validates that health care staff have a very high rate of post-traumatic stress disorder (PTSD), an anxiety disorder commonly manifested by symptoms of hyperarousal. People with PTSD have a heightened fight or flight response and may unreasonably feel threatened by non-threatening situations or statements. Therefore, it is important to include an objective element when determining whether an act or statement is a threat of violence.

Response:
The Board believes that the current language in the "threat of violence" definition includes a reasonableness standard associated with the possibility of physical injury. Even in the event that a person felt "unreasonably threatened," one would still have to determine whether there is a reasonable possibility that the person might be physically injured in order for the definition to apply. The Board therefore declines to make the revision.

Comment PL#3:
DRC requests that the Board add to subsection (f)(3)(E), Verbal crisis intervention and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior.

Most potentially volatile situations can be managed by verbal crisis intervention and de-escalation techniques, and these techniques should be part of standard training for all health care personnel.

Response:
The Board concurs that the recommended change would improve the overall clarity of the training content, and proposes the following modification:

(E) Verbal intervention and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior.

Comment PL#4:
DRC request that the Board delete subsection (f)(3)(G), Restraining techniques and (f)(3)(H), Appropriate use of medications as chemical restraints. All forms of restraint--physical, mechanical and chemical--are dangerous techniques with potentially lethal consequences and should only be used as a last resort. Additionally, they do not create a safer health care environment, to either patients or staff. The National Association of State Mental Health Program Directors has found that "they are extremely costly in terms of staff injury, time, turnover, and litigation." Because of their potential for harm, restraint is addressed specifically in the California Code of Regulations, Title 22, with strict parameters and limitations for its use. Reference to restraint in these proposed regulations overly simplifies a technique that must be used with extreme caution and serves to inadvertently endorse its use.

Response:
The Board thanks DRC for raising this important issue, and proposes to clarify that employees are trained in subsection (f)(3)(G) the appropriate and inappropriate use of restraining techniques in accordance with Title 22; and subsection (f)(3)(H), the appropriate and inappropriate use of medications as chemical restraints in accordance with Title 22.

Daniel Gugala, General Counsel, Crisis Prevention Institute, Inc. (CPI), by electronic mail sent December 17, 2015.

NOTE: The commenter sent an email message supporting the proposal in many areas. Specific recommendations made by the commenter are discussed below.

Comment DG#1:
We encourage the Board to write into the standard that considerations should be given to those training organizations who can support a health facility with training to mitigate the risks associated with all workplace violence types outlined in this definition. For example, at CPI we train staff in de-escalation, prevention, disengagement strategies, debriefing and physical restraint techniques but also have modules in workplace bullying and domestic violence and its impact on the workplace.

Response:
With regard to the selection of training providers, the current language requires that training be effective, and additional language to require consideration of outside training organizations is not necessary. The Board therefore declines to incorporate this recommendation.

Comment DG#2:
In section (9) under (c), Workplace Violence Prevention Plan, CPI supports the procedures for identifying and evaluating patient-specific risk factors, and the assessing of visitors. We do caution however the labeling of patients or visitors solely based on historical data. Additionally, we caution that employees be trained to use "universal precautions" for workplace violence just as they do for other identified risks in health facilities. Even with consistent assessment and evaluation, an individual's (patient or visitor) mental status, or medical status can change quickly and staff should always be prepared to respond.

Response:
The Board thanks CPI for this support. The concept of training employees to use "universal precautions" regarding workplace violence may be helpful for some employers, but may be inapplicable to other employers, depending on their respective patient and visitor populations.

Comment DG#3:
We would recommend adding training in the process for debriefing incidents to the required initial and ongoing training for staff outlined in section (f), Training, in sections (1)(A), (2) and (3). Debriefing should take place with the individual who was in crisis whenever possible, and also all team members who were present at the crisis. This process gives the team who responded the opportunity to identify what worked well to manage the situation, but also to identify where early warning signs may have been missed, where de-escalation strategies may have been ineffective and to make a plan for addressing future situations of this type. This debriefing also helps the organization identify training gaps in teams and individuals to help customize their ongoing training process.

Response:
The Board notes that employees must be trained on the employer's workplace violence prevention plan, including post-incident debriefing required by renumbered subsection (c)(12)(D).

Comment DG#4:
Section (f) Training: CPI respectfully requests the Board consider adding the following language either in the opening paragraph in the training section or within section (1), (2), and (3): "provide effective training from a nationally recognized, evidence-based, training provider to all employees." We make this request for a couple of reasons. First, there are many training programs out there that are not grounded in evidence of effectiveness. There are many health facilities who choose to develop their own training but do not have the expertise or the systems in place for maintaining the training program to ensure it is consistent with best practices. Second, both the Joint Commission Elements of Performance for Behavioral Health and the Centers for Medicare and Medicaid Services Hospital Conditions of Participation for Patients' Rights use this language when they speak about required training. This would create consistency between CA OSHA, The Joint Commission and Centers for Medicare and Medicaid Services conditions for participation.

Response:
Please see the response to Comment DG#1.

Comment DG#5:
As noted earlier in this letter, CPI recommends adding training in debriefing strategies to the elements required for training in this section.

Response:
Please see the response to Comment DG#3.

Esther Brennan, Receptionist, by electronic mail sent December 17, 2015.

NOTE: Ms. Brennan made identical comments as LeadingAge using a form letter and echoed comments made by Ms. Haskins. Please see the responses to Comments JH#1-JH#8 and responses to Comments SH#1-SH#2. The Board thanks the commenter for her participation.

Leah Hewling, Accounts Payable Clerk, Auburn Ravine Terrace, by electronic mail sent December 15, 2015.

NOTE: Ms. Hewling made identical comments as LeadingAge using a form letter and echoed comments made by Ms. Haskins. Please see the responses to comments JH#1-JH#8 and the responses to comments SH#1-SH#2.

Beth Murphy, Social Director, Auburn Ravine Terrace, by electronic mail sent December 16, 2015.

NOTE: Ms. Murphy made identical comments using a form letter by LeadingAge as well as echoed comments made by Ms. Haskins. Please see the responses to Comments JH#1-JH#8 and the responses to Comments SH#1-SH#2.

Jim Bursey, MPH, Executive Director, Auburn Ravine Terrace, by electronic mail sent December 15, 2015.

NOTE: Mr. Bursey made identical comments as LeadingAge as well as echoed comments made by Ms. Haskins. Please see the responses to Comments JH#1-JH#8 and the responses to Comments SH#1-SH#2.

David Shiraishi, MPH, Area Director, Occupational Safety and Health Administration, U.S. Department of Labor by written comment dated March 1, 2016.

Comment DS#1:
The proposed occupational safety and health standard appears to be commensurate with the federal standard.

Response:
The Board thanks Mr. Shiraishi for the comment and for participating in the rulemaking process.

Donald W. Nielsen, Director, Government Relations, California Nurses Association/National Nurses United, by written comments dated December 16, 2015.

NOTE: The commenter sent an email message supporting the proposal in many areas. Specific recommendations made by the commenter are discussed below.

Comment DN#1:
Subsection (a)(1) establishes the scope of these regulations and indicates that they will apply to a wide range of health care settings, including health facilities (as defined), outpatient medical offices and clinics, home health care and home-based hospice, paramedic and emergency medical services, field operations, drug treatment programs, and ancillary health care operations such as school nurse operations and retail clinics. CNA is very appreciative of Cal/OSHA's decision to develop regulations which are so broad in scope.

SB1299 affirmatively mandates the Standards Board to adopt standards for specified types of hospitals, including general acute care hospitals and acute psychiatric hospitals. However, section (e) of that legislation also permits the Board to adopt standards that require other employers to "adopt plans to protect employees from workplace violence." Indeed, it was CNA's and the Legislature's intention to establish strong minimum requirements for the hospital setting specifically referenced in the statute, while also allowing for their application to other settings. We therefore applaud Cal/OSHA's decision to expand the scope of these regulations and ensure that *all* health care workers benefit from these important protections, not just those working in hospitals.

Response:
The Board appreciates the support of CNA, but notes that the regulation has been modified to delete from the scope of the regulation all ancillary health care operations, field operations, and outpatient medical offices and clinics that are not within the license of a “health facility” and are not outpatient medical services provided to the incarcerated in correctional and detention settings. Although this group was proposed for coverage at the first advisory meeting, there is little data to show that the rates of violent incidents is similar to the other settings that remain in the scope.

Comment DN#2:
Subsection (a)(2) of the proposed regulations carves out certain exceptions to the application of these regulations to each of the health care settings described in subsection (a)(1). Specifically, in subsection (a)(2)(B), the proposed regulations state that only general acute care hospitals, acute psychiatric hospitals, and special hospitals shall have to comply with subsection (g), which covers reporting requirements, all other operations and settings shall not.

Although we certainly support the reporting requirements for hospitals, CNA is deeply concerned with the decision to limit these requirements to hospital settings alone. In your Initial Statement of Reasons, you correctly state that these reporting requirements are consistent with SB1299. However, you also correctly state that SB1299 gave the Board the authority to require other employers, including, but not limited to, employers exempted from subdivision (d) of SB1299, to adopt plans to protect employees from workplace violence. The Initial Statement of

Reasons also contends that this broad authority is the grounds upon which the Board determined that the reporting provisions shall also apply to hospitals operated by the State Department of State Hospitals, the State Department of Developmental Services, and the Department of Corrections and Rehabilitation, which are exempted by subdivision (d) of SB1299. CNA is very supportive of the decision to require those additional entitles to comply with reporting requirements. However, the Board has the same authority to determine that all employers covered by the regulation shall also comply with the reporting requirements in subsection (g). Accordingly, we respectfully request the Board to exercise this authority and require all employers covered by the regulation to comply with subsection (g)'s reporting requirements.

CNA is unaware of any evidence that supports the underlying assumption that health care workers in the excluded health care settings are less likely to experience violence or the threat of violence while on the job. Indeed, the health care settings excluded from the reporting requirements are actually those which tend to have fewer administrative and environmental controls than are typically found in hospitals. Of particular concern are retail clinics. Retail settings (an "ancillary health care setting" as defined in subsection (b)) are relatively new places of employment for RNs, physician's assistants, and other health care workers. Retail clinics have many features which may make workers particularly vulnerable to workplace violence. Retail settings typically allow all members of the public to enter under the assumption that they are interested in purchasing goods or services, and thus they may attract individuals who engage in shop lifting or other illegal activities. In addition, retail settings that provide health care services are commonly located in establishments with pharmacies, which can increase the occurrence of crime and violent activities related to robberies and attempted robberies of OxyContin, Vicodin, and other prescription drugs.

Now that RNs and other health care workers are being employed in these retail settings, it is imperative to know whether they will experience an increased incidence of workplace violence. The best way to demonstrate this would be through mandated reporting of workplace violence incidents to Cal/OSHA, as is required for hospitals in subsection (g) of the proposed regulations. The absence of a statutory mandate for settings other than General Acute Care, Acute Psychiatric, and Special hospitals does not relieve Cal/OSHA of the responsibility to establish the highest safeguards for all health care workers regardless of their employment setting.

Given these concerns, CNA respectfully suggests the following modifications to subsection (a)(2):

(2) Application.
(A) All employers with employees in operations identified in subsection (a)(l)(A) through (a)(l)~~(f)~~(G) shall comply with subsections (c), (d), (e), (f), (g) and (h).
~~(B) General acute care hospitals, acute psychiatric hospitals, and special hospitals shall also comply with subsection (g).~~
~~(C)~~(B) Ancillary health care operations shall comply with this section by ensuring that the elements included in subsection (c), (d), (e), and (f) are addressed by the host establishment's injury and illness prevention program or a separate workplace violence prevention plan for the operation. Reporting shall be in accordance with subsection (g).
Recordkeeping shall be in accordance with subsection (h).

Response:
The Board concurs that CNA has initiated the development of an important research tool by requiring hospitals to report incidents of workplace violence. Under the proposed regulation, approximately 500 hospitals will be required to report workplace violence incidents, but over 6,000 entities are covered by the proposed regulation. The Division has no experience receiving or processing data of this nature, and is only prepared to receive and process the data submitted by the 500 hospitals. The Board believes that the additional workload for the Division is not feasible at this time. The Board suggests that an undertaking of this magnitude might be more suitable for the National Institute for Occupational Safety and Health, and respectfully declines to make the recommended change.

Comment DN#3:
Regarding subsection (b), Definitions, "Acute psychiatric hospital" CNA is pleased to see that the Board has adopted a definition of "general acute care hospital" which includes the following language, as suggested by CNA:

> "Acute psychiatric hospital" (APH) means a hospital, licensed by the California Department of Public Health as such in accordance with Section 1250(b), Title 22, California Code of Regulations, and all services within the hospital's license including, but not limited to, emergency, outpatient observation, and outpatient clinics located at the hospital facility and all off-site operations included within the hospital's license" *(emphasis added).*

The inclusion of this language helps ensure that no health care workers will be inadvertently and arbitrarily left out of the proposed workplace violence regulations.

Response:
The Board believes that the original language, which referred to the facility's license, will more accurately cover the operations that are within the scope of the proposed regulation, and therefore has removed the additional language. See also the response to Comment BJ#9.

Comment DN#4:
Regarding the definition of "Ancillary health care operation" CNA supports the broad definition of an "ancillary health care operation" as:

> "[a] health care operation located in a workplace other than those listed in subsection (a)(1)(A) through (a)(1)(F). Examples of ancillary health care operations include retail clinics, school nurse operations, and workplace clinics."

A previous discussion draft circulated during the advisory committee process defined "ancillary health care operation" as "an operation located in a workplace in which less than ten percent of the employees are engaged in provision of health care." CNA submitted comments criticizing this arbitrary ten percent distinction. We noted that the prior definition would exclude several health care settings, including retail clinics, since they are more likely to be settings in which "less than ten percent of the employees are engaged in provision of health care." This was problematic, especially considering that health care workers in retail clinics may be particularly vulnerable to workplace violence (see prior discussion under subsection(a)(2)). This broader

definition will help ensure that *all* health care workers are protected by the proposed regulations and not excluded on an arbitrary basis.

Response:
Please see the response to Comment DN#1.

Comment DN#5:
CNA supports the proposed definition of "patient specific risk factors." However, for the sake of clarity, we recommend the following non-substantive modifications:

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

Response:
The Board thanks CNA and has modified this definition based on the recommended language above. Note: This subsection has also been modified to limit psychiatric conditions and diagnoses to only those associated with increased risk of violence, to avoid discriminating against all patients with a psychiatric condition or diagnosis. Please also see the response to Comment PL#1.

Comment DN#6:
Subsection (c)(7) requires employers to allow employees and their representatives to participate in developing and delivering the trainings required by subsection (f). It is critically important for employers actively to involve employees in the development, implementation, review, and training related to their Workplace Violence Prevention Plan. RNs and other health care workers on the frontline know better than anyone else the true nature of the risks and hazards they face on the job. Without their input and involvement, it is likely that many crucial risks and realities would be disregarded for the sake of the employer's convenience and ease. Requiring input from employees ensures that no risk goes overlooked and that the true experts are consulted in the development of the Plan.

Response:
The Board thanks CNA for this assessment and support, but has determined that it does not seem appropriate to require employees to conduct the classes and therefore has deleted “and delivering” from renumbered subsection (c)(8). Please see the response to Comment GBS#15.

Comment DN#7:
In a previous discussion draft of these proposed regulations, there was a requirement for the Violent Incident Log to include a "description of the employee affected by the incident, including the employee's name, sex, job title, department, and specific assignment at the time of the incident..." In our comments during the advisory committee process, we expressed concern that this requirement was in conflict with the requirement that no individually identifiable medical information be included in the Log. Furthermore, even in situations where the Log

would not contain protected medical information, some employee-victims may nevertheless be uncomfortable having their name and personal information recorded.

Response:
The Board notes that SEIU and CHA expressed a similar concern regarding identification of employees. Please see the responses to Comments GBS#27, KH#16, and KH#17.

Comment DN#8:
It is critically important that the Violent Incident Log include any information that could be relevant to identifying and correcting hazards that led to the violent event, especially since the employer is required to review their Log as part of their annual review of the Plan. At the same time, it is important for employers to respect the privacy of the employee(s) affected by the incident. The language in the proposed regulations strikes the right balance by ensuring that the information most relevant to correcting workplace violence hazards, such as the classification of the type of violence, the location and timing of the incident, the circumstances surrounding the incident, and the consequences following the incident, are included in the Log, whereas personal identifying information is not strictly required.

Response:
The Board thanks the commenter for recognizing the difficulty in balancing privacy with providing relevant information on workplace violence incidents to help the employer correct hazards. The Board has modified the language to provide the most useful information in the Log without including any personal identifying information of employee or patients.

Comment DN#9:
CNA is very supportive of the language contained in subsection (d)(2), which states that each employee who experienced a workplace violence incident shall be allowed to complete a section that includes a description of the incident, a classification of who committed the violence, and a classification of circumstances at the time of the incident. Allowing the employee who directly experienced a violent incident the opportunity to describe the hazardous conditions that contributed to its occurrence is crucial to ensuring that similar incidents are not repeated in the future. At the same time, employees who do not wish to complete such a section should not be forced to do so, especially when doing so could invoke traumatic memories. The permissive language used in this section properly balances both those concerns.

Response:
Please see the response to Comment KH#17.

Comment DN#10:
CNA is glad that the proposed regulations specifically require employers to "have an effective procedure for obtaining the active involvement of employees and their representatives in developing training curricula and training materials, conducting training sessions, and reviewing and revising the training program." Employee involvement is critical because it is the health care workers who understand better than anyone else the nature of the hazards they face and the reality of how situations unfold on the ground. Requiring employee input in the training program

helps ensure that important elements will not be overlooked and everyone will be as prepared as possible if and when a potentially violent situation arises.

Response:
The Board thanks CNA for this assessment and support but notes that it may be inappropriate in some settings to require that employees do the training and therefore has deleted "and deliver." Please see the response to Comment GBS#15.

Comment DN#11:
Although we are glad to see the requirement for interactive questions and answers during the initial and refresher training, we believe that the regulations should go even further by explicitly requiring there to be trained security personnel present at each initial and refresher training in order to interact with employees, practice drills, and answer questions. The presence of *trained* security personnel at the trainings should be required *in addition to* the "person knowledgeable about the employer's workplace violence plan" and *in addition to* any security personnel who are themselves present to receive their initial training. This requirement would only apply to employers that employ or contract with security personnel. CNA respectfully recommends the following modifications to the proposed text:

*Add (f)(1)(A)7.:*

7. Employers that employ proprietary private security officers, contract with a private patrol operator or other security service to provide security guards, or hire or contract for the services of peace officers, shall provide an opportunity for interactive questions and answers with security personnel that are knowledgeable about the employer's workplace violence prevention plan.

*Add to (f)(2):*

(2) Employees performing patient contact activities and those employees' supervisors shall be provided refresher training at least annually to review the topics included in the initial training and the results of the annual review required in subsection (e). Refresher training shall include an opportunity for interactive questions and answers with a person knowledgeable about the employer's workplace violence prevention plan. Employers that employ proprietary private security officers, contract with a private patrol operator or other security service to provide security guards, or hire or contract for the services of peace officers, shall provide an opportunity for interactive questions and answers with security personnel that are knowledgeable about the employer's workplace violence prevention plan during the refresher training.

Response:
The Board acknowledges the importance of coordinating the role of private security in the Plan for each facility or operation where these personnel are employed, and communicating their role to all employees in training. However, the Board believes that the process as suggested for modification can significantly increase the time demand upon the security provider and their personnel in the refresher process, especially when there are many training sessions for the entire facility. For this reason, the Board declines to make the suggested change but has modified subsection (f)(1) to include training on the "role of private security personnel, if any."

Comment DN#12:
For the reasons stated above under the discussion of subsection (a)(2), CNA respectfully suggests that subsection (g) be modified as follows:

(g) Reporting Requirements ~~for General Acute Care Hospitals, Acute Psychiatric Hospitals, and Special Hospitals.~~
(1) Every ~~general acute care hospital, acute psychiatric hospital, and special hospital~~ employer shall report to the Division any incident involving either of the following:
(A)The use of physical force against an ~~hospital~~ employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
(B) An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.
(2) The report to the Division required by subsection (g)(l) shall be made within 24 hours, after the employer knows or with diligent inquiry would have known of the incident, if the incident resulted in injury, involves the use of a firearm or other dangerous weapon, or resents an urgent or emergent threat to the welfare, health, or safety of ~~hospital~~ personnel.
(3) All other reports to the Division required by subsection (g)(l) shall be made within 72 hours.
(4) Reports shall include, at a minimum, the following items:
(A) ~~Hospital~~ Employer name, site address, ~~hospital~~ representative, phone number, and email address, and the name, representative name, and contact information for any other employer of employees affected by the incident;

Response:
As noted in the response to Comment DN#2 above, the Board declines to expand the reporting process from 500 entities to over 6,000, and therefore declines to make the recommended changes.

Comment DN#13:
In subsection (h)(l), the proposed regulations state that "[r]ecords of workplace violence hazard identification, evaluation, and correction shall be created and maintained in accordance with Section 3203(b), **except that the Exception to (b)(l) in Section 3203 does not apply**" *(emphasis added).* In subsection (h)(2) the proposed regulations state that "[t]raining records shall be created and maintained for a minimum of one year and include training dates, contents or a summary of the training sessions, names and qualifications of persons conducting the training, and names and job titles of all persons attending the training sessions. **Section 3203(b) EXCEPTION No. 1 does not apply to these training records**" *(emphasis added).*

CNA is very supportive of this proposed language. A previous discussion draft neglected to state that the exception from Section 3203(b)(1) would not apply, which meant that employers with fewer than 10 employees would not be required to create and maintain workplace violence records under this section. As CNA pointed out during the advisory committee process, this would amount to an arbitrary and senseless distinction, since Cal/OSHA has the same obligation to protect employees of small employers as it does for employees of larger employers. By

specifically stating that the exception found in Section 3203(b) does not apply, these proposed regulations correct that oversight and make clear that *all* employers covered by these regulations will be required to comply with this section. At the same time, we think that the current proposed language could be improved by having consistency between the wording in subsection (h)(l) and subsection (h)(2).

For the sake of consistency and clarity, CNA respectfully recommends the following modifications to the proposed language:

> (h) Recordkeeping.
> (l)Records of workplace violence hazard identification, evaluation, and correction shall be created and maintained in accordance with Section 3203(b), except that Section 3203(b) EXCEPTION No. 1 does not apply ~~the Exception to (b)(1) in Section 3203 does not apply~~.
> (2) Training records shall be created and maintained for a minimum of one year and include training dates, contents or a summary of the training sessions, names and qualifications of persons conducting the training, and names and job titles of all persons attending the training sessions. Section 3203(b) EXCEPTION No. 1 does not apply to these training records.

Response:
The Board thanks CNA for this suggestion and has modified the language in subsection (h) based on the recommended language above.

Denise Duncan, RN, Executive Vice President, United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP), by electronic mail sent December 17, 2015.

Comment DD#1:
UNAC/UHCP appreciates the thoughtful effort put into the current proposal and the fact that the Occupational Safety and Health Standards Board is making workplace violence prevention a priority but we believe the proposed language is in need of some clarification. Specifically, the definition of "workplace violence" should include harassment, intimidation or other threatening disruptive behavior that causes a person to fear for his or her safety. The definition needs to address: a) the threat or use of physical force against an employee resulting in or likely to result in injury, stress, and/or psychological trauma even though such threat or force does not result in physical injury to the employee; b) an incident involving the threat to use a weapon or object(s) that may be used as a weapon regardless of whether the employee sustains an injury; and c) verbal, physical or sexual intimidation that conveys an intent to cause harm to a person, persons or property. Type 2 "workplace violence" should include visitors and/or anyone accompanying a patient who may participate in acts or activities previously referenced. Harassment and intimidation are insidious forms of violence. They create many of the same feelings of insecurity as a threat or actual use of force would and, unfortunately, are sometimes more prevalent behaviors which can often be a precursor to more aggressive forms of workplace violence. For these reasons, we recommend that the definition of workplace violence be expressly modified to encompass harassment and intimidation as well as repercussions.

Response:
The Board is aware and appreciates the many comments that support the change proposed here to address the problem of verbal threats, harassment, and intimidation in general. The Board believes that verbal, physical or sexual intimidation that conveys an intent to cause physical harm to a person is included in the definition of workplace violence subsection (A), but other adverse employee interactions that do not include a threat of physical harm cannot be addressed in enforcement inspections conducted by Division compliance officers. Please also see the responses to Comments KH#4 and KH#5.

Comment DD#2:
The regulation contemplates an annual review of the workplace violence prevention plan between the employer and employees. The regulation should specify that where there is a collective bargaining agreement in effect, the exclusive employee representative should be able to select the employees who serve on the annual review team. In a unionized setting, the institutional union will select the bargaining union members to participate in the design, training, implementation and compliance process. The Plan design should include workplace safety checks or hazard assessments to be conducted on a yearly basis or immediately following a new or recent act of workplace violence.

Response:
The importance of active participation by the affected employees has been recognized and incorporated into the proposed regulation. However, specifying the selection process for the participants that an employer must follow goes beyond the discussions concerning the participants during the advisory meetings. The Board believes it cannot impose a requirement of this nature without a full discussion of its parameters and ramifications, and declines to make the recommended change.

Comment DD#3:
The annual review should include: a) the identification of documented reports of workplace violence within the last 12 months; b) newly identified workplace violence hazards; and c) changes in work or staffing patterns, engineering controls, changes in departmental redesign, cameras, mirrors, and/or alarm/notification systems as well as emergency response systems that may impact or require adjustments to the workplace violence prevention plan. Safe and adequate staffing is crucial to maintaining a safe working environment and should be in place at all times to mitigate acts of violence that occur with longer than expected patient waiting periods. In addition, insufficient resources and prolonged waiting times can often lead to escalating behavior that results in violence.

Response:
The Board believes that these aspects of the Plan have already been identified as areas to review.

Comment DD#4:
The regulation contemplates that employees receive initial and ongoing training, which is a positive development. However, in light of recent tragic events involving armed individuals in the workplace, we believe training provisions and parameters should be redefined. It is imperative the regulation be revisited to include training for the prevention of an “active shooter”

scenario as well as emergency drills and evacuation plans to address the safety of employees in the event of such scenario. Drills should include emergency, evacuation and escape plans in the event of an "active shooter" or other random act of violence. A collaboration with local, state, and federal law enforcement as well as the use of community resources is recommended.

Response:
The Board concurs that this topic should be included as a training subject and has modified the list to include that issue.

Comment DD#5:
The provisions should, also, ensure that employees, who are victims of workplace violence, not be disciplined by the employer for failing to follow any of the steps recommended in any training. We think it is important that there not be an incentive for employers to simply establish a training program and then "blame the victim" for any acts of violence that may occur.

Response:
The Board cannot preclude or require disciplinary action if an employee does not follow instructions from training. For this reason, the Board declines to make the recommended change.

Comment DD#6:
UNAC/UHCP believes some of the recordkeeping provisions should be expanded. Specifically, the Violent Incident Log should require the employer to document what remedial action was taken by the employer to prevent the recurrence of any violent incident. We strongly encourage the addition of two points to the Violent Incident Log. They are as follows: 1) the employee directly involved or a witness to an act of verbal or physical intimidation such as stalking, looming, glaring, or other physical body language that may imply a threat to another person, should be able to document the event; and 2) the documentation should be considered important as it is often a precursor to escalating behaviors that may result in violence and may warn employees or observers of impending violence. Similarly, the report by the hospital to the Division regarding each incident should include whether law enforcement was called to investigate the incident.

Response:
Records of corrections made to prevent a re-occurrence of a violent incident is covered under subsection (h)(1) and duplication of the recordkeeping is not needed on the violent incident log.

The Board notes that many of the advisory meetings included lengthy discussions regarding the need to address intimidating behaviors. Although these problematic behaviors are acknowledged as possible precursors to violent acts, they rely on subjective interpretation. The Log has been structured to reflect the acts that are addressed by the proposed regulation. Please see also the responses to Comments KH#4, KH#5, and KH#18.

Regarding reporting whether law enforcement was called, subsection (g) does require reporting whether security or law enforcement was contacted, and further language has been added to require reporting how security or law enforcement assisted the employees.

Comment DD#7:
The current regulation requires records of workplace violence be maintained for one year. We strongly suggest that this period be substantially extended. It is difficult to get an accurate sense of the true scope of a problem by only looking at one-year data sets. To truly ascertain whether workplace violence prevention plans are effective, it will be necessary to examine trends over 5-year and 10-year periods. Only with this type of data can we evaluate whether Plans are truly having their intended effect of reducing workplace violence. Accordingly, we suggest maintaining the records for 10 years.

Response:
The comment that records of workplace violence are required to be maintained for one year is incorrect. Subsection (h)(3) requires record of violent incidents, including the violent incident logs, be maintained for a minimum of five years.

Comment DD#8:
In order for the information to be useful, and to facilitate evaluation, there needs to be a public right of access for any and all documents required to be prepared and kept by the employer. We suggest adding a provision that makes the documentation available to any person upon written request to the employer, subject to reasonable costs for reproduction. The provision should mandate that the employer provide the requested documentation in electronic form to the extent it is available, and should require the employer to provide the requested information within 30 days of any written request.

Response:
Access to records of occupational exposures are based on the employer-employee relationship as established by Section 3204 which says:

> "The purpose of this section is to provide employees and their designated representatives and authorized representatives of the Chief of the Division of Occupational Safety and Health (DOSH) a right of access to relevant exposure and medical records."

The Board does not have the legal authority to expand the access to the public, and therefore must decline to make the recommended change.

Katherine Hughes, RN, CCRN, Labor Specialist/Nurse Alliance of California Liaison, Service Employees International Union, by written comments dated December 10, 2015.

NOTE: The commenter sent a letter supporting the proposal in many areas. Specific recommendations made by the commenter are discussed below.

Comment KH#1:
Regarding subsection (a), Scope and Application, as permitted by SB1299, DOSH and the Occupational Safety and Health Standards Board have included an appropriate and comprehensive list of health care settings, service categories and operations.

Response:
The Board thanks SEIU for this analysis. Please note, however, that ancillary health care operations, field operations, and outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings have been removed from this regulation in response to comments from other stakeholders.

Comment KH#2:
With regard to subsection (b), definition of "Outpatient medical offices and clinics" we propose adding language to the list of examples to address outpatient services in correctional or detention settings in order to be consistent with the Health and Safety Code and in order to clarify the definition (10) Correctional treatment center, which does not include outpatient services.

Response:
The Board concurs since there is a significant risk of violence in correctional settings and has added outpatient medical services to the incarcerated in correctional and detention settings to the scope of the regulation. Other outpatient medical clinics/offices that are not included within the license of a hospital are not within the scope of the modified proposal.

Comment KH#3:
In subsection (b), definition of "Patient specific risk factors," history of violence, this language accurately reflects the testimony and examples shared during the advisory committee process that any history of violence should be taken into consideration when assessing for risk factors that may increase the likelihood of a violent incident and we thank the Division.

Response:
This subsection has been modified to limit psychiatric conditions and diagnoses to only those associated with increased risk of violence, to avoid discriminating against all patients with a psychiatric condition or diagnosis. See also the response to Comment PL#1.

Comment KH#4:
With regard to the subsection (b) definition of "Threat of violence," we continue to adamantly advocate for the following definition in order to address the discussions between stakeholders, testimony from victims of WPV and current research on the topic of WPV: "means a statement or conduct – for example, harassment, intimidation, or other threatening disruptive behavior – that causes a person to fear for his or her safety and that serves no legitimate purpose." If this alternative definition is not accepted, then at a minimum the word "physically" should be removed as a qualifier for injury from the current proposed definition. The use of the term injury is consistent with the language in the Labor Code, current H&S codes and Title 8 regulations which use the term(s) injury or injured (For example, see Section 3203 (IIPP)).

Response:
The Board recognizes that there is a considerable amount of verbal intimidation that many would consider threatening that occurs in workplaces, including health care. However, the Board believes that attempting to address harassment and intimidation without threat of physical injury would put a tremendous burden on Division compliance officers to determine whether a threat

involving only psychological injury served no legitimate purpose. Behaviors perceived as threats can sometimes include legitimate work-related actions such as warnings of possible disciplinary action. On August 20, 2015, when the Board denied a petition for a standard to prevent workplace bullying, Board members noted that workplace bullying is not something that is appropriate for the Division to handle. The Board recognized that other agencies are authorized by statute to use a subjective process of weighing and balancing societal values to protect employees from hate violence, harassment, workplace violence, unfair employment practices, and discrimination. Those statutes provide for in-depth investigations, discovery of evidence, hearings, and resolution of complaints through legally-reasoned opinions, judgments, and decisions that compare prior rulings and decisions to the current dispute. By contrast, the Division must issue citations within a six-month statute of limitations and lacks the legal authority to use a longer, more in-depth process to resolve complaints of harassment and intimidation. The Board therefore declines to make the recommended change.

Comment KH#5:
With regard to the subsection (b), definition of "Workplace violence" we propose to add the language below, as (C), to reflect that such behavior or conduct is part of the continuum of WPV and often a warning sign or precursor of impending violence and thus should be considered part of the definition:

Workplace violence includes the following:
(A) The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.
(B) An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury;
(C) Conduct such as verbal, physical or sexual intimidation that conveys an intent to cause harm to persons or property

Response:
The Board notes that in subsection (A), the existing definition of workplace violence includes the actions covered by the language suggested for subsection (C). The Board believes that the recommended addition is redundant and therefore declines to make the recommended change. Please also see the response to Comment KH#4.

Comment KH#6:
In subsection (b), definition of workplace violence regarding Type 2 violence: we recommend including "visitors or others accompanying a patient" to this list of examples. We recognize that this is not an exhaustive list, but we believe that it's important to add visitors to the list as they are frequently present and don't really apply to any of the categories listed.

Response:
The Board concurs that the Type 2 definition should be modified and has proposed to add "visitors or other individuals accompanying a patient" to the definition.

Comment KH#7:
In subsection (c)(3), we propose to change "employees have a role in implementing the Plan" to "employees understand their respective roles in implementing the Plan" in order to clarify the expectations that contracted employees need to understand their role in order to comply with the Plan, but also to help ensure their safety and the safety of others in the workplace.

Response:
The Board concurs that the modification proposed here better addresses the problem and proposes to add: "understand their respective roles as provided" in the Plan. The Board also proposes modifications so that all employees working in a facility are covered by the Plan.

Comment KH#8:
We would also point out that these hazard assessments should occur along with the "at least annually" review of the Plan, subsection (e) and "when a new or previously unrecognized workplace violence hazard has been identified," subsection (f)(1)(B).

Response:
The Board concurs that a newly identified hazard needs to be assessed within the unit where the hazard exists, or the entire facility if that is the extent of the problem, and has modified subsection (e) accordingly. Please see the response to Comment KH#20.

Comment KH#9:
In subsection (c)(8)(A)(2), we don't believe this sentence makes sense and would propose to reword it as, "Poor illumination or blocked visibility of areas where employees or possible assailants may be present."

Response:
The Board concurs that this passage has an error and proposes the following modification: "Poor illumination or blocked visibility ~~or~~ of areas where ~~employees or~~ possible assailants may be present."

Comment KH#10:
In subsection (c)(9), we propose that "or other persons in the work setting" be added here. As it could be more than a patient or visitor and the broader phrasing is used further down in this section.

Response:
The Board agrees that "other persons who are not employees" should be added to the group of persons who should be assessed. Please note that this is renumbered to subsection (c)(10).

Comment KH#11:
In subsection (c)(10)(A), we would propose to add the language "to implement the Plan at all times, to prevent and immediately respond," as this language is used in this proposed regulation and other H&S codes and regulations.

Response:
The Board believes this is already required as part of renumbered subsection (c)(11)(A) and is intended to allow flexibility in providing a Plan appropriate for a unit. Therefore, the Board declines to make the proposed change.

Comment KH#12:
In subsection (c)(10)(F), we would propose to add the language "security personnel, who can implement the Plan at all times, maintain order," as this language is used in this proposed regulation and other H&S codes and regulations. We support and thank the Division for the language regarding "sufficient staffing" available not only to maintain order but also to implement the Plan at all times as ordered by the proposed regulation.

Response:
The Board believes that the existing proposed language is sufficiently clear, and this proposed modification might be construed to say that a specific minimum number of security personnel is required to be present at all times, and therefore declines to make the recommended change.

Comment KH#13:
Regarding subsection (c)(10)(I), all of these are emergency action plan elements and this is very good language. We would just propose some additional language to this section as needed, regarding a single incident of assault with limited victims or a facility wide emergency and what steps an employee will take: "what actions employees will take, including evacuation to designated safe areas or sheltering in place for safe refuge."

Response:
The Board concurs that emergency planning needs to include an evaluation of the appropriate actions to take in the event of a mass casualty attack and proposes a modification to renumbered subsection (c)(11)(I) to require procedures for responding to these emergencies. The employer would have to identify and implement feasible procedures such as evacuating or sheltering in place as well as warning employees of the emergency condition, and having a process for contacting law enforcement.

Comment KH#14:
In subsection (c)(10)(J), we would replace the word minimum with sufficient as this is performance language that determines if there is enough staff to get this work done, implement the Plan at all times and ensure safety.

Response:
The Board concurs that the use of minimum might be misconstrued, and has replaced "minimum" with "sufficient." Please note this is renumbered as subsection (c)(11)(J).

Comment KH#15:
We suggest that a subsection (c)(12) be added to require that the Plan include: "An effective procedure for obtaining the active involvement of employees and their representatives in reviewing and updating the Plan, as required by subsection (e), with respect to workplace violence hazards in their respective work areas or departments."

Response:
The Board concurs and is proposing this change in subsection (e).

Comment KH#16:
In subsection (d)(2), we recognize the importance of maintaining the confidentiality of victims and/or patients. This non-confidential document will be reviewed at the institutional and unit level, such as a health & safety committee, to see what's happened, what worked, what didn't, how long responses took, etc. We would strongly advocate that it's necessary to know the job title of the employee(s) involved, specific assignment(s) at the time of the incident and the supervisor's name and job title in order to gather sufficient information and better use this tool to track incidents, do follow up, make corrections, prevent future occurrences, evaluate the effectiveness of the Plan and the standard itself over time. Much like the sharps injury log which provides non-confidential information for review and has been an effective tool for 15 years in evaluating the employer's program.

Response:
The Board notes that privacy is an important concern for a number of stakeholders. The Board believes that although information identifying the persons involved in a violent incident would greatly assist in the review process, there is an overriding concern regarding individual privacy for the patients and employees. Therefore, the Board has modified subsection (d) to require the employer to omit any information that could reveal the identity of any person involved in a violent incident. The Board declines to add the elements suggested by SEIU, because those elements could reveal identities in some work settings.

Comment KH#17:
In subsection (d)(3), we acknowledge the importance of employees not being mandated to fill out this section. But, we would advocate very strongly that if this portion is not filled out by the affected employee(s) that it is filled out with their direct participation. This is an accounting of the incident by someone directly involved, who has a unique perspective of the event and thus should be reflected by whoever is filling out this section; even if that is simply to state that the involved employee is opting out of filling out this section.

Response:
The Board has determined that the process of collecting the information for the Log should be more consistent with the Sharps Injury Log from Section 5193 and should guard against the unintentional inclusion of information that could undermine privacy. The requirement that employees who experienced workplace violence be allowed to complete sections of the Log has been deleted. Instead, the employer will collect the information and will solicit pertinent information about the incident from each affected employee, and will ensure that privacy of the persons involved in the incident is safeguarded. The person who completes the Log entry will be identified, to allow follow-up as needed.

Comment KH#18:
In subsection (d)(4)(B), we propose that these two data elements be added into the Log: "Verbal or physical intimidation." We believe that this behavior is part of the continuum and often a

precursor or warning sign of impending WPV. "Verbal intimidation and physical intimidation, such as implied threats, yelling or other raised voice, stalking, looming, glaring or staring, pacing, arm or fist waving."

Response:
The Board believes that verbal intimidation alone, without threat of physical violence, cannot be addressed by the proposed standard. While verbal intimidation is often a precursor to a violent act, some forms of intimidation are purely psychological, and are covered by labor law and other areas of employment law. See also the responses to Comments KH#4 and KH#5. Therefore, the Board declines to make the suggested modification.

Comment KH#19:
Subsection (d)(5) should read "job title," not just "title," for clarity.

Response:
The Board concurs and has made this change in renumbered subsection (d)(8).

Comment KH#20:
Regarding subsection (e), Annual Review of the Workplace Violence Prevention Plan, we agree that the Plan should be reviewed periodically, and at least annually. However, as with Bloodborne Pathogens, we believe that there are other events that should also trigger a review or update to the Plan. We would suggest that the title of subsection (e) be changed to Review of the Workplace Violence Prevention Plan and language added to the current proposed regulation. It is not our intention to eliminate the current proposed language, this is an addition:

> The Plan shall be reviewed and updated at least annually and whenever necessary as follows:
> 1. To reflect new or modified tasks and procedures which may affect how the Plan is implemented, such as changes in staffing, engineering controls, construction or modification of facilities, evacuation procedures, alarm systems and emergency response;
> 2. To include newly recognized workplace violence hazards;
> 3. To review and evaluate workplace violence incidents which occurred since the previous update; and
> 4. To review and respond to information indicating that the Plan is deficient in any area.

We would also propose to add the language, "and their representatives," after "in conjunction with employees."

Response:
The Board agrees that certain events should trigger a review of the Plan in addition to the annual review and notes that the proposed standard is based on the processes required by Section 3203. The Board has therefore added subsection (e)(5) based on Section 3203(a)(4)(B) and (C), which requires inspection and evaluation:

(B) Whenever new substances, processes, procedures, or equipment are introduced to the workplace that represent a new occupational safety and health hazard; and
(C) Whenever the employer is made aware of a new or previously unrecognized hazard.

The Board has incorporated portions of the suggested language, with review and updating for units of a facility, the facility as a whole, or the particular operation, as applicable. Beyond the annual review, the new language, which is in new subsection (e)(5), does not require review and updating after every single incident, but only after incidents resulting in serious injury or death.

Regarding the inclusion of employee representatives in each review, please see the response to Comment SEIU#5 made during the first 15-day comment period.

Comment KH#21:
We believe that the training should be interactive with questions and answers and there should be a component for employees to practice the roles they are expected to take when there is an imminent hazard, such as an active shooter or some such trigger. This training should include mock training drills/exercises for all employees, as well as the training in subsection (f)(3).

Response:
The Board recognizes the increasing occurrence of active shooter incidents nationwide. However, requiring all employers to conduct drills of this nature, which can impose high administrative costs, might not be appropriate for some facilities, especially for small service providers who rent space and would have to have the permission of the building owner. Therefore the Board declines to require drills, but points out the need for employers to include training about specific emergency procedures for their operations.

Comment KH#22:
In subsection (f)(3), we propose that training be quarterly, but at least every six months, because people are being assigned to go into a potentially dangerous and violent situation, and they may not practice it at all in a given year.

Response:
The current language in subsection (f)(3)(I) requires that employees who have to respond to violent incidents or control persons exhibiting aggressive behavior have:

> An opportunity to practice the maneuvers and techniques included in the training with other employees they will work with, including a meeting to debrief the practice session. Problems found shall be corrected.

The training and practice is required prior to initial assignment and at least annually thereafter. Requiring practice more than once a year would be unduly burdensome to many employers. Therefore the Board declines to make the proposed change.

Comment KH#23:
We would suggest that subsection (f)(3)(J) be added to require that the training include:

> Procedures regarding how they are to interface with law enforcement personnel and other emergency response agencies in the event of an emergency requiring outside intervention, such as an active shooter.

Response:
The Board recognizes the need for employers to have clear procedures for communicating with their respective law enforcement agency that a critical emergency is in progress to ensure that an immediate and appropriate response is provided by the agency. The Board has therefore added subsection (c)(4) requiring that the employer establish an effective procedure for obtaining assistance from law enforcement. Subsection (f)(1)(A)(6) includes this training topic.

Comment KH#24:
In subsection (f)(4), we suggest adding, "emergency, including safe areas and evacuation plans."

Response:
The Board has added, "how to use identified escape routes or locations for sheltering, as applicable," in new subsection (f)(1)(A)4, and has deleted subsection (f)(4).

Kimberly Rosenberger, Esq., California State Council, Service Employees International Union, by electronic mail sent December 17, 2015.

NOTE: The commenter sent an email message supporting the proposal in many areas. Specific recommendations made by the commenter are discussed below.

Comment KR#1:
Requests to Delay or Exclude Implementation for Smaller Facilities and Ancillary Hospitals. Modern health care is evolving to move away from in-patient, hospital based services toward more outpatient and ambulatory care settings – including home-based care settings. In fact, small and in-home care, such as long term care providers, are just as important as large scale hospitals. According to the WCIS provided in DOSH's review, long-term care workers were the second highest assaulted.

As such, we would urge that the regulation should not exclude the full continuum of health care delivery settings. We believe the regulation has been drafted to allow for rational flexibility and a tailored approach to assessing the types of threats that apply in each workplace setting. Smaller facilities, including long-term care and home-like settings are just as vulnerable to threats of workplace violence. The regulation as proposed would allow these providers, including facilities that have experienced little to no violence to create plans that work best for them while ensuring larger facilities or those with higher rates of violence must implement stronger plans.

The regulation is written in a manner that considers the nuances of health care and challenges faced by different facilities. We ask that such flexibility remain in the regulation and that ancillary facilities not be excluded or delayed as a safe workplace is imperative for all health care workers regardless of their staff size and workplace setting.

Response:
The Board concurs that workers employed in small long-term care and in-home care settings are at risk of exposure to workplace violence and believes small employers are able to achieve compliance with the proposed standard by conducting an assessment of the workplace violence factors that exist in their own operation with the involvement of employees which would include

their own history of violent incidents. This assessment may or may not require them to implement engineering or work practice controls. The Board believes that the proposed standard is designed and intended to be flexible according to the needs and experience of the employer. The Board, however, notes that there is insufficient data showing that health care workers in ancillary health care operations are at increased risk of workplace violence and therefore these operations will not be included in this proposed standard.

Comment KR#2:
Firefighters and Emergency Medical Services (EMS) Should Be Excluded:
The proposed regulation would cover firefighters and other emergency responders when they are engaged in delivering paramedic or emergency care services only. Again, the aim of this regulation is to ensure that the workplace violence prevention standards apply broadly in the delivery of health care services. First medical responders feed into other systems of care and as such, cannot be excluded.

Response:
Please see the response to BT#1. The Board believes that paramedics and employees who provide medical transport should be protected from violence experienced while transporting patients or from violent situations related to the conditions at the receiving facility.

Mark Catlin, Health and Safety Director, Service Employees International Union, by electronic mail sent December 17, 2015.

NOTE: The commenter sent an email message supporting the proposal in many areas, and mirroring comments made by Katherine Hughes, RN, CCRN, Labor Specialist/Nurse Alliance of California Liaison, Service Employees International Union. Please see the responses to Katherine Hughes Comments KH#1 through KH#24.

Christine Boardman, President, SEIU Local 73, by electronic mail sent December 16, 2015.

NOTE: The commenter sent an email message supporting the proposal in many areas. Specific recommendations made by the commenter are discussed below.

Comment CB#1:
Special education classroom assistants in the Chicago Public Schools, in Chicago's suburban school districts, and across Illinois who educate and care for students with behavioral health disorders experience workplace violence daily. Not only health care and social services workers need an effective and well defined workplace violence standard, but so do all workers. Airport security officers at Midway and O'Hare Airports-members of SEIU Local 73, also need an effective workplace violence standard to protect themselves, as well as the millions of airline passengers who fly through these airports every year, from the threat of terrorism and violence. Whether an unsafe workplace is caused by actual violence or threats and intimidation, workers deserve safety and security. This standard is a good first step to provide just that.

Response:
Although this proposed standard does not apply beyond health care settings, the Board notes that a petition subsequent to the petitions that initiated this rulemaking seeks a workplace violence prevention regulation for all industries. The Board believes that the anticipated advisory committee process will provide an opportunity for employers and employees of the settings mentioned in the comment to present information about these circumstances and thanks SEIU for identifying problematic work settings. Please also see the response to Comment RB#1.

Jon Youngdahl, Executive Director, SEIU California, by written comments sent December 17, 2015.

NOTE: The commenter sent an email message supporting the proposal in many areas, and mirroring comments made by Katherine Hughes, RN, CCRN, Labor Specialist/Nurse Alliance of California Liaison, Service Employees International Union. Please see the responses to Katherine Hughes. A separate comment made by the commenter is discussed below.

Comment JY#1:
In light of the recent tragedy it is important to highlight that Social Services providers, such as the San Bernardino center where 10 SEIU members were killed, are the second most likely targets of violence.

The Workplace Violence Prevention Plan includes procedures regarding how they are to interface with law enforcement personnel and other emergency response agencies in the event of an emergency requiring outside intervention, such as an active shooter. We suggest adding, "emergency, including safe areas and evacuation plans."

Response:
Regarding social services providers, please see the response to Comment RB#1. Regarding safe areas and evacuation plans, in subsection (f) on training, the Board has added that initial training must include use of identified escape routes or locations for sheltering, as applicable.

The Board has also added the following requirement to the employer response plan in the event of a workplace violent emergency in renumbered subsection (c)(11)(I):

> …The response plan shall also include procedures to respond to mass casualty threats, such as active shooters, by developing evacuation or sheltering plans that are appropriate and feasible for the facility, a procedure for warning employees of the situation, and a procedure for contacting the appropriate law enforcement agency.

Alysabeth Alexander, Vice President of Politics, SEIU 1021, by electronic mail sent December 17, 2015.

NOTE: The commenter sent an email message generally supportive of the proposal and provided background information on the topic of workplace violence from the perspective of health care professionals. The Board thanks the commenter for their support and the background information.

Robert LaVenture, Director, United Steelworkers (USW) District 12, by electronic mail sent December 15, 2015.

NOTE: The commenter sent an email message supporting the proposal in many areas. Specific recommendations made by the commenter are discussed below.

Comment RL#1:
We implore the Board to address what we and our members see as two major gaps in the proposed regulations: First and foremost, the definition of "workplace violence" must include all threatening behavior and intimidation including bullying and harassment that might damage the psychological and health of employees. Similarly, the definitions of "patient contact" and "threat of violence" should also give due attention to bullying and harassment as well as psychological health effects.

Response:
The Board acknowledges that many employees have expressed concern over the behavioral violence that stops short of physical harm, or the actual attempt to inflict physical harm. The Board recognizes that there is a considerable amount of verbal intimidation that many would consider threatening that occurs in workplaces, including health care. Please see the response to Comments KH#4 and KH#5.

Comment RL#2:
We strongly recommend that the training programs mandated by the proposed regulations include unit specific drills, which give employees the opportunity to practice expected roles and responsibilities in a safe environment. We believe this is an important component of any workplace violence prevention and remediation program and will strongly improve the overall effectiveness of all Plans.

Response:
The Board notes that subsection (f)(3) includes a requirement to give employees who are expected to confront persons exhibiting aggressive or violent behavior an opportunity to practice techniques and maneuvers with co-workers, and believes this addresses the comment.

Comment RL#3:
Regarding the definition of "Patient Contact," we respectfully recommend the deletion of the phrase "direct physical" from the definition of patient contact. As the National Institute for Occupational Safety and Health describes workplace violence as ranging from "offensive or threatening language to homicide," we strongly believe that workplace violence can and does often take place during exchanges that may or may not involve physical contact. The inclusion of "direct physical" therefore unnecessarily excludes potential instances of workplace violence.

Response:
The purpose of the definition of "patient contact" in subsection (b) is to identify environmental factors for fixed workplaces under renumbered subsection (c)(9) and to specify the group of

employees who must be given annual refresher training under subsection (f)(2). The "patient contact" definition does not limit the proposed definition of "workplace violence."

Comment RL#4:
Regarding the definition of "Patient Specific Risk Factors," this definition accurately reflects our members' experiences and we appreciate the intent to capture risk factors that may increase the likelihood of a patient acting violently in the health care setting. We also underscore the importance of practices, which enable workers to communicate these patient specific risk factors to co-workers during shift-changes and other similar patient hand-offs between workers.

Response:
The Board agrees that risk factors need to be identified and evaluated as art of the employer's workplace violence prevention plan. The Board notes that the list of factors has been modified to avoid discriminating against all patients with a psychiatric condition or diagnosis. Please see the response to Comment PL#1.

Comment RL#5:
Threat of Violence: We are deeply concerned with the inclusion of the word "physically" in this definition insofar as it implies the exclusion of psychological injury. As the National Institute for Occupational Safety and Health includes psychological trauma as a possible consequence of workplace violence, the inclusion of any conduct that causes a person to fear for his or her own safety and that serves no legitimate purpose is responsible, accurate, and consistent with workplace violence discourse. Therefore, at the very least, we recommend removing the word "physically" from the definition of "threat of violence."

Response:
The Board recognizes that this type of behavior exists. However, determining when a threat involving only psychological injury serves no legitimate purpose would be extremely difficult for the Division. For this reason, the Board declines to make the recommended change. See also the responses to Comments KH#4 and KH#5.

Comment RL#6:
We agree that the delineation of workplace violence into four types will empower workers and providers to better identify and address each type of violence. To this end, we respectfully recommend that "visitors and others accompanying a patient" be included in the definition of Type 2 violence for the sake of clarity and inclusivity.

Response:
The Board concurs that the Type 2 definition should be modified. Please see the response to Comment KH#6.

Comment RL#7:
Regarding subsection (c)(5), procedures to ensure that supervisory and non-supervisory employees comply with the Plan: We must note that preventing occupational illness and injury is the employer's responsibility. While worker involvement is crucial to designing and implementing a Plan that reflects actual work conditions and threats or incidents of violence, the

joint labor/management development, implementation, and review of Plans must be constructive and occur in a way that does not blame and discipline any individual worker or victim for incidents of workplace violence. Workplace violence prevention plans must be focused on a review of the systems and the hazards that cause or contribute to workplace violence, not on individual behaviors. This note is consistent with the proposed regulations language in the subsequent subsection (6)(C) which creates communications procedures for employees to document concerns without fear of reprisal.

Response:
The Board notes that renumbered subsection (c)(6) specifically refers to Section 3203(a)(2), which does not limit the methods for obtaining compliance. The Board therefore declines to modify the proposal.

Comment RL#8:
Corrective actions as outlined in subsection (c)(6)(D) should be equally focused on the systems and hazards that cause or contribute to workplace violence rather than on individual behaviors. In order to create an environment, which empowers workers to report concerns, safety violations, or incidents without fear of reprisal for themselves or a coworker, employees must also be informed of the outcomes of their actions.

Response:
The Board concurs and notes that renumbered proposed subsection (c)(7)(C) requires that the Plan include procedures on how employees can communicate workplace violence concerns without fear of reprisal.

Comment RL#9:
Regarding subsection (c)(7), procedures to develop and provide the training required in subsection (f), it is unclear to us why the Board has included the word "allowed" when describing employee participation in developing and delivering the training. This implies a lower-level of involvement than prescribed in subsection (c)(2) and we respectfully recommend this language be modified to read: "Employees and their representatives shall participate in developing and delivering the training."

Response:
The Board notes that in response to another comment, a modification has been made in renumbered subsection (c)(8) to clarify that employees will be allowed to participate in developing the training, but will not necessarily deliver the training. Please see the response to Comment GBS#15. In addition, the Board declines to place a mandate on employees and their representatives to develop and deliver training, which is the responsibility of the employer. The Board believes that the proposed language is appropriate for ensuring that employees are involved in the training process.

Comment RL#10:
Regarding subsection (c)(10)(F), maintaining sufficient staffing, including security personnel, who can maintain order in the facility and respond to workplace violence incidents in a timely manner in an effort not only to respond to workplace violence incidents, but to at all times adhere

to the Plan in order to reduce the risk of and actual incidents of workplace violence, we respectfully recommend modifying this language to read: "Maintaining sufficient staffing, including security personnel, who can implement and adhere to the Plan at all times and maintain order in the facility and respond to workplace violence incidents in a timely manner."

Response:
The Board believes that the current language applies to all work covered by the proposed regulation and does not allow for periods when sufficient staffing is not maintained. The Board therefore declines to make the recommended change.

Comment RL#11:
Regarding subsection (d), Violent Incident Log: The type of incident . . . accurate documentation of incidents is vital in order to provide a complete and accurate analysis. Therefore, we strongly recommend adding examples of verbal or physical intimidation to the list of possible occurrences. Further, as verbal and/or physical intimidation are often important signs of escalation, they must be documented and analyzed. Therefore, we propose an additional (seventh) descriptor: "Verbal or physical intimidation such as implied threats, yelling or other raised voice, stalking, looming, glaring or staring, pacing, arm or fist waving."

Response:
The Board notes that these types of actions are subsumed under "threat of physical force," which is among the examples listed in renumbered subsection (d)(6).

Comment RL#12:
Regarding subsection (e), Annual Review of the Workplace Violence Prevention Plan, we strongly recommend that reviews of the Plan happen at least once per year in addition to after any and all documented workplace violence incidents. Timely review of any and all incidents and the response to them is key to effective implementation and will allow the Plan to be modified as necessary. As previously noted, each Plan shall require employee involvement in review of the Plan as it applies to their specific work areas and job duties.

Response:
Although the Board concurs that the review of the Plan is critical to ensure that it becomes and continues to be effective as conditions change, the Board must establish a reasonable basis for reviewing the Plan more frequently than annually. To be consistent with Section 3203, the Board concurs that more than an annual review may be needed in response to changes to procedures or identifying a new violence related hazard, and has proposed a modification to this subsection. Please also see the response to Comment KH#20.

Comment RL#13:
Regarding subsection (f) Training, we applaud the comprehensive approach to training as recommended by the proposed regulations and respectfully submit the addition of mandatory annual, unit-specific drills, which give all employees the opportunity to practice the roles and actions they are expected to take during an imminent hazard. These drills should include a participatory de-brief to discuss what went well and what roles and expectations should be modified, revisited, or need additional practice.

Response:
The Board notes that subsection (f)(3) requires this training for the employees who will be expected to confront or control patients exhibiting aggressive or violent behavior including drills on an annual basis, which seems consistent with the recommendation.

Gail Bateson, Executive Director, Worksafe, by electronic mail sent December 16, 2015.

NOTE: The commenter sent an email message mirroring comments made by Katherine Hughes, RN, CCRN, Labor Specialist/Nurse Alliance of California Liaison, Service Employees International Union. Please see the responses to Katherine Hughes Comments KH#1 through KH#24.

Michael Musser, Liaison, California Teachers Association (CTA), by electronic mail sent November 25, 2015.

NOTE: The commenter sent an email message supporting the proposal in many areas. Specific recommendations made by the commenter are discussed below.

Comment MM#1:
Subsection (c) requires each employer covered by this section to establish, implement and maintain an effective written workplace violence prevention plan***. Who evaluates the individual Plans to prove they are effective?***
Subsection (c)(4) requires that the Plan have provisions prohibiting employers from disallowing an employee from, or taking punitive or retaliatory action against an employee.
Subsection (c)(6) requires that the employer have procedures for communicating workplace violence matters. ***Who will evaluate the procedures? Are there time line requirements?***
Subsection (c)(7) requires that the employer establish appropriate training and content and explain how employees and their representatives shall be allowed to participate. ***Who will evaluate the training?***
Subsection (c)(11) requires that incidents of violence are investigated and appropriate steps are taken to address employee injuries and trauma. ***Who evaluates what is required in an investigation, what are appropriate steps and what is trauma?***
Subsection (f), the employer must provide effective training to all employees. Requires active involvement of employees and their representatives in the creation of the training curriculum and training materials, conduct of training sessions and the review and revision of the training program. ***Once again, we speak of effective training and appropriate content based on the employees education level, literacy and language. Who will be the judge here?***

Response:
These comments primarily deal with the question of who evaluates various sections of the Plan. The employer, with employee involvement, will evaluate the effectiveness of the overall Plan and its components at least annually as required by subsection (e). The Division will determine if the Plan and its components are effective when the Division conducts enforcement inspections of employers. The proposed regulation is based on Section 3203 which applies the basic principle that an employer needs to assess their workplace, identify occupational hazards, and take steps to

correct the problems they identify, investigate injuries and illnesses and train their employees in the proper procedures to avoid harm from the hazard(s) identified. When conducting an enforcement inspection, the Division evaluates the effectiveness of an employer's IIPP. This approach will similarly be applied to how the Division will evaluate an employer's Plan.

Comment MM#2:
The commenter suggests adding the words, "with affected employee input" to subsections (c)(8)(A), (c)(8)(B), (c)(8)(C), and (c)(10).

Response:
The Board believes that the recommendation to add "with affected employee input" is already addressed by subsection (c)(2) and does not need to be repeated in each subsection.

Comment MM#3:
The commenter asks who enforces sufficient staffing levels as referenced in subsection (c)(10)(F).

Response:
Staffing levels are determined by the employer after considering all of the information gathered in the workplace evaluation. The Division enforces Title 8 regulations and would ensure, during enforcement actions, that the employer's procedures are effective. Please also see the response to Comment MM#1.

Some employers such as hospitals have other regulatory staffing requirements and this regulation is not intended to conflict with existing statutes and regulations governing minimum staffing levels.

Comment MM#4:
The commenter asks who has access to the Log referenced in subsection (d).

Response:
Employees, employee representatives, and the Chief of the Division have access to records, such as the violent incident log, as provided in subsections (h)(4) and (h)(5) of the proposed regulation.

Comment MM#5:
The commenter recommends that subsection (e), annual review of the Plan, which includes the involvement of employees, should also include their recognized representatives.

Response:
The Board has made the recommended change in subsection (e).

Comment MM#6:
The commenter agrees that private security officers, private patrol operations and/or other security services as referenced in subsection (f)(1) must also participate in the workplace violence prevention training.

Response:
The specific requirement to include contracted private security guards was deleted in the revised text of subsection (f)(1). They are considered employees working at the facility and are already required to be provided training pursuant to the remaining language in the revised text of subsection (f)(1). The Board appreciates CTA's evaluation and comment.

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Barbara Schroeder, by electronic mail sent November 8, 2015.

NOTE: The commenter sent an email generally supportive of the proposal. The Board thanks the commenter for this support.

Scott Byington MSN, RN, CCRN, St. Francis Medical Center staff nurse, by electronic mail sent November 19, 2015.

NOTE: The commenter provided background information on the topic of workplace violence from the perspective of hospitals. The Board thanks the commenter for this background information.

Gladys Conui, by electronic mail sent November 21, 2015.

NOTE: The commenter sent an email message describing intimidation in the workplaces. Please see the response to Comments KH#4 and KH#5.

Carol Stockman, RN, California Nurses Association (CNA), by electronic mail sent November 25, 2015.

NOTE: The Board notes that this form letter was received from over 500 members of the California Nurses Association generally supportive of the proposal. The Board thanks the commenters for their support.

Robyn Brown, Animal Control Officer II, Sonoma County Animal Services, by electronic mail sent December 2, 2015.

Comment RB#1:
The commenter asks why animal control officers are not included in the proposed standard.

Response:
This rulemaking is in response to Petitions 538 and 539 filed by two health care worker unions, requesting the Board to adopt a new standard that would address workplace violence in health care, as well as a bill addressing workplace violence in health care, SB1299, which was specifically focused on certain hospitals (general acute care hospitals or acute psychiatric hospitals), but which also gave permission for the Standards Board to include other types of health care operations in proposed standards. Another petition, Petition 542, requested the Board to adopt a workplace violence prevention standard for workers in educational settings and was

granted to the extent that the Division has been requested to convene an advisory committee to address workplace violence prevention in educational and all California workplaces, which will include animal control officers.

Workplaces not included by this proposed rulemaking are currently covered under Title 8 Section 3203, IIPP, which 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.

Tim Tuscany, RN, PHN, by electronic mail sent December 2, 2015.

Comment TT#1:
As a nurse, I strongly recommend implementing standards that provide a safe place for nurses by requiring training, frequent to constant observation of compliance by a neutral party, adequate staffing and training on managing assaultive clients to all staff, a method to remove unwanted entries and posts that may be detrimental in the eyes of the staff, and specific legal remedies to assaults and threats against the offending person.

Response:
The Board thanks the commenter for supporting this process. Although the proposed regulation requires employers to establish a Plan and provide training to prevent workplace violence, the proposal does not specifically address removing unwanted entries and posts, or legal remedies against the perpetrators of workplace violence.

Lourdes Mendez, Placement Specialist, Jobs Now Youth Program, City and County of San Francisco, Workforce Development Division, by electronic mail sent December 2, 2015.

Comment LM#1:
The commenter states that security is not allowed to call the police and they can't really do anything to help, although management is trying to address the issue. Also, the employees cannot defend themselves against client attacks. It would be helpful to have security in the office and off-site.

Response:
Although social service workers face significant risks of workplace violence, this particular rulemaking applies to certain health care facilities, service categories, and operations. Another petition, Petition 542, was granted to the extent that the Division has been requested to convene an advisory committee to address workplace violence prevention in all California workplaces. Please also see the response to Comment RB#1.

Herbert J. Weiner MSW Ph.D., Retired Social Worker of the City and County of San Francisco, by electronic mail sent December 2, 2015.

NOTE: The commenter sent an email message recommending regulations against workplace harassment. Please see the response to Comments KH#4 and KH#5.

Jo Anne Roy, Licensed Vocational Nurse, Inpatient Tobacco Treatment Coordinator, San Francisco General Hospital & Trauma Center, by electronic mail sent December 4, 2015.

NOTE: The commenter sent an email message describing workplace bullying. Please see the response to Comments KH#4 and KH#5.

Anonymous commenter, by written comments received at the Public Hearing on December 17, 2015.

Comment AC#1:
Please consider expanding the above standards to other California workers who have extensive public contact such as Social Services Agencies including government workers either State, County or Non-Profit who are engaged in Child Protective Services (CPS), Social Workers and Eligibility Workers who engage in extensive public contact often with clients under severe psychological stress.

Response:
See the response to Comment RB#1.

Comment AC#2:
The definition of workplace violence needs to include psychological threat(s) by someone in higher authority such as a supervisor or upper management who can exercise dominion over the working conditions of your job such as threats, intimidation, gesturing, micro-management, harassment, gesturing which can cause psychological damage if repeated over long periods and nothing is done by the employer despite the employee reporting such incidents.

Response:
Please see the responses to Comments KH#4 and KH#5.

Kathleen Sullivan, RN, BSN, PHN, by electronic mail sent December 17, 2015.

Comment KS#1:
In subsection (a) inclusion of "home health care and home-based hospice" is noted; and later it is stated that "other off-site operations" are included. I suggest a specific inclusion of the practice environment of public health nurses and ancillary staff who provide services through home visiting, but which are neither home health care nor hospice. Perhaps, "home-base public health care" or similar wording could be added. It seems to me this profession should be specifically included rather than fall under "other."

Response:
The Board notes that the scope of the proposed regulation applies to work performed in specified health care facilities, service categories, and operations rather than specific occupations. Public health nurses who provide health care services to patients at their homes would be considered

home health care and be covered by the regulation. Although public health nursing services are primarily prevention based, rather than medical treatment, it is still a health care service.

Thea Weintraub RN, Harbor UCLA Psychiatric Emergency Department, by electronic mail sent December 17, 2015.

NOTE: The commenter described experiences with workplace violence. The Board thanks the commenter for this information.

Cecilia Mendoza, Family Nurse Practitioner, LA Sheriff Department, by electronic mail sent December 17, 2015.

NOTE: The commenter described experiences with workplace violence. The Board thanks the commenter for this information.

Carol Carroll RN, Men Central Jail, by electronic mail sent December 17, 2015.

NOTE: The commenter described experiences with workplace violence. The Board thanks the commenter for this information.

Monty Clouse, by written comments received at the Public Hearing on December 17, 2015.

Comment MCL#1:
It is clear that there continues to "be a great need for an early intervention that is demonstrably effective after a trauma," and there is also agreement that health care staff members require support soon after events that evoke critical incident stress, such as patient assaults upon hospital staff members. At the present time the findings regarding Critical Incident Stress Debriefing (CISD) indicate that this intervention has important benefits including staff members' appreciation of this support and improved morale, use as a means of screening staff members for more intensive follow-up and for dissemination of psychoeducational information. However, adequate empirical support for CISD’s prevention of diagnosable disorders does not exist. Group interventions using similar formats should therefore be provided within specific parameters.

A consensus document of the American Red Cross, the U.S. Departments of Defense, Justice, Health and Human Services, and Veterans Affairs reports best practices for early psychological interventions after critical incidents. These findings argue for the provision of a multicomponent set of early psychological interventions to support staff. In any situation as organizationally complex as a psychiatric hospital, the needs of various staff members following a critical incident will vary widely. Early interventions are matched to the degree of exposure and the varying needs of staff members.

Critical Incident and Early Psychological Interventions:
A critical incident is a work-related event that evokes strong emotional reactions. A critical incident may be defined by the staff member experiencing the event or by other people who witness or hear about the incident Accordingly, any of these parties may request early

psychological interventions to support staff following a critical incident Participation is always voluntary and confidential.

Training Components for ES Team Members
Background issues:
• Critical Incidents
• Early Psychological Interventions

Research findings on critical incident stress debriefing, and implications for Early Psychological Interventions
Interventions used by EPS Team Members:
• Defusings
• Individual Crisis Support contacts
• Critical Incident Debriefings
• Peer Support Group contacts

Actions taken by EPS Team Coordinators:
• Referrals for Treatment
• Administrative Liaison contacts

Response:
The Board thanks Mr. Clouse for providing this detailed analysis of post-incident treatments. However the Board believes that prescriptive psychological interventions should not be included in a regulation of this nature, and declines to make the recommended modification. Renumbered subsection (c)(12)(C) of the proposed regulation requires employers to offer individual trauma counseling to all employees affected by an incident.

Wen-Chi Chang, R.N., UNAC/UHCP Member, by written comments received at the Public Hearing on December 17, 2015.

NOTE: The commenter described experiences with workplace violence. The Board thanks the commenter for this information.

Cres Elchico, RN, Olive View Medical Center, by written comments received at the Public Hearing on December 17, 2015.

NOTE: The commenter described experiences with workplace violence. The Board thanks the commenter for this information.

Diana Hansen, R.N., UNAC/UHCP Member, by written comments sent December 17, 2015.

NOTE: The commenter described experiences with workplace violence. The Board thanks the commenter for this information.

Dorlah Lawrence R.N., SEIU 721, by written comments sent December 17, 2015.

NOTE: The commenter described experiences with workplace violence. The Board thanks the commenter for this information.

Grace Corse, by written comments sent December 17, 2015.

NOTE: The commenter described experiences with workplace violence. The Board thanks the commenter for this information.

Isela Martinez, Immigration Coordinator, Unite Here Local 49, by written comments sent December 17, 2015.

NOTE: The commenter sent a letter generally supportive of the proposal. The Board thanks the commenter for this support.

II. Oral Comments

Oral Comments received at the December 17, 2015, Public Hearing in Sacramento, California.

Lois Richardson, CA Hospital Association

Comment #LR1:
Ms. Richardson stated that her organization has three main concerns regarding this proposal. Her organization is concerned that the effectiveness of a hospital's workplace violence prevention plan will be measured on whether or not a workplace violence incident occurs. Even with workplace violence prevention plans in place, workplace violence will still occur. Her organization believes that hospitals should be held accountable for having a good workplace violence prevention plan in place, along with proper training, but when an incident occurs, the Division should look at the hospital's workplace violence prevention plan instead of automatically concluding that the hospital should be penalized because something occurred.

Response:
The Board notes that the Division investigates incidents in response to complaints, reports of serious injuries or fatalities, primarily investigating the circumstances to see if the employee had been properly trained and provided adequate protection as established by the Plan for that hospital. Enforcement personnel would also be instructed to ensure that the incident did not result from improper implementation of the Plan.

Comment #LR2:
Ms. Richardson's organization would like to see confirmation in the proposal that allows the employer to retain the discretion to determine appropriate staffing levels, and that a dedicated security staff is not required at all times in every setting, recognizing that other staff would have to be appropriately trained if there is no security staff.

Response:
Patient staffing is subject to the applicable Health and Safety Code requirements, not these orders. However, the proposed standard does call for an assessment by management and employees to establish appropriate methods to prevent workplace violence, to the extent feasible. If the response to a violent outburst requires a response by several employees, sufficient staffing is a factor that may affect the determination of appropriate staffing levels. The proposed standard does not require employers to hire security professionals, or to contract for security services. Please see the response to Comment GBS#2.

Comment #LR3:
Ms. Richardson's organization is concerned about the short timeframe for developing and implementing workplace violence prevention training. The final version of this regulation will come out in July, but employers must comply by October. Large hospitals that provide multiple types of care may have to develop multiple workplace violence prevention plans to properly suit their needs, and then they must train their thousands of employees on it, and with such a limited timeframe, they may not be able to get it done in time.

Response:
To ensure that employers affected by this proposed regulation implement their Plans in an effective manner, an implementation schedule has been added in new subsection (a)(4) to allow employers sufficient time to assess their facility or operation with the involvement of their employees, determine an appropriate course of action to take to implement appropriate and feasible control measures, implement changes, and provide training to the employees. These elements would be implemented by one year after the effective date of the regulation.

Yvonne Choong, California Medical Association

Comment #YC1:
Ms. Choong stated that providing guidance to employers regarding the need for a workplace violence prevention plan, and the elements that should be included in the Plan, is a valuable resource, but establishing a regulatory mandate to develop and implement a Plan, employee training, and record keeping with highly prescriptive requirements could place a substantial burden on physician practices that could impact patient care. This proposal is a one-size-fits-all approach framework that applies the same to small physician practices as it does to large hospitals. The definition of workplace violence that is listed in the proposal could be interpreted very broadly to include conflicts, such as employee conflicts, that do not rise to the level of workplace violence. These incidents would have to be logged in the violent incident log and would take up a lot of time and resources to do so, which creates an administrative burden for the employer. Because this regulation is very complex, employers will need additional time to implement it. While large health care facilities may already have some kind of a workplace violence prevention plan in place, other smaller facilities may not, and they may have additional issues to address, such as leasing office space and physical plan issues, so that they can develop a robust Plan that complies with the regulation, and the additional time to do that would be beneficial.

Response:
The Board notes that these comments are also expressed in written form and addressed in detail. Please see the responses to comments for Ms. Choong's letter of December 10, 2015, (Comments YC#1 through YC#8). The Board would like to reiterate that although some individuals believe the proposed standard requires all health care employers to have the same Plan as a large institution, such as a hospital, the actual requirement is that an employer establish a Plan that is appropriate for the type of operation they have and to involve the employees in identifying the workplace violence issues, finding corrective measures that are feasible, and implementing the Plan that has been collaboratively developed. The Board also notes that the proposed regulation has been modified with an implementation schedule in new subsection (a)(4) and that the proposed regulation has also been modified to remove from the scope of the proposed regulation all outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings. The Board thanks CMA for participating in the advisory process and specifying their concerns.

Jedd Hampton, LeadingAge California

Comment #JH1:
Mr. Hampton stated that his organization is concerned about this regulation because it seems to apply a one-size-fits-all framework to all health care facilities that is more suited for larger health care facilities. Many of the health care facilities that will be affected by this regulation are small facilities that are set up as residential health care settings in rural areas. His organization is concerned about how health care facilities will be assessed under this new regulation. Gary Passmore, Congress of California Seniors, echoed Mr. Hampton's comments.

Response:
The Board notes that these comments have also been submitted in written form and answered separately as responses to Mr. Hampton's letter of December 12, 2015. Please also see the response to Comment YC#1. The Board would add that the Division would apply the same criteria for compliance that is currently applied to Section 3203(a) as well as ensuring that the employer has implemented the additional requirements in the proposed regulation.

Laurel Mildred, Mildred Consulting, representing 221 adult day health centers in California

Comment #LM1:
Ms. Mildred urged the Division to exempt community-based long term service and support (LTSS) programs, including adult day health centers, from this regulation. Her organizations are concerned that this regulation extends to community-based LTSS programs, and they feel that this standard was not designed for community-based LTSS settings. This regulation is fundamentally misaligned with the character mission and requirements of LTSS settings, and this is probably due to the fact that no LTSS providers or California Department of Aging representatives were included in the process of developing these regulations. By exempting community-based LTSS programs from this regulation, it will allow stakeholders, providers, and government agencies who oversee LTSS programs to come together and develop workable standards that will prevent workplace violence in community-based LTSS programs while

recognizing their unique home- and community-based settings. LTSS programs that provide health care and social service supports are not institutional in character, and therefore, they do not have the same workplace violence concerns, infrastructure, or resources as hospitals, nursing homes, or emergency departments. This proposal brings an institution-type culture to home- and community-based programs, which would put providers of these programs at odds with the federal requirements and guidance issued by the Centers for Medicare and Medicaid Services, which could jeopardize their ability to get federal funding for these programs. Gary Passmore, Congress of California Seniors, echoed Ms. Mildred's comments.

Response:
Please see the responses to Comments LMI#1, LMI#2, and LMI#3.

Bill Taylor, PASMA

Comment #BT1:
Mr. Taylor stated that his organization is concerned about the fact that paramedics and firefighters are included in the scope and application of this regulation in subsection (a)(1)(D). This will pose significant costs to fire and emergency medical agencies statewide while doing little to prevent workplace violence. The training component alone will cost them $14 million because there are 40,000 firefighters and paramedics throughout the state who will have to be trained. It does not make sense to subject firefighters, paramedics, and other first responders to this regulation while leaving out others, such as police officers, who have a much higher risk of experiencing workplace violence. The definition of ancillary health care operations is too broad and should not include settings such as nurses working at a first aid station at a convention.

Response:
These comments have been made in a letter dated December 14, 2015. The Board reiterates that the costs stated assume that firefighters and paramedics would have to be fully trained in person by every employer served by that person. The training subsection has been modified to eliminate these misunderstandings. The Board also notes that police officers are not health care personnel and have their own protocols for avoiding violent acts, as does the National Guard of California and the comparison does not diminish the occupational exposure that paramedics, whether private or firefighters, face in the course of their work. The Board also notes that police officers who perform emergency medical services or transport patients are not exempt from the regulation.

The Board has determined that there is currently little data on the actual rate of violent acts in ancillary health care operations and has removed those facilities from the scope of the regulation, but also stresses that the employer of a nurse at a convention is responsible for providing for the safety and health of the nurse under Section 3203(a). The Board thanks PASMA for allowing this clarification to be stressed.

Please see the response to Comment #JS1 regarding the cost of including firefighters and paramedics in the regulation.

Elizabeth Treanor, Phylmar Regulatory Roundtable

Comment #ET1:
Ms. Treanor stated that her organization is concerned about the inclusion of employer on-site health clinics in this regulation. These clinics are not open to the public and can only be accessed by employees. There are no examples to show that workplace violence occurs at these clinics. There are limited resources available for workplace safety and health programs, and for settings such as employer on-site health clinics that have a very low risk for workplace violence, it would be better to spend those resources on addressing the risks that exist for the employees who work at that workplace. Bruce Wick, CALPASC, echoed Ms. Treanor's comments.

Response:
The Board thanks the commenter for this information and notes that the proposed regulation has been modified to remove from its scope all ancillary health care operations and all outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings. As a result, on-site occupational health clinics are not covered by the regulation.

John Robinson, California Attractions and Parks Association

Comment #JR1:
Mr. Robinson stated that the proposal is too broadly constructed, and further clarification and distinction are needed to distinguish ancillary health care operations, such as first aid providers at amusement parks, from other facilities that offer further care and are more likely to experience workplace violence. The parks only provide basic first aid services, and if further services are needed, the patron is referred or transported to a licensed health care facility. He asked the Division to provide a better definition of what an ancillary health care facility is so that facilities, such as amusement parks, which provide basic first aid services are not considered to be the same as a hospital or acute care facility. He suggested language in his written comments to address that [Please see the file copy of the Board packet to view this written comment].

Response:
Please see the response to Comment JR#1.

Paul White, Securitas Healthcare Division

Comment #PW1:
Mr. White stated that he has a lot of experience in helping health care facilities design and implement workplace violence prevention plans. This regulation does a good job of addressing the loopholes in the current law, but it needs to include both law enforcement and security personnel in the notification process when a workplace violence incident occurs that requires outside assistance. He encourages employees to call law enforcement for assistance when necessary, but when they do, they often do not also inform security as to what is happening, and when law enforcement responds, it takes extra time to inform the security staff about what is happening.

Response:
The Board concurs that subsection (c)(4) needs clarification to allow for facilities that need to have law enforcement contacts coordinated so that they can be directed to the right location or entry point while allowing employees to contact law enforcement on their own when they cannot utilize the system in place, or have some other circumstance that would impede a response. The following modification is proposed:
(c)(4) Effective procedure for obtaining assistance from the appropriate law enforcement agency during all work shifts. The procedure may establish a central coordination procedure. This shall also include a policy statement prohibiting the employer from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs.

Comment #PW2:
Mr. White stated that he has seen many health care facilities have difficulty in getting employees involved in helping to develop and implement workplace violence prevention plans because employees do not show up to participate or the management decides that this will affect their employees' productivity, so they do not follow through. Hospitals should be required to make a diligent effort to involve employees in the development, implementation, and training on the workplace violence prevention plan, and employees who have been affected by workplace violence must be involved in that process.

Response:
The Board notes that subsection (c)(2) requires employers to have effective procedures to obtain the active involvement of employees and their representatives.

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Dr. Richard Pan, State Senator

Comment #DRP1:
Dr. Pan stated that this proposal is a major step forward in ensuring a safe workplace for health care workers. Health care workers deserve to be safe at their jobs, and when there is a lack of safety, it affects patient care. He asked the Board to consider the effects of psychological violence and threats on employees, in addition to physical violence. Regem Corpuz, Southern California Coalition for Occupational Safety and Health (So. Cal COSH), echoed this comment.

Response:
The Board acknowledges that many individuals and groups have expressed concern over the prevalence of actions or threats that cause psychological harm but do not pose risks of physical harm. The Board respectfully declines to make the proposed modification. Please see responses to Comments KH#4 and KH#5.

Mitch Seaman, California Labor Federation

NOTE: The commenter expressed overall support of the proposal. The Board thanks the commenter for this support.

Bonnie Castillo, Associate Executive Director, California Nurses Association (CNA)

NOTE: The commenter expressed support for the proposal. A specific recommendation made by the commenter is discussed below.

Comment #BC1:
Ms. Castillo stated that her organization strongly supports the proposed regulations, but there are some adjustments that need to be made. Her organization supports the wide scope and application that this proposal provides, as well as the inclusion of threats, the emphasis on prevention of workplace violence instead of criminalization, and the requirements for employee involvement in developing and implementing a workplace violence prevention plan and comprehensive training requirements. The proposal needs to extend the reporting requirements to all health care settings in order to build on the strength of the regulations and provide protections to all health care workers regardless of the setting that they work in. Suzi Goldmacher, Worksafe, echoed this comment.

Response:
Please see the response to Comment DN#2.

Malinda Markowitz, RN at Good Samaritan Hospital and President of CNA

NOTE: The commenter expressed overall support of the proposal. The Board thanks the commenter for this support.

Monica Aleman, UNAC/UHCP

Comment #MA1:
Ms. Aleman stated that this regulation is a good start, but is still a work in progress. As new threats emerge, new training and resources must also emerge. The definition for workplace violence needs to include harassment, intimidation, or other threatening or disruptive behavior that causes a person to fear for his or her safety. Regem Corpuz, So. Cal COSH, echoed this comment. Ms. Aleman said that the workplace violence prevention plan should allow union members to participate in the design, training, implementation, and compliance process, and the ongoing training should address new threats, as well as offer emergency drills and evacuation plans. The regulation should require employers to maintain records of workplace violence for at least 5 to 10 years.

Response:
The Board acknowledges that many individuals and groups have expressed concern over the prevalence of actions or threats that cause psychological harm but do not pose risks of physical harm. The Board respectfully declines to make the proposed modification. Please see responses to Comments KH#4 and KH#5. The Board also believes that the proposed regulation includes the process for employee participation. Regarding maintenance of the violent incident logs, subsection (h)(3) requires record of violent incidents, including the violent incident logs, be maintained for a minimum of 5 years. The Board thanks the commenters for their participation.

John Youngdahl, SEIU California

Comment #JY1:
Mr. Youngdahl stated that violence against health care workers can take on several forms, including physical, emotional, sexual, and verbal assaults. Social workers and health care workers make up 70% of the workplace violence that occurs annually. He asked the Division to remove the word "physical" as a qualifier for determining injury that occurs due to workplace violence. Social workers are the second most likely group of workers to be targeted for workplace violence. He asked the Division to add the phrase "emergency, including safe areas and evacuation plans" to address this.

Response:
Please see the responses to Comments KH#4, KH#5 and KH#24.

Katherine Hughes, RN and Nurse Alliance of California, SEIU Local 121RN

Comment #KH1:
Ms. Hughes thanked the Division for its work on this proposal and stated that it will go far in protecting health care workers from workplace violence. Her organization would like to see the two data elements regarding verbal and physical intimidation put back into the violent incident log.

Response:
The Board thanks SEIU for its support and involvement in this rulemaking. Please see the response to Comment KH#18.

Mark Catlin, SEIU, Washington, D.C.

Comment #MC1:
Mr. Catlin asked the Division to continue moving this proposal forward. Employers should already have some form of a workplace violence prevention program in place because it is required in their IIPP, so they can build on that. Employees working in off-site facilities should not be exempt from this regulation because there have been cases where employees at these facilities have been murdered by family members. Health care is becoming more decentralized and is moving further away from hospital and institutional settings, and this is all the more reason why these employees should be included in the regulation.

Response:
The Board thanks the commenter for this input. However, the Board has modified the proposed regulation to remove from its scope all ancillary health care operations, field operations, and outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings.

Katy Roemer, RN, Kaiser and member of CNA

Comment #KR1:
Ms. Roemer stated that she strongly supports the proposed broad scope of the regulation that covers workers in all health care settings, including outpatient medical clinics, home health care and home-based hospice, paramedics and EMS services, drug treatment centers, and ancillary health care operations. The regulations will implement a broad definition of workplace violence that incorporates actual acts of violence, as well as threats of violence and use of a dangerous weapon, regardless of whether or not an employee is injured. The threat of violence has very real impacts on health care workers, including psychological trauma and stress.

Response:
The Board thanks the commenter for this input. However, the Board has modified the proposed regulation to remove from its scope all ancillary health care operations, field operations, and outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings.

Seyma Anajafi, RN, Long Beach Memorial and member of CNA

NOTE: The commenter expressed overall support of the proposal. The Board thanks the commenter for this support.

Kathy Dennis, RN, Mercy General Hospital Sacramento and member of CNA

Comment #KD1:
Ms. Dennis said that the proposal requires employers to get the active involvement of employees in developing and implementing workplace violence prevention training, conducting training sessions, and reviewing and revising training plans, since employees know firsthand the risks and hazards that they face. This ensures that important elements will not be overlooked, and training will include opportunities for interactive questions and answers with people who are knowledgeable about the workplace violence prevention plan. It should go further by requiring security personnel to be present at every training session to interact with employees, practice drills, and answer questions. The proposal also requires that training sessions emphasize preventative measures, such as:

- How to recognize the potential for violence.
- How to counteract factors that contribute to the escalation of violence.
- When and how to seek assistance.
- Strategies to avoid physical harm.

Employees who are trained to respond to workplace violence alerts must be specifically trained on the following elements:

- How to recognize aggression in patients and visitors.
- How to use verbal and physical maneuvers to diffuse and prevent violent behavior.

- Various restraining techniques, and employees must be given an opportunity to practice these techniques.

The training required by this proposal will prepare employees to deal with workplace violence when it occurs.

Response:
Although the Board concurs that it is important to involve security personnel in initial training for facility personnel, an added requirement to have them attend all training sessions would impose significant time demands on the employers of the security personnel beyond what was discussed at the advisory meetings. For this reason, the Board declines to make the recommended change. The Board also believes that the training elements listed in the comment are included in the regulation, and thanks Ms. Dennis for her participation in this rulemaking.

Marcia Santini, ER Nurse, Ronald Reagan UCLA Medical Center and member of CNA

Comment #MS1:
Ms. Santini stated that her organizations support the reporting requirements in subsection (g) for general acute care hospitals, acute psychiatric hospitals, and special hospitals, but they are concerned because these requirements do not apply to all health care settings. Several of the exempt facilities have fewer administrative and environmental controls than those found in hospitals, leaving workers vulnerable to workplace violence. Retail health care clinics are a relatively new idea, so not much is known about the workplace violence that employees in these setting experience. It is important to know what the risk is for workplace violence for these workers, and the only way to find that out is through mandated reporting of workplace violence incidents. These kinds of settings can also leave employees vulnerable to workplace violence because these locations can be accessed by any member of the public, they have large amounts of cash on hand, and some have on-site pharmacies that dispense highly-sought-after drugs, such as Oxycontin and Vicodin, which can invite criminal activity, such as theft, robbery, and shoplifting, into their workplace.

Response:
The Board thanks the commenter for this input. However, the Board has modified the proposed regulation to remove from its scope all ancillary health care operations, field operations, and outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings. Retail health clinics are no longer included in the regulation due to these modifications, so expanding reporting requirements would not provide any data on these establishments. Please also see the response to Comment DN#2.

Amy Glass, RN, Kaiser Modesto and member of CNA

NOTE: The commenter expressed overall support of the proposal. The Board thanks the commenter for this support.

Susie Ingall, Staff Nurse, St. John's Regional Medical Center in Oxnard, and member of SEIU 121

NOTE: The commenter expressed overall support of the proposal. Suzi Goldmacher, Worksafe, echoed this support. The Board thanks the commenters for their support.

Richard Webb, RN, Allview Medical Center

NOTE: The commenter expressed overall support of the proposal. The Board thanks the commenter for this support.

Alysabeth Alexander, SEIU Local 121

Comment #AA1:
Ms. Alexander stated that health care workers suffer a lot of psychological stress and PTSD as a result of workplace violence. This violence can come from co-workers, patients, or supervisors, and workers are often told by supervisors not to report incidents of workplace violence, because if they do, it will do more harm than good and will put the facility at greater risk. As a result of this type of bullying, many workers end up quitting their jobs or going on disability. She also stated that the current classification system for patients does not reflect the level of care that is needed, which makes staffing ratios inadequate. Staffing ratios do not lead to more hiring, and as a result, employees sometimes end up working mandatory overtime, which can lead to sleep deprivation and mistakes on the job.

Response:
The Board notes that the proposed requirement to record incidents of violence and the periodic review process should address part of the problem described in this comment. However, this proposed regulation cannot establish a patient classification system because this is governed by the Health and Safety Code and is outside the jurisdiction of the Board.

Gayle Batiste, RN, SEIU Local 121RN

Comment #GB1:
Ms. Batiste stated that the violent incident log that is listed in this proposal will allow employers to track incidents and establish a review process and action plan to address workplace violence that occurs. She asked the Division to add the following recommendations to the definition of workplace violence that is listed in the proposal:

- Warnings of job-related disciplinary actions.
- Unreasonable supervisory actions.
- Statements that point to an intent to inflict harm.

Intimidation and disruptive behaviors often come from officials in power, and verbal and psychological harm are not an HR issue. Workers who experience workplace violence can be affected by it to the point that they make mistakes at their job, which could be costly or deadly. She asked the Division to move this proposal forward to protect health care workers from workplace violence.

Response:
The Board believes that it is inappropriate to automatically and categorically classify job related sanctions as being a form of workplace violence under the proposed regulation. Please also see the responses to Comments KH#4 and KH#5. The Board also notes that statements of intent to inflict physical harm are already included in the proposed standard in the definitions of workplace violence and threat of workplace violence. Therefore, the Board declines to make the recommended changes.

Jeannie King, RN, SEIU Local 121RN

Comment #JK1:
Ms. King stated that workers in health care who experience workplace violence are not given any kind of mental counseling following the incident. Mental counseling is very necessary for health care workers who experience workplace violence, and her organization would like for the Division to consider adding a provision for that to the proposal.

Response:
The Board notes that this is addressed in renumbered subsection (c)(12):
(12) Procedures for post-incident response and investigation, including:
(A) Providing immediate medical care or first aid to employees who have been injured in the incident;
* * * * *
(C) Making available individual trauma counseling to all employees affected by the incident;

Sue Yell, Social Worker

Comment #SY1:
Ms. Yell stated that she is very pleased with this proposal for health care workers, and she would like to see it extended to all other workplaces as well. Michael Musser, California Teachers Association**,** echoed this comment. Ms. Yell asked the Division to consider including public sector workers who work in social services, including social workers, eligibility workers, CPS, and other workers who regularly interact with the public, when it develops a similar standard that will apply to other workplaces. She asked the Division to include threats and intimidation in the proposal, especially those that are inflicted by those in higher authority, including management and supervisors.

Response:
The Board thanks the commenters for supporting this rulemaking. Please see the responses to Comments RB#1, KH#4 and KH#5.

The following individuals also commented in support of the proposal:
- Ching, RN, St. Jude Medical Center Fullerton
- Regem Corpuz, So. Cal COSH
- Maria Cristina Sandere, Licensed Clinical Social Worker and member of SEIU 721

- Irma Alcantar
- Elsa Monroe, RN and SEIU member, representing RN's at San Quentin State Prison
- Grace Corse, SEIU Nurse Alliance and Local 721
- Tami Olenik, LA County USC Medical Center
- Kathleen Berberian
- Jonathan Sully, SEIU Member
- Theresa Rutherford, Shop Steward at Laguna Honda Hospital

Response:
The Board thanks all the commenters for their continued participation and support of this rulemaking project.

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Barbara Smisko, Board Member

NOTE: This Board member expressed overall support of the proposal.

John Sacco, Board Member

Comment #JS1:
Mr. Sacco stated that SB1299 specifically applies to hospitals, but the proposal goes further than that, and he feels that it will be difficult for small physician's offices to implement. He asked the Division to review subsections (b) thru (g) of the scope of the proposal and come up with some compelling reasons why firefighters, paramedics, and first aid providers should be included. He does not see any reason why firefighters and paramedics should be included, and first aid providers should be exempt. He also asked the Division to revisit its assessment of the costs to implement the required training. He said that there will be a lot of additional required training that is beyond what is covered in the IIPP in Section 3203, and he feels that the cost for that training will be significant.

Response:
The concern regarding small physician offices has been addressed in the responses to CMA comments. Please see the responses to Comments YC#1 through YC#8. Firefighters are included only where their duties are to provide emergency medical services that are the same as would be provided by private responders since they have the same occupational exposure to workplace violence. This exposure is well documented in two documents cited in the response to PASMA comments. Please see the response to Comment BT#1. An analysis of the National Fire Fighter Near-Miss Reporting system found that assaults are the largest cause of near misses and injuries to firefighters during emergency medical calls.

The cost for including emergency medical services is detailed in the final statement of reasons, but the costs will be offset by a reduction in workers' compensation, lost time and absenteeism. Preventing workplace violence injuries to workers will also improve employee morale.

"First aid providers" would most likely fall under the category of ancillary health care operations which have been removed from the scope of the regulation. Regarding the training requirements, please see the response to Comment BT#4.

Dr. Robert Blink, Board Member

Comment #RB1:
Dr. Blink stated that some of the issues regarding workplace violence in health care are very complicated, so the breadth of this proposal needs to be thought through very carefully. The issue regarding ancillary health care operations should be researched further to make sure that this proposal does not cause detriment to good things, such as employee on-site health clinics. He asked the Board staff to consider how employees working in small facilities and homes will be protected, and whether or not it is reasonable to address these issues with one approach. He also asked the Board staff to consider whether or not it is appropriate to include firefighters in this regulation.

Response:
A modification has been made to exclude ancillary health care operations and outpatient medical clinics and offices from this rulemaking (other than outpatient medical services to the incarcerated in correctional and detention settings). Concerns about home health care services are addressed in renumbered subsection (c)(9)(B), separately from hospitals. Firefighters are included to the extent that they provide emergency medical services and medical transport. Two documents cited in the response to PASMA comments show high rates of workplace violence for personnel providing those services. Please see the response to Comment BT#1.

Comment #RB2:
Dr. Blink stated that the requirements for recordkeeping and reporting violent incidents to the Division could be very burdensome for facilities whose patients frequently make threats. The Division and Board staff needs to find a way to simplify that for employees in those facilities so that they are not buried by paperwork for no particular reason or benefit. Some facilities have a much lower risk for workplace violence than others, so the flexibility of this proposal needs to be expanded so that it is appropriate for the situations that workers find themselves in. There is no definition listed in the proposal for the term "non-employee personnel" that is used in item number 4 in subsection (f)(4). He stated that this brings up the issue regarding the many types of contractors who work in health care facilities, and the Division and Board staff needs to determine how to cover these employees and protect them from workplace violence, and how to include them in the details of the workplace violence prevention plans for the facilities where they work.

Response:
The Division is working with hospital stakeholders to develop an appropriate system and process for reporting violent incidents online. It is unclear why employees would be buried with paperwork since many hospitals are already required to report violent incidents to other institutions, and most such systems are automated. In addition, SB1299 mandated that hospitals report workplace violence incidents to the Division. A properly designed reporting system

should provide at least a baseline of information regarding the occurrence of violence and the contributing factors in hospitals.

Regarding contractors who work in health care facilities, subsection (f) has been revised to require the employer to provide only the training that addresses the workplace violence risks that the particular employees are reasonably anticipated to encounter in their jobs. Subsection (f) has also been reorganized to cover training of employees generally, without reference to whether the employees are in traditional employment relationships, contract employees, temporary employees, or part-time employees. The responsibilities of employers in multi-employer and dual-employer settings are set forth in Labor Code sections 6400 and 6401.7; California Code of Regulations, Title 8, sections 336.10 and 3203; and case law interpreting and applying these statutes and regulations. All employers are responsible for the safety and health of their employees regardless of the nature of the employment relationships. Subsection (f)(4) has been deleted from the text and the term 'non-employee' is no longer in the proposed regulation.

Laura Stock, Board Member

Comment #LS1:
Ms. Stock stated that she is concerned about the fact that this proposal only requires acute care facilities to report incidents of workplace violence to the Division. This new regulation is the first of its kind in the nation, so therefore, there is no data available regarding its effectiveness at addressing workplace violence, and in order to get that data to measure its effectiveness at all health care facilities, all of the facilities included in this proposal should be required to report incidents of workplace violence to the Division. This data will help determine if this proposal is effective in reducing workplace violence in health care and will help identify and address issues that arise. The violent incident log should include verbal, physical, and psychological threats and harassment. By logging these incidents in the violent incident log, they can be monitored and tracked in the Log so that they will be less likely to escalate into physical violence. This proposal is very flexible and allows all health care facilities to come up with a workplace violence prevention plan that best suits them. This would be a good time to begin looking into developing a workplace violence prevention proposal that will apply to all California workplaces, and that may have some bearing on some of the issues that are being discussed today for workplace violence prevention in health care.

Response:
Although it is true that having a reporting system that can assess the prevalence and occurrence of violent incidents and basic contributing factors would provide information that is extremely useful in developing prevention strategies as commented, the sheer magnitude of the undertaking, by the Division, makes this infeasible at this time. Please see the response to Comment DN#2. Regarding psychological threats and harassment, please see the responses to Comments KH#4 and KH#5. Regarding a workplace violence prevention regulation for all employers, the current rulemaking process has identified many issues to consider in the next rulemaking effort. The Board acknowledged unanimously in the June 2015, public business meeting that work to develop that regulation may need to wait until after the current rulemaking effort has concluded.

David Harrison, Board Member

Comment #DH1:
Mr. Harrison said that instead of narrowing the scope of this regulation, he would rather see it applied with a phased-in approach beginning with large health care facilities and hospitals, and then applying it to ancillary health care facilities shortly after that.

Response:
Board members will see that an implementation period is proposed in new subsection (a)(4) to ensure that employers have sufficient time to assess their facility or operation with the involvement of their employees, determine an appropriate course of action to take to implement appropriate, applicable and feasible control measures, implement changes and provide training to the employees. The modification proposes one year from the effective date of the regulation for employers to comply with certain subsections of the regulation.

The Board has decided not to implement a phased-in approach beginning with large establishments and then including smaller establishments after a delay. Modifications have been made to eliminate ancillary health care operations, outpatient offices and clinics, and field operations from the scope of the regulation, except for off-site operations included within the license of a "health facility" and outpatient medical services to the incarcerated in correctional and detention settings. The broad scope of the terms, "ancillary health care operations," "outpatient medical offices and clinics," and "field operations," would have included many entities not intended to be included in the regulation, such as school nurses, first aid stations at public events, first aid clinics at amusement parks, on-site workplace clinics, and retail clinics. The Board may initiate follow-up rulemaking in the future to expand the scope of the regulation to include additional facilities, services, and operations, as appropriate.

Patty Quinlan, Board Member

Comment #PQ1:
Ms. Quinlan stated that employee on-site health clinics should be included in the regulation because even employees who have been vetted can get violent for some reason.

Response:
Although worksite health clinics were identified in the advisory meetings for inclusion in the scope of coverage, there is little documentation to show that these have a rate of violent incident occurrence that is higher than the average for non-health care employment. Therefore this segment of employers has been excluded from this current rulemaking.

Dave Thomas, Board Chair

NOTE: This Board member expressed overall support of the proposal.

## MODIFICATIONS AND RESPONSE TO COMMENTS RESULTING FROM THE FIRST 15-DAY NOTICE OF PROPOSED MODIFICATIONS (August 2, 2016 – August 17, 2016)

Following the first 15-Day public comment period from August 2, 2016, to August 17, 2016, the following modifications were made that are the result of public comments and/or Board staff evaluation.

Subsection (a) Scope and Application.
A modification is proposed for subsection (a)(l) to delete categories (B), "Outpatient medical offices and clinics," and (E), "Field operations such as mobile clinics and dispensing operations, medical outreach services, and other off-site operations," from the proposed regulation. The categories are overly broad and include many workplaces where there is insufficient evidence of workplace violence comparable to other workplaces included in the regulation. The categories would have included workplaces that the Standards Board does not intend to include in the regulation, such as small physician offices, first aid providers at community events and street fairs, movie and television production set medics, amusement park first-aid stations, and worksite medical clinics for employees. The previous modification deleted the category "ancillary health care operations," but this deletion was insufficient because many of the same operations that the Standards Board does not intend the regulation to cover also fall within the definition of "outpatient medical offices and clinics" or "field operations."

A modification is proposed for subsection (a)(l) to add category (E), "Outpatient medical services to the incarcerated in correctional and detention settings," to the regulation. The addition is necessary since the category "outpatient medical offices and clinics," which included "outpatient medical services to the incarcerated in correctional and detention settings" in its definition in subsection (b), was deleted from the scope and application of the regulation. The Standards Board intends to retain correctional and detention settings in the regulation due to the higher risk of workplace violence at these locations.

A modification is proposed to renumber the items in subsection (a)(l) and renumber references to those items in subsections (a)(2) and (a)(4). The renumbering is necessary due to the proposed additions and deletions to subsection (a)(l ) described above.

A modification is proposed to exclude facilities operated by the California Department of Corrections and Rehabilitation (CDCR) from the proposed regulation. These facilities shall still comply with Section 3203. CDCR will collaborate with the Division of Occupational Safety and Health (DOSH) to ensure that its existing workplace violence prevention program is as effective as the requirements in the proposed regulation.

Subsection (b) Definitions.
A modification is proposed to delete the definition of "Field operation," since this category is proposed to be removed from the scope of the regulation for the reasons stated above.

A modification is proposed to delete the definition of "Outpatient medical offices and clinics," since this category is proposed to be removed from the scope of the regulation for the reasons stated above.

Subsection (c) Workplace Violence Prevention Plan.
A modification is proposed to delete subsection (c)(9)(B). This subsection is specific to "field operations," which is proposed to be removed from the scope of the regulation for the reasons explained above.

A modification is proposed to renumber portions of subsection (c)(9). The renumbering is necessary due to the proposed deletion of subsection (c)(9)(B).

Subsection (e) Review of the Workplace Violence Prevention Plan.
A modification is proposed to add employee representative participation in the review of the workplace violence prevention plan. Employee representative involvement in the review is already required in subsection (c)(2) and is proposed to be added to subsection (e) for consistency.

Subsection (f) Training.
A modification is proposed in subsections (f)(l)(C) and (f)(2) to require that employers respond to employee questions regarding training within one business day instead of within 24 hours. The change was made in response to comments that training may be taken at odd hours and weekends, and employers may not have the ability to respond to questions until the next business day.

Subsection (g) Reporting Requirements for General Acute Care Hospitals, Acute Psychiatric Hospitals, and Special Hospitals.
A modification is proposed in subsection (g)(l)(A) to clarify that the term "injury" means an injury meeting the criteria found in Title 8 section 14300.7(b)(l). Prior to this modification, the proposal did not contain any criteria for determining what constitutes an "injury" for purposes of reporting under subsection (g).

A modification is proposed in subsection (g)(2) to change "resulted in injury" to "results in injury" to make the verb tenses consistent in this subsection.

A modification is proposed in subsection (g)(2) to delete redundant language regarding the 24-hour limit to report certain incidents.

A modification is proposed in subsection (g)(2)(A) to clarify which injuries must be reported within 24 hours.

A modification is proposed in (g)(2)(B) in response to comments that calling 911 is not an appropriate threshold for determining if an event is an urgent or emergent threat. The commenters noted that 911 may be called in response to minor events and at other times 911 is not called when there is a serious event if police are onsite at the facility. The language

concerning 911 is proposed to be replaced by defining an urgent or emergent threat as one that exposes hospital personnel to "a realistic possibility of death or serious physical harm."

A modification is proposed in subsection (g)(4)(F) to add the term "or other measures" to the list of protective measures to be reported by hospitals.

## Summary and Response to Written Comments Received during the First 15-Day Notice of Proposed Modifications:

Gail M. Blanchard-Saiger, Vice-President, Labor & Employment, California Hospital Association (CHA), written comments sent August 17, 2016.

Comment CHA#1:
Regarding subsection (a) – student health clinics and occupational health clinics are ancillary health care operations and should not be covered by the regulation. Health care services provided "*offsite*" in airports, schools, retail stores, etc. should not be covered by the regulation.

Response:
The Board has removed from the scope of the proposed regulation outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings. Student health clinics, worksite occupational health clinics, and offsite health care services provided at airports, schools, and retail stores would therefore not be covered by the regulation, as long as they are not within the license of a "health facility."

Comment CHA#2:
Regarding subsection (a)(1) and (a)(2) – it is unclear how the proposed regulation applies to third party employers who contract with covered employers. Many hospitals contract with staffing agencies to provide temporary staff. Are those agencies covered by the regulations because their staff work in a health facility and may provide direct patient care? Many hospitals contract with a third party to staff and manage the entire department of the hospital, such as dietary or housekeeping. Are those third-party employers covered by this regulation?

Response:
The responsibilities of employers in multi-employer worksites and dual-employer settings are set forth in Labor Code sections 6400 and 6401.7; California Code of Regulations, Title 8, sections 336.10 and 3203; and case law interpreting and applying these statutes and regulations. All employers are responsible for the safety and health of their employees regardless of the nature of the employment relationships. Please see also the response to Comment CHA#1 provided during the second 15-day comment period.

Comment CHA#3:
Regarding subsection (b) - adding outpatient services in correctional settings to the definition of outpatient medical clinics creates confusion in the scope of the regulations.

Response:
The Board has modified the proposed regulation to remove from the scope of the proposed regulation outpatient medical offices and clinics that are not within the license of a health facility and are not "outpatient medical services provided to the incarcerated in correctional and detention settings." Because of the high risk of violence in correctional settings, those settings are included in the scope.

Comment CHA#4:
Regarding subsection (b) and patient specific risk factors - symptoms of psychiatric illness, rather than a diagnosis, confer risk of violent behavior. A patient shouldn't be labelled as potentially violent due to a diagnosis of mental illness because it creates a stigma. Patient risk factors should be patient specific and not by categories of diagnosis. CHA requests to remove "*diagnosis*" from definition of patient specific risk factors.

Response:
The Board notes that certain specific diagnostic categories are associated with increased risk of violent behavior and finds that the suggested change is not necessary. In addition, a condition or diagnosis associated with an increased risk of workplace violence is only one of several factors to be considered.

Comment CHA#5:
Regarding subsection (c)(3) - CHA requests confirmation that the training obligation of hospitals is limited to direct employees of the hospital or where a joint employment relationship exists with the hospital and that the hospital is not responsible for the training of employees of other employers on the premises.

Response:
The responsibilities of employers in multi-employer worksites and dual-employer situations are set forth in Labor Code sections 6400 and 6401.7; California Code of Regulations, Title 8, sections 336.10 and 3203; and case law interpreting and applying these statutes and regulations. All employers are responsible for the safety and health of their employees regardless of the nature of the employment relationships.

A hospital will not necessarily be required to provide training directly to an employee who is also employed by another employer, as long as effective training is provided by either the hospital or the other employer. The Division intends to provide further guidance to hospitals on methods to comply with the training requirements of the proposed regulation after it is adopted.

Comment CHA#6:
Regarding subsection (c)(4) – some law enforcement agencies have declined to work cooperatively with hospitals and don't always respond. Requiring effective procedures to obtain assistance from law enforcement is thus unrealistic if they aren't willing to participate. The regulatory language should say "*contact*" law enforcement rather than "*obtain assistance from law enforcement."*

Response:
The Board finds that no change in the regulatory language is necessary. Procedures for obtaining assistance from the appropriate law enforcement agency must be "effective" only to the extent possible. Hospitals will not be held responsible for failures by law enforcement to respond to requests for assistance.

Comment CHA#7:
Regarding subsections (f)(1)(C) and (f)(2) – the regulation should allow responses to questions that arise during training to be responded to within 1 business day rather than 24 hours.

Response:
The Board agrees and has changed the requirements to respond within one business day rather than 24 hours, to questions that arise during training not given in person.

Comment CHA#8:
Regarding subsection (g)(1)(A) – hospital employers should not have to report work place violence incidents affecting employees who are not employees of the hospital or employed through joint employment.

Response:
Please see the response to Comment CHA#2. The Board declines to incorporate this recommendation. The reporting must include any affected employee working in a hospital.

Comment CHA#9:
Regarding subsection (g)(2) – the subsection uses the word "*include*" which indicates that there may be other types of incidents that must be reported within 24 hours. If this is not the case, then the word "*include*" should be deleted.

Response:
The Board agrees that the word "*include*" in subsection (g)(2) created confusion and has deleted the phrase, "*incidents that must be reported within 24 hours include*," to clarify that no other types of incidents, except those specifically mentioned in subsection (g)(2) must be reported within 24 hours.

Comment CHA#10:
Regarding subsection (g)(1)(A) –what qualifies as an injury for reporting purposes? CHA requests that injury for reporting purposes be defined as a lost time injury or an injury requiring medical treatment beyond first aid as defined in LC 5401(a).

Response:
The Board agrees that criteria for what qualifies as an injury for reporting purposes should be clarified. The term injury, in subsection (g)(1)(A), is an injury that meets the criteria established in Title 8 section 14300.7(b)(1)(A) through 14300.7(b)(1)(F). The Board has added a note to subsection (g)(1)(A) to clarify the meaning of injury.

Comment CHA#11:
Regarding subsection (g)(2)(B) – the definition of urgent or emergent threat as used in the subsection is not appropriate. 911 can be used for minor incidents and at other times 911 is not called in major incidents if police are onsite. CHA recommends using "*an incident that poses an imminent danger of serious (or significant) bodily injury or death requiring immediate law enforcement intervention*" or "*where there is a realistic possibility that death or serious physical harm could result.*"

Response:
The Board agrees that the description of urgent or emergent threat in subsection (g)(2)(B) is not appropriate. The Board has changed the language to:

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

Comment CHA#12:
Regarding subsection (g)(4) – there are too many data elements and some are subjective. It may not be possible to gather all the necessary information in 24 hours.

Response:
The data elements are necessary for a useful analysis of workplace violence incidents in hospitals. It is not required that all data elements be reported within 24 hours if the data is not available at the time of the initial report. To comply with the reporting requirement, the employer need only provide known data during the initial report. The employer will be allowed to supplement the report later on as more information becomes available.

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Yvonne Choong, Vice-President, Center for Health Policy, California Medical Association (CMA), written comments sent August 16, 2016.

Comment CMA#1
Additional information is needed about how compliance will be assessed and the nature of the expected outcomes. If the intent is to develop workplace violence policies which result in zero workplace violence incidents of any kind, this is likely to be an unattainable objective for some health care settings.

Response:
Compliance will not be assessed based on the employer preventing all workplace violence incidents. The Board acknowledges that an effective workplace violence prevention program will not prevent all incidents. Instead, compliance will be assessed by determining whether the employer has implemented the requirements of the regulation, and employers will not be expected to implement infeasible or inapplicable control measures. The Division intends to provide further guidance to employers on methods to comply with the requirements of the proposed regulation after it is adopted.

Comment CMA#2:
CMA requests that staggered compliance dates apply to the violent incident log and recordkeeping requirements. This will ensure that all components of the workplace violence prevention plan are developed and implemented consistently and in accordance with the same timeline.

Response:
The Board declines to provide additional delays to implementation of the regulation. The Log and records of workplace violence hazard identification, evaluation, and corrections are needed prior to the other requirements that have a delayed implementation date. The Log and records provide valuable information needed to assist employers in developing their Plan.

Comment CMA#3:
The requirements of the regulation are not appropriate for physician offices.

Response:
The Board agrees and has deleted outpatient medical clinics, offices and field operations from the scope of the regulation (with the exception of outpatient services provided at detention and correctional settings). As a result, physician offices that are not within the license of a health facility are excluded from the regulation.

Comment CMA#4:
Regarding subsection (f)(3) – the training requirements for employees who respond to alarms is excessive. The training requirements include use of physical maneuvers, restraining techniques and use of medications. This level of training is not needed for employees who have responsibility for responding to alarms generally, but are not to engage violent persons. This would include office staff that calls law enforcement or security assistance in response to an alarm. Employers in an outpatient setting may specifically discourage these designated employees from physically engaging with individuals exhibiting violent behavior.

We recommend that requirements (E)-(I) be removed from subsection (f)(3) for individuals who are not expected to confront or control persons exhibiting violent behavior.

Response:
The Board finds that the recommended changes are not needed. Employees, whose only duty is to call for assistance, are not covered by subsection (f)(3). Subsection (f)(3) is applicable only to those employees who are assigned to confront or control violent or potentially violent persons.

Comment CMA#5:
Regarding subsection (h), recordkeeping – the regulation does not recognize exemptions in section 3203 for small employers. CMA requests to keep the small employer exceptions.

Response:
The Board notes that most small employers have been removed from the scope of the regulation due to the deletion of outpatient medical clinics, offices and field operations.

Subsection 3203(b)(2) Exception 1 allows employers with less than 10 employees to maintain a log of instructions provided to employees for each hazard unique to the employees' job assignment, rather than maintaining employee training records.

The proposed regulation requires initial training be provided to all exposed employees, annual training provided to employees with patient contact activities, and initial and annual training to employees who respond to violent incidents. Section 3203 does not specify training topics and does not require annual refresher training. Due to the different types of training and the increased frequency of training of the current proposal compared to section 3203, the Board believes it is easier for employers with less than 10 employees to maintain training records for employees rather than maintain logs of instructions given to employees. Therefore, the Board believes that the exception in subsection 3203(b)(2) does not provide any benefit to small employers and declines to include it in the current proposal. At the time the exception was written, training records were frequently kept as written documents. With current technology, most training records are stored digitally, eliminating the advantage of maintaining logs compared to maintaining individual training records.

The exception to subsection 3203(b)(1) permits employers with fewer than 10 employees to maintain records of inspections to identify and evaluate hazards only until the hazard is corrected. In the current proposal, records of inspections to identify and evaluate hazards are used during and of critical importance to the review of the workplace violence prevention plan required by subsection (e). Without records of inspections to identify and evaluate hazards, the employer will not be able to comply with subsection (e). The Board declines to include the exception similar the exception in subsection 3203(b)(1) in the current proposal as the records are necessary and there is little or no additional cost to keeping the records compared to disposing of the records.

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Matt Antonucci, Vice President Production Affairs and Safety, Contract Services Administration Trust Fund (CSATF) and Melissa Patack, Vice President and Senior Counsel, Motion Picture Association of America, Inc. (MPAA), written comments sent August 17, 2016.

Comment CASTF/MPAA#1:
The definition of field operations should be revised to include only services beyond first aid. As currently written, it may include first-aid providers at community events, street fairs, and run/walk events. Field operations as currently defined may also include medics at television/movie production sets. These medics only provide basic first-aid, non-clinical assessment and stabilization of individuals until emergency assistance arrives.

Response:
The Board agrees and has removed field operations, as well as ancillary health care operations, from the scope of the proposed regulation. As a result, first aid providers at community events, street fairs, and run/walk events are excluded from the regulation. Medics at television/movie production sets are also excluded from the proposed regulation.

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Elizabeth Treanor, Director, Phylmar Regulatory Roundtable – OSH Forum, written comments sent August 16, 2016.

Comment Phylmar#1:
Regarding subsection (a), we agree that ancillary health care operations and occupational health clinics should not be included in scope of the regulation.

Response:
The Board has also removed from the scope of the proposed regulation outpatient medical offices and clinics that are not within the license of a "health facility" and are not outpatient medical services provided to the incarcerated in correctional and detention settings. Thus, an occupational health clinic would not be covered by the regulation, as long as the clinic is not within the license of a "health facility."

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Daniel Gugala, General Counsel, Crisis Prevention Institute (CPI), written comment sent August 17, 2016.

NOTE: The commenter sent a letter supporting the modifications made for the first 15-day comment period.

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Lisa Hall, Director of Regulatory Affairs, California Association of Healthcare Facilities (CAHF), written comment sent August 17, 2016.

Comment CAHF#1:
We support the comments from CHA.

Response:
Please see the responses to the comments from CHA.

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Susan Weinstein, RN, Executive Director, Service Employees International Union (SEIU) 121RN, Ingela Dahlgren, RN, Executive Director, SEIU Nurse Alliance of California, Kimberly Rosenberger, Legislative Analyst, SEIU California, and Mark Catlin, Occupational Health and Safety Director SEIU, Washington, DC – written comments sent August 17, 2016.

Comment SEIU#1:
Regarding subsection (f)(1)(C) – training should be given in person as trainees must participate in the training for it to be effective. The changes which allow for remote training are unacceptable. Active participation and interaction provide for the best learning. It is of utmost importance for workers to be able to ask questions in real time in order to better understand the issues. It is not useful to wait 24 hours for a response to a question.

Response:
The proposed regulation requires employers to train large numbers of employees with widely varying risks of exposure to workplace violence, and the costs of in-person training are much higher than training not given in person. Yet computer-based or web-based training, for example, can be effective, and the proposed regulation still requires employers to provide effective training. Therefore, the Board will not propose that employers be required to give all training in person.

Comment SEIU#2:
Regarding subsection (d), violent incident log - direct employee participation was removed from the violent incident log. It is impossible to identify an incident with only the information currently required in the log. It is important to get the employee's description of the incident in the employee's own words. We oppose elimination of any direct participation by the involved employee in completing the violent incident log. We oppose the elimination of the identity of the injured/involved employee.

Response:
During the 45-day comment period, SEIU recognized the importance of maintaining employee and patient confidentiality in the violent incident log. The Board agrees and is thus proposing that that employee and patient identities be protected. Direct employee participation is not included in the proposed regulation as the Board is not authorized to require employees to implement regulatory requirements. Instead, the proposed regulation requires employers to solicit information from employees who experienced workplace violence and describe the incidents based on information provided by those employees.

Comment SEIU#3:
Regarding subsection (b) - the definition of workplace violence should include verbal, physical or sexual intimidation that can convey intent to cause harm. We request that the workplace violence definition include: "*a statement or conduct – for example, harassment and intimidation (either verbal or physical), or other threatening disruptive behavior - that causes a person to fear for his or her safety and that serves no legitimate purpose."*

Response:
Please see the responses to Comments KH#4 and KH#5 submitted during the 45-day comment period.

Comment SEIU#4:
Regarding subsection (a) – the implementation dates of the regulation should not be delayed.

Response:
The delay is needed to ensure that employers are able to come into full compliance with the regulation. As a result, the Board declines to change the delayed implementation dates.

Comment SEIU#5:
Regarding subsection (e) – the proposed language does not include employee representatives in the annual review of the workplace violence prevention plan.

Response:
The Board agrees employee representative participation in the review of the workplace violence prevention program is required by subsection (c)(2). The Board has added employee representative participation in subsection (e) for clarity and consistency.

Comment SEIU#6:
Regarding subsection (a) – removal of ancillary health care operations will result in nurses in a box and school nurses being included in the regulation as outpatient clinics.

Response:
It was not the intention of the Board to include nurses in a box and school nurses in the scope of the regulation. To ensure they are not included, outpatient medical offices and clinics as well as field operations have been deleted from the scope of the regulation.

Comment SEIU#7:
Regarding subsection (f), training - the phrase "*activities that each employee is reasonably anticipated to perform under the plan*" should not have been removed. Employees need to know what actions they'll be expected to perform.

Response:
The Board determined that the phrase was unnecessary, because employee activities under the Plan are already embedded in the lists of training topics in subsection (f).

Comment SEIU#8:
Regarding subsection (c)(4) – employers should not take punitive or retaliatory actions against employees who call law enforcement even if there is a central coordination procedure in place.

Response:
The proposal prohibits employers from retaliating or taking punitive action against employees who call law enforcement as a result of a workplace violence incident. The requirement applies regardless of whether there is a central coordination procedure.

Comment SEIU#9:
Regarding subsection (c)(11) – employers should be required to correct all hazards; not just hazards that may cause a serious injury.

Response:
Subsection (c)(11) does require employers to correct all workplace violence hazards and to do so in a timely manner, with serious hazards to be corrected within seven days.

Donald W. Nielsen, Director, Government Relations, California Nurses Association/National Nurses United (CNA), written comments sent August 17, 2016.

NOTE: The commenter sent a letter supporting the proposal in many areas. Specific recommendations made by the commenter are discussed below.

Comment CNA#1:
Regarding subsection (c)(2) – CNA requests the following change to subsection (c)(2) [in underline format] because it is important to involve all security personnel in the workplace violence prevention plan.

> (c)(2) Effective procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing the Plan, including their participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating workplace violence incidents. To the extent it is feasible within existing contracts and duty statements, this process shall also include the involvement of security personnel who provide security services to the employer.

Response:
The Board has determined that no change is needed because security personnel who are employees of a hospital are already required to be included in the Plan pursuant to subsection (c)(2). This includes employees directly employed by the hospital as well as employees who are not direct employees of the hospital, but are considered employees of the hospital in a multi-employer or dual-employer setting, under Labor Code sections 6400 and 6401.7; California Code of Regulations, Title 8, sections 336.10 and 3203; and case law interpreting and applying these statutes and regulations.

Comment CNA#2:
Regarding subsection (c)(4) - employers should not be allowed to take punitive or retaliatory actions against employees who call law enforcement even if there is a central coordination procedure in place.

Response:
Please see the response to Comment SEIU#8.

Comment CNA#3:
Regarding subsection (c)(8) – removal of language in the modified text that employees and their representatives are allowed to deliver training was not necessary since it is permissive language and does not mandate employees and their representatives to deliver training.

Response:
Employees and their representatives may still deliver training even with the permissive language deleted. The intent of the Board is to leave the matter to individual employers and their employees and not address it in the regulation. As a result, the Board finds that no further change is needed.

Comment CNA#4:
Regarding subsection (f)(1)(C) and (f)(2) – CNA believes training should be given in person. Allowing remote training will severely undermine the strength and effectiveness of the training and conflicts with the requirements of Senate Bill 1299 subsection (b)(3)(A). The intent of Senate Bill 1299 was to require in person training.

Response:
Please see the response to Comment SEIU#1.

Comment CNA#5:
Regarding subsection (g)(4)(F) - CNA recommends the following change to clarify that changes made to address workplace violence are not limited to engineering controls and work practices.

> Whether there is a continuing threat, and if so, what measures are being taken to protect employees by engineering control modifications, ~~or~~ work practice modifications, or other effective measures.

Response:
The Board agrees that there may be other methods to reduce workplace violence risks in addition to engineering controls and work practices and has changed subsection (g)(4)(F) to the following:

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

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Eric Robles, Political and Legislative Director, United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP), written comment sent August 19, 2016.

Comment UNAC/UHCP#1:
Regarding subsection (f)(1)(C) – the modifications allow training to be done remotely and not in person. This diminishes the value and reduces the effectiveness of the training.

Response:
Please see the response to Comment SEIU#1.

Comment UNAC/UHCP#2:
Regarding subsection (d) – more specificity is needed in the workplace violence log.

Response:
The Log requires many specifics of a workplace violence incident to be recorded such as:

- The date, time, specific location, and department of the incident,
- A detailed description of the incident
- A classification of who committed the violence

- A classification of circumstances at the time of the incident
- A classification of where the incident occurred
- The type of violence
- Consequences of the incident
- Actions taken to protect employees from a continuing threat

The Board does not believe any further specificity is required in the violent incident log.

Comment UNAC/UHCP#3:
Regarding subsection (b) – the definition of workplace violence is unnecessarily narrow.

Response:
Please see the responses to Comments KH#4 and KH#5 submitted during the 45-day comment period.

Comment UNAC/UHCP #4:
The implementation dates should not be delayed.

Response:
Please see the response to Comment SEIU#4.

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Nicole Marquez, Staff Attorney, Worksafe, written comments sent August 17, 2016.

NOTE: The commenter sent a letter mirroring comments made by Susan Weinstein, RN, Executive Director, Service Employees International Union (SEIU) 121RN, Ingela Dahlgren, RN, Executive Director, SEIU Nurse Alliance of California, Kimberly Rosenberger, Legislative Analyst, SEIU California, and Mark Catlin, Occupational Health and Safety Director SEIU, Washington, DC. Please see the responses to their comments.

## MODIFICATIONS AND RESPONSE TO COMMENTS RESULTING FROM THE SECOND 15-DAY NOTICE OF PROPOSED MODIFICATIONS (August 26, 2016 – September 12, 2016)

No further modifications are proposed as a result of the second 15-Day public comment period from August 26, 2016, to September 12, 2016.

## Summary and Response to Written Comments Resulting from the Second 15-Day Notice Of Proposed Modifications:

Gail M. Blanchard-Saiger, Vice-President, Labor & Employment, California Hospital Association (CHA), written comments sent September 12, 2016.

Comment CHA#1:
As currently written, the hospital employer is required to ensure that all employees of other employers who work in the same health care facility, service or operation are provided training and understand their respective roles as provided in the Plan. Hospitals have a range of "employees of other employers" on their premises, including contracted staff who are present every day, medical device manufacturer technicians who may be on the premises once per month for a specialized procedure, individuals who periodically service equipment in the cafeteria, construction workers repairing or renovating facilities and physicians (who are generally not employed by the hospital) treating patients.

CHA believes the training obligation should be limited to situations where a joint employment relationship exists and not to all employees of other employers who happen to be performing work on the premises. We believe this is consistent with the obligation set forth in Labor Code section 6400, requiring an employer to provide a safe work environment for all employees on the premises. This obligation is met by adopting a workplace violence prevention plan, assessing and correcting hazards, and reviewing and updating the Plan annually. While employee training is a component of the Plan and an important aspect of prevention, it does not follow that it is necessary to ensure that all individuals who happen to be performing work on-site must be trained. One hospital reported that it is involved in a project that could involve 4,000-12,000 contingent workers. The training obligation would be staggering if the hospital had to train all of these individuals regardless of the number of hours they spent at the hospital or their role.

Response:
The responsibilities of employers in multi-employer and dual-employer settings are set forth in Labor Code sections 6400 and 6401.7; California Code of Regulations, Title 8, sections 336.10 and 3203; and case law interpreting and applying these statutes and regulations. All employers are responsible for the safety and health of their employees regardless of the nature of the employment relationships.

Applying the training requirements only to direct employees of the hospital or where a joint employment relationship exists is not consistent with Labor Code 6400. A hospital employer is considered a controlling employer responsible for safety and health conditions at the hospital and must ensure that all employees at the hospital receive the proper training.

A hospital will not necessarily be required to provide training directly to an employee who is also employed by another employer, as long as effective training is provided by either the hospital or the other employer. The Division intends to provide further guidance to hospitals on methods to comply with the training requirements of the proposed regulation after it is adopted.

Comment CHA#2:
CHA remains concerned that the definition of "patient specific risk factors" in subsection (b) is ambiguous. As noted in our earlier communications, scientific literature is unclear on how to predict whether a patient may be at increased risk for violence. We request that the definition be clarified, consistent with subsection (c)(10), that "patient specific risk factors" are just that — "patient specific" — and that patients are evaluated by their behavior combined with the other listed factors.

Response:
The Board notes that certain specific diagnostic categories are associated with increased risk of violent behavior and finds that the suggested change is not necessary. In addition, a condition or diagnosis associated with an increased risk of workplace violence is only one of several factors to be considered.

Comment CHA#3:
Given there remains much work to be done to operationalize the reporting system and the current version of the proposed regulations gives employers one year to comply with the substantive aspects of the regulation, a delayed compliance date for the recording and reporting obligation seems to logically follow. Requiring hospitals to record and report incidents before a Plan is in place, assessments conducted, corrective action taken and training provided does not seem appropriate or constructive.

Response:
The Board declines to provide additional delays to implementation of the regulation. The violent incident log and records of workplace violence hazard identification, evaluation, and corrections are needed prior to the other requirements that have a delayed implementation date. The Log and records provide valuable information needed to assist employers in developing their workplace violence prevention plan.

Labor Code section 6401.8(c) requires the Division to begin posting reports regarding violent incidents at hospitals by January 1, 2017. The Board is therefore unable to delay the hospital reporting requirements.

Comment CHA#4:
CHA seeks clarification on the Note to subsection (g)(1)(B), which states "*these reports do not relieve the employer of the requirements of Section 342 to immediately report a serious injury, illness, or death to the nearest Division district office.*" However, section 342 exempts reporting injuries or illnesses caused by the commission of a Penal Code violation. Any workplace violence incident that causes serious injury or death would necessarily be a violation of the Penal Code (assault, battery, murder, manslaughter, etc.). Therefore, it appears that Section 342 would not apply to workplace violence incidents. The Note to subsection (g)(1)(B) should be deleted.

Response:
Many, but not all, workplace violence incidents are the result of a penal code violation. Patients may suffer from medical conditions, such that violent incidents they commit may not be considered a penal code violation. Such cases would need to be reported to a Division district office pursuant to section 342. In cases where there is a penal code violation, the employer is not required to report the injury to a Division district office pursuant to section 342, but must still report the injury online to the Division in accordance with the current proposed regulation.

Comment CHA#5:
The last sentence in subsection (h)(3), which reads, "*These records shall not contain 'medical information' as defined by Civil Code Section 56.05(j)*" is not appropriate given the current

requirements. This sentence should be deleted. The current version properly requires employers to omit personally identifying information from the Log, but employers are required by the regulation to include whether the employee was, for example, "raped" – which is medical information.

Response:
Civil Code 56.05(j) defines medical information as the following:

> "Medical information" means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

The proposed regulation prohibits personal identifying information from being included in the violent incident log. Any information that does not contain personal identifying information is not medical information pursuant to Civil Code 56.05(j). As a result, the information on the Log will not be medical information and the Board finds no reason to delete the phrase, "*These records shall not contain 'medical information' as defined by Civil Code Section 56.05(j),*" from subsection (h)(3).

Comment CHA#6:
The proposed change in scope will result in similar workplaces being treated differently simply by virtue of how the workplace is licensed. Specifically, many hospitals operate off-site clinics under their hospital license. These clinics are similar to other unlicensed clinics that provide primary care services, urgent care, rehabilitation therapy, etc. While the unlicensed clinic falls outside the scope of the regulation, the clinic that happens to fall under the hospital license would be covered. Of note, an individual hospital may operate some clinics that fall under its license and others that don't. There is no justification for treating clinics that pose similar levels of safety risk due to geography, services and patient population differently merely by virtue of whether the service is connected to a hospital license or not.

Hospitals may offer hospital licensed services off-campus in a commercial location or medical office building. In some cases, hospitals have multiple clinics where both licensed and unlicensed space operate within the same suite. Some of the employees are hospital employees, some are medical network employees and some are affiliated medical group employees. In some cases, hospital services are located in a medical building with other medical clinics that could be licensed by another hospital. In some clinics there are hospital licensed services such as pharmacy, lab and imaging, but the rest of the clinic is non-hospital staff.

For example, many hospitals offer pharmacy services in an off-campus medical office building that is leased to various entities, including physician offices and stand-alone clinical services. As

a result of the recent change, the pharmacy operation could be covered by the regulation, but the remainder of the medical office building — which likely includes some clinics or other independent health care services — would not.

One potential solution to these problems is to modify the definition of "general acute care hospital" to mean a hospital licensed by the California Department of Public Health, meeting the definition provided in Health and Safety Code Section 1250(a) or California Code of Regulations, Title 22, Section 70005 and all services within the hospital license *provided on the hospital campus*.

Response:
Labor Code section 6401.8(b)(1) requires hospitals' workplace violence prevention plans to include "*inpatient and outpatient settings and clinics on the hospital's license.*" Therefore, the Board cannot exclude outpatient clinics and offices on the hospital's license from the proposed regulation.

The Board acknowledges that requiring outpatient medical offices and clinics that are on the license of a health facility to comply with the regulation while not requiring similar offices and clinics to comply with the regulation may appear arbitrary. The Board, however, is proposing to exclude outpatient offices and clinics not on the license of a health facility because those offices and clinics include lower-risk operations that the Board did not intend to regulate, such as school nurse offices, first aid stations at public events, first aid clinics at amusement parks, on-site workplace clinics, and retail clinics. Because the Board may be excluding particular categories of offices and clinics that should be included in the regulation, the Board may initiate follow-up rulemaking in the future to include those offices and clinics.

Comment CHA#7:
Other situations call into question the reasonableness of the current scope. Hospitals may lease space to an entity on the hospital campus where health care services are provided. In these cases, the employer is not the acute care hospital, and the employer is not otherwise covered by the regulation. Thus, the building where those health care services are located is not covered by the regulation, but the remainder of services provided on the hospital campus by the acute care hospital are covered. Again, distinguishing scope and application simply by virtue of the hospital license and ignoring the fact that similar risks may be presented because operations are close in proximity and serve similar populations seems illogical and is likely to cause significant confusion and disparity.

Response:
A separate entity leasing space within a hospital campus to administer health care services would be covered by the regulation, regardless of whether the entity is part of the hospital's license. In subsection (b) of the proposed regulation, the definition of "health facility" states, in part, "… *a health facility includes hospital based outpatient clinics (HBOCs) and other operations located at a health facility…."* Inclusion of the phrase, "*other operations located at a health facility,*" means that leased portions of a health facility are also covered by the regulation.

Comment CHA#8:
The definition of "workplace violence" should be revised slightly for clarity and consistency. The underlined words below should be added to maintain consistency with the shaded words, which are already included in the regulation:

(A) The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
(B) An incident involving the threat or use of a firearm or other dangerous weapon against an employee, including the use of common objects as weapons, regardless of whether the employee sustains an injury;
(C) Four workplace violence types:
(1) "Type 1 violence" means workplace violence directed at employees committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
(2) "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.
(3) "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.
(4) "Type 4 violence" means workplace violence against an employee committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee

Response:
The Board does not believe the changes are necessary as the definition of workplace violence, subsection (A), is clear that the threat or use of physical force is against an employee. This concept does not need to be repeated in other portions of the definition.

Comment CHA#9:
CHA appreciates that "injury" is defined for purposes of the reporting obligation in subsection (g)(1). For clarity and consistency, we believe it is appropriate to apply that definition to all aspects of the regulation, not just the reporting section. As such, we request that the limited definition be removed from subsection (g) and be added to the definitions in subsection (b).

Response:
"Injury" is defined in subsection (g)(1) only for purposes of the reporting obligation in that subsection. "Injury" is defined differently in subsection (g)(2) for purposes of the 24-hour obligation. Neither definition is intended to be used as criteria for establishing a plan to prevent workplace violence. The Board thus declines to make the requested change.

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Yvonne Choong, Vice-President, Center for Health Policy, California Medical Association (CMA), written comments sent August 29, 2016.

NOTE: The commenter sent a letter supporting the modifications made for the first 15-day comment period.

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Braden Oparowski, Director of Policy, Advocacy and Public Affairs, California Association for Health Services at Home (CAHSAH), written comments sent September 9, 2016.

Comment CAHSAH#1:
Subsection (e) requires an annual review of the Workplace Violence Prevention Plan. Please reduce the training requirements to every two years instead of every year.

Response:
The Board declines to reduce the training requirement. Employers will be required to review the effectiveness of their workplace violence prevention plan at least annually and correct problems found during each review. Annual training is necessary to keep employees up-to-date on the results of the reviews and on changes made to the employer's program based on the reviews.

Comment CAHSAH#2:
Clarify what "change of condition" means on Page 7, subsection (c)(9)(B). It appears that the regulations are attempting to say that whenever there is a change in the client's home environment the employee must re-evaluate the home for potential risks; but it is not clear. Please clarify if this refers to changes in the patient's disease process, changes in the home or other changes.

Response:
Subsection (c)(9)(B) states the following:

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

"*Change in conditions*" refers to changes in environmental risk factors, such as changes in the home that may affect an employee's risk of being exposed to workplace violence.

Comment CAHSAH#3:
CAHSAH is very concerned that individual owners or managing staff could be held directly responsible for an employee's stress on a claim if an employee perceived their health was at risk by some unknown behavior that was not demonstrated or which resulted in a non-injury to the employee. Can the regulations address this type of situation?

Response:

The Division will assess an employer's compliance with the proposed regulation by determining whether the employer has implemented the requirements of the regulation. An employee claiming stress, by itself, will not provide a basis for finding any violations.

Regarding potential liability of individuals, the requirements in the proposed regulation apply to employers, not individual owners or managers, and the proposed regulation does not impose any additional liability outside of actions taken by the Division to require employers to comply with the regulation.

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Susan Weinstein, RN, Executive Director, Service Employees International Union (SEIU) 121RN, Ingela Dahlgren, RN, Executive Director, SEIU Nurse Alliance of California, Kimberly Rosenberger, Legislative Analyst, SEIU California, and Mark Catlin, Occupational Health and Safety Director , SEIU Washington, DC – written comments sent September 12, 2016.

Comment SEIU#1:
SEIU disagrees that the previous version of the proposed regulation included workplaces for which there was insufficient evidence of workplace violence compared to other workplaces. Based on this misguided assumption, subsections (a)(1)(B) and (E) have been deleted. Numerous workers from these out-patient settings testified and shared their personal experiences of actual violence or threats of violence at hearings and advisory meetings. The WCIS data provided in the review of the original petition shows numerous instances of violence in these workplaces that have now been deleted from the scope of the regulation. They do not appear to experience the same level of violence as in the hospital setting, but there is no accurate way to determine the magnitude of violence from this data and when we combine the number of incidents across these workplaces the numbers are not insignificant. The data raises the important question of how do we quantify the levels of workplace violence a worker in an out-patient clinic operating under its own CDPH license experiences, and the more important moral question of whether their safety is equally important as that of other workers?

SEIU is very concerned that much of our public health system, in particular, our health care workers dedicated to providing care to our underserved communities are no longer covered. Workers like the victims of the tragedy in San Bernardino will no longer be covered.

Response:
The Board is proposing to exclude outpatient offices and clinics not on the license of a health facility because those offices and clinics include lower-risk operations that the Board did not intend to regulate, such as school nurse offices, first aid stations at public events, first aid clinics at amusement parks, on-site workplace clinics, and retail clinics. However, because the Board may be excluding particular categories of offices and clinics that should be included in the regulation, the Board may initiate follow-up rulemaking in the future to include those offices and clinics.

Comment SEIU#2:
Underreporting of workplace violence incidents is worse in clinics and outpatient workplaces than in other settings.

Response:
Underreporting of workplace violence incidents is a problem in all sectors of health care. The Board does not have data showing it is worse in outpatient clinics than in other settings.

Comment SEIU#3:
SEIU disputes the cost calculations estimating the potential cost could exceed $50 million dollars, thus categorizing this proposed regulation a "major" regulation, because the affected employers should already have an IIPP in place and they would not be required to develop a separate plan for workplace violence prevention. Employers would not need to develop a new Plan or training; in addition, they wouldn't have to completely revamp their current Plan.

Response:
The proposed regulation contains important requirements not contained in the IIPP regulation: developing, implementing, and reviewing the employer's workplace violence prevention plan with the active involvement of employees and their representatives; creating and maintaining a violent incident log; providing training to large numbers of employees on specific topics; and, for hospitals, reporting incidents of workplace violence to the Division. Many employers will need to expand their IIPP to meet the requirements of the proposed regulation. Please see the final statement of reasons for details on the estimated costs and benefits of the proposed regulation.

Comment SEIU#4:
SEIU disagrees with CDCR's assertion that it would cost "tens of millions" of dollars if this proposed regulation applied to them. They are using this overinflated cost estimate to excuse their failure to protect workers. The policies they currently have in place do not adequately protect their health care workers. We have all heard the horrifying stories of violence from workers who provide health care at CDCR.

Response:
The Board does not have sufficient data to refute the Department of Corrections' costs estimates. CDCR has committed to collaborating with the Division to ensure that its workplace violence prevention program is as effective as the requirements in the proposed regulation.

Comment SEIU#5:
Subsection (f) Training: It was bad enough that training, especially initial training will not be given in person and that questions may be answered within 24 hours, but now the employers will be given a whole business day to respond. These changes lead us to conclude that employers have no intention of providing in-person trainings with interactive questions and answers with a person knowledgeable about the employer's workplace violence prevention plan as stated in the regulation. We cannot imagine how these employers are going to provide effective training, developed with the active involvement of employees and their representatives and address the

hazards of workplace violence identified in the facility, unit, service or operation as specified in their Plan.

Response:
The Board changed the response time to questions from "*within 24 hours*" to "*within one business day*" because training may be provided prior to a non-business day. As a result, a knowledgeable employer representative may not be available to answer questions within 24 hours.

Also, the Board notes that in subsection (f)(3)(I), for employees who are assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior, the employer must provide the employees with an opportunity to practice the maneuvers and techniques included in the training with other employees they will work with, including a meeting to debrief the practice session. This training must be in-person.

Donald W. Nielsen, Director, Government Relations, California Nurses Association/National Nurses United (CNA), written comments sent September 12, 2016.

Comment CNA#1:
In subsection (a)(l), the Board has opted to eliminate two substantial categories from coverage: (B), *"Outpatient medical offices and clinics,"* and (E), *"Field operations such as mobile clinics and dispensing operations, medical outreach services, and other off-site operations."* The justification offered by the Board is that these categories are "overly broad and include many workplaces where there is insufficient evidence of workplace violence comparable to other workplaces included in the regulation." While it is possible that some of the settings encompassed by those categories, such as small physician offices, do in fact experience less workplace violence overall, the Board has also eliminated settings that are prone to high rates of violence, such as public health clinics. We are disappointed that the Board chose to make such a sweeping change to the scope of the regulations rather than carving out the specific areas which may be less urgently in need of coverage. CNA firmly believes that *all* health care workers, regardless of their specific employment setting, deserve protection against workplace violence incidents.

Response:
Please see the response to Comment CHA#6. Public health clinics may be added to the regulation in future rulemaking.

Comment CNA#2:
Given that the Board specifically acknowledged the high incidence of workplace violence in correctional and detention settings, CNA finds it unfortunate that the Board would simultaneously choose to exclude facilities operated by the CDCR from coverage under these regulations. In its reasoning, the Board includes a caveat that "CDCR will collaborate with DOSH to ensure that its existing workplace violence prevention program is as effective as the requirements in the proposed regulation." CNA remains concerned that these facilities, with their

heightened risk of workplace violence, will nevertheless be held to a lower standard of protection.

Response:
Please see the response to Comment SEIU#4. The Board believes that CDCR will employees will be given the same level of protection through collaboration with DOSH.

Comment CNA#3:
In this second round of modifications, the Board proposes to require that employers respond to employee questions regarding training within one business day instead of 24 hours. CNA is concerned with this as well as it potentially delays employer response time unnecessarily; e.g., employer response concerning an incident occurring on a Friday is now potentially delayed until the following Monday.

Response:
The requirement to respond to questions within one business day pertains to questions that arise during training, which is covered in subsection (f). It does not apply to post-incident responses and investigations, which are covered in renumbered subsection (c)(12). Please see also the response to Comment SEIU#5.

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Eric Robles, Political and Legislative Director, United Nurses Associations of California/Union of Health Care Professionals (UNAC/UHCP), written comments sent September 12, 2016.

Comment UNCA/UHCP#1:
The proposed modifications would strike "outpatient medical offices and clinics" from the list of facilities in section 3342(a) to which the regulation applies. UNAC/UHCP has worked with the Board and the other stakeholders to ensure that the regulation was adequate to provide the necessary workplace protections for all of its members. The proposed deletion of outpatient medical offices and clinics will deprive many of our members of the protection and security they deserve.

The asserted justification for deleting outpatient facilities and clinics is that "there is insufficient evidence of workplace violence comparable to other workplaces in the regulation." This is a shocking and offensive standard to employ. Exactly how much workplace violence is sufficient to warrant protection? Apparently the Board is content to have some undefined level of workplace violence occur in these facilities without the protection of the very regulation that could prevent it from occurring in the first place.

UNAC/UHCP strongly objects to the deletion of "outpatient medical offices and clinics" from the list of facilities in section 3342(a), and urges the Board to keep such facilities included within the scope of the regulation.

Response:
Please see the response to Comment SEIU#1.

Comment UNCA/UHCP#2:
The regulation is designed to *prevent* workplace violence from occurring. It is intended to be proactive. It is therefore illogical to demand that workplaces must have a certain frequency of workplace violence before they enjoy the protection of the regulation. Quite the opposite, the Board should make it its objective to prevent and eradicate workplace violence in as many settings as possible. Otherwise, the Board creates an irrational incentive to have more workplace violence so that employees can finally get the protection of the regulation.

Response:
The Board is required to show that a regulation is necessary and cannot include employers within the scope of a regulation without providing evidence establishing the necessity to do so. Workplace violence potentially exists in all workplaces throughout California. The current rulemaking addresses parts of the health care industry with the documented, high rates of workplace violence.

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Nicole Marquez, Staff Attorney, Worksafe, written comments sent September 12, 2016.

NOTE: The commenter sent a letter mirroring comments made by Susan Weinstein, RN, Executive Director, Service Employees International Union (SEIU) 121RN, Ingela Dahlgren, RN, Executive Director, SEIU Nurse Alliance of California, Kimberly Rosenberger, Legislative Analyst, SEIU California, and Mark Catlin, Occupational Health and Safety Director, SEIU Washington, DC. Please see the responses to their comments.

California RN, written comment emailed August 26, 2016.

Comment RN#1:
It is very important to include outpatient medical offices or departments in workplace violence. It is vital for RN safety.

Response:
Please see the response to SEIU#1.

Herbert J. Weiner, MSW Ph.D., written comment emailed August 26, 2016.

Comment HW#1:
Do these proposed changes include the protection of social work, marriage family therapist and psychology interns from colleges and universities in correctional settings from any form of physical harassment, including punches, slaps, kicks or other forms of violence? Would these students by protected by law, whether or not they were students from private or public institutions?

Response:
The proposal would cover interns from colleges and universities only to the extent that the interns are "employees," as defined in Labor Code section 6304.1. (The type of institution where the interns are students would not matter.) In correctional settings, the work performed by an

intern must be considered "outpatient medical services to the incarcerated," meaning the intern is participating in diagnosing, managing, or providing care for an incarcerated patient to combat the patient's disease or disorder.

Comment HW#2:
Could these proposed changes be extended to social work agencies to protect social workers from these forms of violence?

Response:
Please see the response to Comment CB#1 made during the 45 day comment period

Comment HW#3:
Violent incidents are preceded by bullying by superiors at the worksite. Shouldn't workers be protected against bullying by superiors or peers?

Response:
Please see the response to KH#4 and KH#5.

## ADDITIONAL DOCUMENTS RELIED UPON AND REPONSE TO COMMENTS

Pursuant to Government Code Section 11346.8(d), the Board gave notice of the opportunity to submit comments concerning additional documents relied upon. The additional documents were added to the rulemaking file on August 2, 2016, with modifications to the proposal and no comments on the documents were received during the 15-day comment period from August 2, 2016, to August 17, 2016.

- Franks, P., Kocher, N., and Chapman, S. January 2004. Emergency Medical Technicians and Paramedics in California. University of California, San Francisco, The Center for the Health Professions https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/9.1%20(Issue%20Brief)%202004-01_EMTs_and_Paramedics_in_California.pdf
- Kirkwood, S. May 2013. It's Time to Stop the Violence, NEMSMA launches initiative to address attacks on EMS providers. National EMS Management Association http://www.naemt.org/docs/default-source/Health-and-Safety-Documents/EMS_28_BestPractice0513.pdf
- Oliver, A. and R. Levine. 2015. Workplace Violence: A Survey of Nationally Registered Emergency Medical Services Professionals. Epidemiology Research International Vol. 2015. http://dx.doi.org/10.1155/2015/137246
- Taylor JA, Davis AL, Barnes B, Lacovara AV, Patel R. Injury risks of EMS responders: evidence from the National Fire Fighter Near-Miss Reporting System. BMJ Open. 2015;5. http://bmjopen.bmj.com/content/5/6/e007562.full.pdf+html
- California Health and Human Services Agency, Department of Developmental Services, Plan for the Closure of Sonoma Developmental Center, October 1, 2015: https://dds.ca.gov/sonomanews/docs/closurePlan10_01_15.pdf
- California Health and Human Services Agency, Department of Developmental Services, Plan for the Closure of Fairview Developmental Center and Porterville Developmental

Center General Treatment Area, April 1, 2016:
http://www.dds.ca.gov/fairviewNews/docs/FDC-PDC_ClosurePlan040112016.pdf

- The Future of State Developmental Centers, 2015 May Revision:
http://www.dds.ca.gov/Budget/Docs/DCClosures-2015MayRevision.pdf

Pursuant to Government Code sections 11346.8(d), 11346.9(a)(1), and 11347.1, the Board gave notice of the opportunity to submit comments concerning additional documents relied upon. The additional documents were added to the rulemaking file on September 27, 2016. Comments on the documents were received during the 15-day comment period from September 27, 2016, to October 12, 2016.

1. Data on the number of employees in the California Department of State Hospitals: http://www.dsh.ca.gov/About_Us/default.aspx
2. Data on the number and type of health facilities in state government, local government and the private sector licensed by the California Department of Public Health: https://chhs.data.ca.gov/Facilities-and-Services/Department-of-Health-Care-Services-DHCS-Licensed-R/rzbp-crfv and https://chhs.data.ca.gov/Facilities-and-Services/Healthcare-Facility-Locations/ir29-xyw6#column-menu
3. Data on the number of California state entities and local government entities which provide emergency medical services or patient transport services: http://www.cpf.org/go/cpf/?LinkServID=86C34E47-1CC4-C201-3E156C299B32F183
4. Data on the number of employees in various health care sectors in state government, local government and the private sector in California: http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=621600, http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=621900, http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=622100, http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=622200, http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=623100, http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=623200
5. Data on the number of local government and private sector employers which provide emergency medical services or patient transport services in California: http://www.the-caa.org/docs/Calif-EMS-Safety-Net.pdf
6. Data on the number of local government correctional facilities in California: http://www.ppic.org/main/publication_show.asp?i=1061
7. Data on the number of private sector correctional facilities in California: http://www.cca.com/locations?state=CA#filters and http://www.geogroup.com/locations
8. Data on the rate of lost day work injuries due to workplace violence in health care

in California:
http://www.dir.ca.gov/OPRL/Injuries/Demographics/2014/PrivateIndustry/2014Table18-PrivateIndustry.pdf

9. Data on employment numbers in the category of health care practitioners/technical operations in California: http://www.bls.gov/oes/current/oes290000.htm
10. Data on the employment numbers in the category of health care support in California: http://www.bls.gov/oes/current/oes310000.htm .
11. Data on the cost of injuries from workplace violence in healthcare: https://www.osha.gov/Publications/OSHA3826.pdf
12. Data on the indirect costs of workplace injuries: https://www.osha.gov/SLTC/etools/safetyhealth/mod1_costs.html
13. Criteria for determining small business: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=11342.610
14. Department Of Health And Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health. NIOSH Hazard Review, Occupational Hazards in Home Healthcare, Publication No. 2010–125, January 2010 https://www.cdc.gov/niosh/docs/2010-125/pdfs/2010-125.pdf
15. Bureau of Labor Statistics. Table R-4. Number of nonfatal occupational injuries and illnesses involving days away from work by industry and selected events or exposures leading to injury or illness, 2006. Washington, DC: U.S. Department of Labor, Bureau of Labor Statistics www.bls.gov/iif/oshwc/osh/case/ostb1796.txt
16. G. C. Hanson, N.A. Perrin, H. Moss, N. Laharnar, and N. Glass. Workplace violence against homecare workers and its relationship with workers health outcomes: a cross-sectional study, BMC Public Health, vol. 15, no. 11 (2015): 1-13 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4308913/
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18. United States Government Accountability Office. Workplace Safety And Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence, Report to Congressional Requesters (GAO-16-11). March 2016 http://www.gao.gov/assets/680/675858.pdf
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Copies of these documents are available for review Monday through Friday, from 8:00 a.m. to 4:30 p.m., at the Standards Board's office at 2520 Venture Oaks Way, Suite 350, Sacramento, California 95833.

**Summary of Comments and Response Received During The 15-Day Comment Period from September 27, 2016, To October 12, 2016 for Additional Documents Relied Upon**.

Susan Weinstein, RN, Executive Director, Service Employees International Union (SEIU) 121RN; Ingela Dahlgren, RN, Executive Director, SEIU Nurse Alliance of California; Kimberly Rosenberger, Legislative Analyst, SEIU California; and Mark Catlin, Occupational Health and Safety Director , SEIU Washington, DC – written comments sent on October 12, 2016.

Comment SEIU #4.1:
We are unsure how these 19 documents support the deletion of (B) Outpatient medical offices and clinics and (E) Field operations from (a) Scope and application of the proposed regulation when they were included in the initial statement of reasons (ISOR).

Response:
The additional documents relied upon were not used to support the deletion of outpatient medical offices and clinics and field offices from the scope of the regulation. The documents were used to help determine the economic impact of the revised regulation after the outpatient medical offices and clinics and field operations were deleted from the scope.

Comment SEIU #4.2:
We are also unsure how the numbers of employees in these industries and the supposed cost of including them in the proposed regulation exceed the fifty million dollar cost threshold based on these documents.

Response:
The cost of the proposed regulation is discussed in the Final Statement of Reasons. The anticipated cost of the revised regulation is less than 50 million dollars. The determination of costs in the revised economic assessment contained in the Final Statement of Reasons was not made with outpatient medical offices and clinics and field operations included in the scope. The Board believes that is not necessary to do a revised economic assessment of a previous version of the proposal, which is not under consideration.

Comment SEIU #4.3:
This blanket deletion leaves workers vulnerable to workplace violence, rather than refining these definitions in order to include outpatient/ambulatory clinics and other outpatient services that actually experience over 3,000 incidents of workplace violence according to 2013 Bureau of Labor Statistics (BLS) while excluding medical/doctor offices which experience less than 1,000 annually. Especially when outpatient services should already have IIPPs in place that include plans and training, while medical offices do not. Not to mention that the plans and training would only reflect the hazard assessment of those facilities. That means employers with a low incidence of violence would only incur cost that addresses those identified hazards. For example, if a clinic is only at risk for worker on worker or active shooter violence than their plan and training would not include more than Type III violence

Response:
This comment is unrelated to the Notice of Additional Documents. Please see the response to SEIU #1 during the second 15-day comment period concerning the removal of outpatient clinics and offices and field operations from the scope of the regulation.

Comment SEIU #4.4
Field operations do not appear in any of the 'relied on' documents that we could find. And, we had already concluded at stakeholder meetings and subsequent conference calls that it would only include operations that offered more than first aid.

Response:
The documents were not added to the record to explain or support the Board's decision to remove field operations from the scope of the regulation. Please see the response to SEIU 4.1.

Ross Elliott, Executive Director, California Ambulance Association. Written comments sent on October 12, 2016

Comment #CAA 4.1

The California Ambulance Association (CAA) respectfully requests that the public comment period for the proposed regulations be extended by 45 days, to November 28, 2016. The ambulance industry recently learned of these proposed regulations. The regulations directly affect the ambulance industry, yet the industry has not been a party to the regulation development process. CalOSHA failed to invite and include the ambulance industry's participation in the regulation development process.

Response:
The pre-rulemaking activities for this regulation were open to the public. Open advisory committee meetings were held in September 2014, November 2014, February 2015, April 2015, and June 2015. All of the advisory committee meetings were posted on the Division's public website at least 30 days prior to each meeting. Every effort was made to notify stakeholders, and all of the meetings were well attended by stakeholders including many employers and employer associations. The Public Agency Safety Management Association (PASMA), American Medical Response, and Care Ambulance Service, all of which represent employers who operate ambulances and whose employees are exposed to risks of workplace violence, were invited to the meetings. In addition, a representative for Schaefer Ambulance Service attended and spoke during the April 2015 advisory committee meeting. Schaefer Ambulance Service is a member of the California Ambulance Association.

The formal rulemaking for this regulation was also open to the public. Interested parties were notified as required by the Government Code when formal rulemaking began in October 2015 with a 45-day comment period and again regarding three additional public comment periods in 2016. The notifications were sent to PASMA, American Medical Response, and Care Ambulance Service. PASMA commented during formal rulemaking on the effects of the proposed regulation on local government, emergency medical response, and patient transport.

The latest comment period held from September 27th to October 12th is specific to additional documents added to the rulemaking file. This comment is unrelated to the Notice of Additional Documents. Comments during this comment period must pertain to those documents added to the record.

The Board respectfully declines to open additional comment periods.

Comment #CAA 4.2
Proposed Section 3342 consists of 14 pages of regulations. Existing regulations covering workplace violence (Section 3203 - Injury and Illness Prevention Program) are about two pages. Consequently, the proposed regulations are significantly more onerous, complex, and expensive to implement.

Response:
This comment is unrelated to the Notice of Additional Documents. Comments during this comment period must pertain to those documents added to the record.

Comment #CAA 4.3
CalOSHA has made no attempt to notify the industry, through its trade association, of these changes. It appears that the regulations have been in development since prior to October 2015. The California Ambulance Association (CAA) first became aware of these proposed regulations from another State agency, the California Emergency Medical Services Authority, in late September 2016; just a few days ago.

Response:
Please see the response to CAA 4.1. This comment is unrelated to the Notice of Additional Documents. Comments during this comment period must pertain to those documents added to the record.

Comment #CAA 4.4
In California, 85 percent of ambulance transports are conducted by privately-owned ambulance companies. Eighty five percent! Fire departments and other public agencies account for only 15 percent of ambulance service. The omission of the private ambulance industry from the regulation development process invalidates the proposed regulations.

Response:
Please see the response to #CAA 4.1.

## ADDITIONAL DOCUMENTS INCORPORATED BY REFERENCE

None.

## REVISED ECONOMIC IMPACT ANALYSIS/ASSESSMENT

The Board has made a determination that this proposal should not result in a significant, statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states. The Board anticipates that any potential costs would in part be balanced by avoiding or minimizing the costs inherent in workers' compensation claims, lost work time, and productivity losses that would have been caused by workplace violence deaths and injuries.

The proposed regulation is a mixture of performance and prescriptive elements. The establishment of the workplace violence prevention plan in subsection (c) of the proposal is a performance standard.

However, parts of the required Plan, may be considered prescriptive, as employers are required to assess various violence risk factors and consider various violence prevention methods as applicable to the employer's operation. In addition, the proposal contains prescriptive requirements to establish and maintain records of violent incidents and report violent incidents to the Division. The proposal also contains prescriptive requirements on topics that must be included in employee training. The prescriptive elements of the proposal are necessary for the following reasons:

The authorizing legislation (California Labor Code section 6401.8) for the proposal requires specific topics to be included in employee training, requires specific elements to be included within the workplace violence prevention plan, and contains specific requirements for reporting and keeping records of workplace violence incidents. In order to be consistent and compliant with the authorizing legislation, the proposal must also contain these prescriptive elements.

Performance based requirements to prevent workplace violence in health care currently exist (Title 8 section 3203 and Health and Safety Code section 1257.7 and 1257.8), but have not been effective in reducing the number of workplace violence incidents. Unfortunately, workplace violence is on the increase for health care establishments in recent years despite the existence of performance requirements.

Employers are currently required by California Code of Regulations, title 8, section 3203 to have in place an effective injury and illness program (IIPP) to identify and evaluate workplace hazards, investigate occupational injuries and illnesses, correct unsafe or unhealthful conditions, and provide training and instruction to employees. In addition, hospital employers are currently required by Health and Safety Code sections 1257.7 and 1257.8 to develop a security plan to protect employees from aggressive or violent behavior, conduct annual assessments of the security plan, track incidents of aggressive or violent behavior, develop training policies, involve

affected employees and their representatives in the development of the plan and annual assessments, and have sufficient personnel to provide security.

The current proposal specifies in detail the programmatic steps that hospitals and other employers covered by the proposal must follow and the control measures they must consider to address risks of workplace violence. The calculated costs assume that all employers covered by the proposal are in compliance with the existing IIPP regulation and that the hospitals are in compliance with Health and Safety Code sections 1257.7 and 1257.8.

# 1.0 SCOPE OF THE REGULATION

The following workplaces are covered by the proposed regulation, Title 8 section 3342. Workplace Violence Prevention in Health care. Employers in categories 1.1 – 1.14 and 1.16 are licensed under the California Department of Public health, Licensing and Certification Program. Reporting requirements in the proposed regulation (required by Labor Code section 6401.8) apply only to employers in categories 1.1, 1.2 and 1.6 (hospitals).

1.1 General acute care hospital
1.2 Acute psychiatric hospital
1.3 Skilled nursing facility
1.4 Intermediate care facility
1.5 Intermediate care facility/developmentally disabled habilitative
1.6 Special hospital
1.7 Intermediate care facility/developmentally disabled
1.8 Intermediate care facility/developmentally disabled-nursing
1.9 Congregate living health facility
1.10 Correctional treatment center
1.11 Nursing facility
1.12 Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)
1.13 Hospice facility
1.14 Home health care and home-based hospice
1.15 Emergency medical services and medical transport,
1.16 Drug treatment programs
1.17 Outpatient medical services to the incarcerated in correctional and detention settings.

# 2.0 STATE GOVERNMENT COST

## 2.1 Department Of State Hospitals (DSH) Total Cost

The Department of State Hospitals (DSH) manages the California state hospital system and provides mental health services to its patients. DSH operates five state hospitals and three psychiatric programs located in state prisons. Patients sent to DSH through the criminal court system have committed or have been accused of committing crimes linked to their mental illness. In addition, DSH treats patients who have been classified by a judge or jury as Sexually Violent Predators.

DSH will incur higher costs than other state agencies due to the high level of workplace violence existing in their facilities and due to the fact that DSH operates forensic psychiatric hospitals where more violence is expected as compared to acute care hospitals for the general public. At the same time, it is anticipated that the Department in State Hospitals will also benefit the most from reductions in workers' compensation claims, employee absenteeism, lost work time and lost productivity.

In 2013, after investigating problems with workplace violence in DSH hospitals, the Division of Occupational Safety and Health (DOSH) issued a Special Order requiring these hospitals to create and implement workplace violence prevention plans as part of their already-required injury and illness prevention programs (IIPPs). The Special Order contains many of the same provisions contained in the proposed regulation. The calculated costs reflect additional resources needed to comply with requirements of the proposal that are not contained in the Special Order and not specified in Health and Safety Code section 1257.7 or 1257.8.

**Subsections 3342(c) and 3342(e): Workplace Violence Prevention Program and Review**

DSH estimates that it would cost $885,000 annually to hire 8 Program Analysts (1 for each facility) to administer all components of the workplace violence prevention program. Proposed subsection 3342(c)(10)(H) requires the creation of an effective means to alert employees of the presence, location, and nature of a security threat. The Board estimates that this requirement may be met through a variety of options, for example, audible devices such as sirens or horns; pagers or PDA messaging (urgent email/text); and radio communication with employees. The Board estimates the cost of an Emergency Notification System at $3.75 per staff, per year. As of 2015, DSH had approximately 12,000 employees (http://www.dsh.ca.gov/About_Us/default.aspx), bringing the total annual cost to approximately $45,000.

Proposed subsection 3342(e) requires covered employers to review their workplace violence prevention plan at least annually and correct deficiencies in the program. DSH is currently required to establish an Injury and Illness Prevention Committee that meets at least 4 times per year to analyze the effectiveness of Injury and Illness Prevention Program and recommend

updates to the plan. The requirements in the proposed subsection provide greater specificity in the criteria for evaluating the annual review than current requirements, which may result in a cost to DSH.

**Subsections 3342(d) and 3342(g): Recording and Reporting Workplace Violence Incidents**

Proposed subsection 3342(d) requires covered employers to maintain records of workplace violence incidents (violent incident log). The DOSH Special Order and DSH Injury and Illness Prevention Program currently require DSH to maintain records of workplace violence incidents. There will be a cost to DSH to update current practices to meet the additional requirements of proposed subsection 3342(d).

Proposed subsection 3342(g) requires most hospitals to report certain workplace violence incidents to DOSH. Currently, DSH is only required to report workplace violence incidents that result in a serious injury to employees. The proposed section will result in an increase in reports of workplace violence incidents, given the requirements, and DSH will incur initial and ongoing costs as a result of proposed subsections 3342(g).

DSH estimates it will incur a one-time cost of $550,000 to develop the information technology system and an ongoing cost of $87,000 for one full time programmer/analyst to the maintain the information technology system and comply with proposed subsections 3342(d) and 3342(g).

**Subsection 3342(f): Employee Training**

Proposed subsection 3342(f) requires covered employers to provide initial training to employees exposed to workplace violence risks. DSH is already required to provide initial workplace violence prevention training to employees pursuant to the existing DOSH Special Order and DSH Injury and Illness Prevention Program. The proposal requires additional training components, which are estimated to cost $286,000 for initial year training.

Subsection 3342(f) also requires covered employers to provide annual refresher training to employees performing patient contact activities and to those employees' supervisors. The DOSH Special Order and DSH Injury and Illness Prevention program contain requirements for refresher training, but do not specify the content and frequency of the refresher training. As a result, DSH estimates that it would incur an ongoing annual cost of $191,000 to provide 1 hour of training time for all 12,000 employees in DSH. The cost will increase to $286,000 per year if the 1 hour is overtime pay for all employees. Because only employees performing patient contact activities and their supervisors must be provided annual refresher training, this estimate may be higher than the actual cost.

**Subsection 3342(h): Recordkeeping**

The proposed subsection 3342(h) requires covered employers to retain training records and records of workplace violence hazard identification, evaluation, and correction for one year. DSH already retains these records for one year pursuant to the DOSH Special Order and the existing DSH Injury and Illness Prevention Program, resulting in no additional cost to DSH.

The proposed subsection 3342(h) also requires covered employers to retain records of violent incidents for 5 years. Currently DSH only retains records of violent incidents for one year pursuant to the DOSH Special Order and the DSH Injury and Illness Prevention Program. DSH estimates that it will cost $180,000 annually for the additional record storage.

**Total projected cost of proposed section 3324 to DSH**

The total projected costs for DSH is provided in the table below.

**TABLE 1: TOTAL COST OF THE PROPOSAL TO THE DEPARTMENT OF STATE HOSPITALS**

| Requirement | Initial Setup Plus First Year Cost[4] | Ongoing Cost Thereafter |
|---|---|---|
| Workplace Violence Prevention Program Administration, Implementation and Annual Review. | $885,000 | $885,000/year |
| Alert employees of the presence, location, and nature of a security threat | $45,000 | $45,000/year |
| Recording and Reporting of Workplace Violence Incidence | $637,000 | $87,000/year |
| Employee Training | $286,000 | $286,000/year |
| Record Keeping | $180,000 | $180,000/year |
| **Total** | **$2,033,000** | **$1,483,000/year** |

## 2.2 The California Department of Corrections and Rehabilitation (CDCR)

CDCR is exempt from the regulation and will incur no costs or benefits.

## 2.3 The California Department of Development Services (DDS)

DDS provides services and supports to individuals with developmental disabilities through contracts with 21 nonprofit regional centers. Although the private regional centers must comply

with section 3342, it will not have a direct impact on DDS since it will be the responsibility of each private regional center to ensure compliance with the regulation.

DDS also operates three developmental centers licensed and certified as general acute care hospitals and one skilled nursing intermediate care non-hospital facility. The three hospitals are scheduled to close and are exempt from the regulation. The cost of the proposal to the skilled nursing intermediate care facility is included in the state costs for non-hospitals explained in section 2.4.2, below.

**2.4 Costs for Remaining State Entities**

The costs for remaining state entities are divided into the following:

- Workplace violence prevention plan (Plan) costs for hospitals (categories 1.1, 1.2 and 1.6 of the scope)
- Plan costs for licensed non-hospital entities (categories 1.3 - 1.5, 1.7 - 1.14 and 1.16 of the scope)
- Plan cost for emergency medical services or patient transport (category 1.15 from the scope)
- Plan costs for outpatient medical services to the incarcerated (category 1.17 from the scope)
- Training costs for all state entities except DSH,CDCR, and DDS.

The Plan cost includes all costs associated with implementing the regulation (including recordkeeping and reporting costs), except for the training requirements.

**2.4.1 Plan Cost for University of California Hospitals (categories 1.1, 1.2 and 1.6 from the scope):**

There are eighteen[1] state government general acute care, acute psychiatric or special hospitals. Eight of the hospitals are operated by DSH or DDS; their costs are described in section 2.1 and 2.3, above. The remaining 10 state hospitals are operated by the University of California (UC) on 5 university campuses.

UC estimates that it would cost $750,000 annually to hire 5 Manager and Senior Professionals (1 position for each UC campus) to administer all components of the workplace violence prevention program including recordkeeping and reporting requirements[2]. UC would incur this cost the first year the proposal is effective and annually thereafter.

[1]Communications with the California Office of Statewide Planning and Development
[2] Communications with the University of California

### 2.4.2 Plan Costs for Non-Hospital, Licensed Health Care Facilities Operated by California State Agencies and UC (categories 1.3 - 1.5, 1.7 - 1.14 and 1.16 from the scope)

There are eleven[3] non-hospital, licensed health care facilities operated by California state agencies covered by the regulation. The Board estimates that the initial cost to establish a workplace violence prevention plan in a non-hospital setting is approximately 40 hours of administrative time. Once the program is established, the Board estimates that the cost of maintaining the Plan and complying with the recordkeeping requirements is approximately 8 hours per year. There is no reporting requirement for non-hospitals. Assuming an administrative cost of $50 per hour for non-hospitals, the first year[4] cost for establishing and implementing the Plan in non-hospital state facilities is $22,000, and the ongoing cost of maintaining the program is $4,400 per year thereafter.

Calculations: First Year Program Cost = $50/hour * 40 hours * 11 = $22,000
Annual Program Cost = $50/hour * 8 hours * 11 = $4,400

### 2.4.3 Plan Costs for Emergency Medical Services/Transport (category 1.15 from the scope).

The majority of state agencies that perform emergency medical services or patient transport are licensed facilities included in other categories listed in the scope. The Board identified ten[5] state entities that provide emergency medical services or patient transport that are not included in other categories listed in the scope. The Board estimates that the initial cost to establish a workplace violence prevention plan for these state entities is approximately 40 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the recordkeeping requirements is approximately 8 hours per year. There is no reporting requirement for employers that provide emergency medical services or patient transport. Assuming an administrative cost of $50 per hour for emergency services/patient transport entities, the first year cost[4] for establishing and implementing the Plan is $20,000 and the ongoing cost of maintaining the Plan is $4,000 per year.

Calculations: First Year Program Cost[4] = $50/hour * 40 hours * 10 = $20,000
Annual Program Cost = $50/hour * 8 hours * 10 = $4,000

### 2.4.4 Plan Costs for Outpatient medical services to the incarcerated (category 1.17 from the scope)

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[3] https://chhs.data.ca.gov/Facilities-and-Services/Department-of-Health-Care-Services-DHCS-Licensed-R/rzbp-crfv, and https://chhs.data.ca.gov/Facilities-and-Services/Healthcare-Facility-Locations/ir29-xyw6#column-menu
[4] First year cost refers to the first year after all the requirements of the proposal are to be fully implemented.
[5] http://www.cpf.org/go/cpf/?LinkServID=86C34E47-1CC4-C201-3E156C299B32F183

These operations are all within the Department of Corrections, which is exempt from the regulation.

**2.5 Training Costs for all state entities covered by the regulation (except DSH & CDCR)**

There are approximately 100,000 state employees[6] covered by the regulation (excluding DSH, DDS hospitals and CDCR). The costs of establishing the training program is included in the cost of establishing the Plan, calculated above. The Board believes this cost should be minimal, as it is currently required by Title 8 section 3203. The Board estimates that annual training, which is not required by section 3203, will cost approximately one hour of employee time per year. Assuming employee time at a cost of $25 per hour, the training cost to the state (excluding DSH, CDCR and DDS hospitals) is $2.5 million per year.

Calculations: Annual Training Cost = 1hour * $25/hour * 100,000 = $2,500,000

[6] Communications with the University of California,
http://www.labormarketinfo.edd.ca.gov/iomatrix/IndList.asp#H,
http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=621600,
http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=621900,
http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=622200,
http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=622100,
http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=623100,
http://www.labormarketinfo.edd.ca.gov/iomatrix/Staffing-Patterns3.asp?IOFlag=Ind&SIC=623200

**2.6 Total State Agency/UC Costs (all numbers rounded to the nearest thousand):**

| Table 2. Total State Agency/UC Costs | | |
|---|---|---|
| **Category** | **Initial Setup Plus First Year Cost**[4] | **Annual Cost Thereafter** |
| 2.1 DSH Total Cost (Plan & Training) | $2,033,000 | $1.5 million / year |
| 2.4.1 UC Hospitals Plan Cost | $750,000 | $750,000 / year |
| 2.4.2 Non-Hospital licensed facilities Plan Cost | $22,000 | $4,000 / year |
| 2.4.3 Emergency Medical Services Plan Cost | $20,000 | $4,000 / year |
| 2.4.4 Correctional Settings Total Cost | $0 | 0 |
| 2.5 Training Cost for all state entities (except DSH, CDCR) | $2,500,000 | $2,500,000 |
| **TOTAL STATE COST** | **$5,325,000** | **$4,758,000 / year** |

## 3.0LOCAL GOVERNMENT COSTS

The costs for local government entities are divided into the following:

- Plan costs for hospitals (categories 1.1, 1.2 and 1.6 of the scope)
- Plan costs for licensed non-hospital entities (categories 1.3 - 1.5, 1.7 - 1.14 and 1.16 of the scope)
- Plan costs for emergency medical services or patient transport (category 1.15 from the scope)
- Plan costs for outpatient medical services to the incarcerated (category 1.17 from the scope)
- Training costs for all local government entities

**3.1 Plan Cost for Hospitals (categories 1.1, 1.2 and 1.6 from the scope):**

There are 64[1] local government general acute care, acute psychiatric or special hospitals. The Board estimates that the initial cost to establish and implement a workplace violence prevention plan required by the proposal is approximately 80 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the

reporting and recordkeeping requirements is approximately 40 hours of administrative time per year. The Board estimates the cost of the reporting requirements is approximately 20 hours per year per hospital. Assuming an administrative cost of $75 per person-hour for hospitals, the first year cost[4] for establishing and implementing the Plan for the 64 local government hospitals is $384,000, and the ongoing cost of maintaining the Plan is $192,000 per year.-

Calculations: Initial program cost = 80 hours/hospital * $75/hour = $6000/hospital * 64 hospitals = $384,000

Annual program cost = 40 hours/hospital * $75/hour = $3000/hospital * 64 hospitals = $192,000

Reporting Cost per hospital = 20 hours * $75/hour = $1,500

### 3.2 Plan Costs for Non-hospital, Licensed Health Care Facilities Operated by Local Government (categories 1.3 – 1.5, 1.7 - 1.14 and 1.16 from the scope):

The Board identified 55[2] non-hospital licensed local government health facilities covered by the regulation. The Board estimates that the initial cost to establish a workplace violence prevention plan in a non-hospital setting is approximately 40 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the recordkeeping requirements is approximately 8 hours per year. There is no reporting requirement for non-hospitals. Assuming an administrative cost of $50 per hour for non-hospitals, the first year cost[4] for establishing and implementing the Plan in non-hospital local government facilities is $110,000, and the ongoing cost of maintaining the Plan is $22,000.

Calculations: Initial program cost=40 hours * $50/hour=$2000/facility * 55 facilities= $110,000

Annual program cost is 8 hours * $50/hour= $400/facility * 55 facilities = $22,000

### 3.3 Plan Costs for Emergency Medical Services/Patient Transport (category 1.15 from the scope)

There are approximately 545[7] local government entities including fire departments in California that provide emergency medical services or patient transport. The Board estimates that the initial cost to establish a workplace violence prevention plan for these entities is approximately 40 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the recordkeeping requirements is approximately 8 hours per year. There is no reporting requirement for employers who provide emergency medical services or patient transport. Assuming an administrative cost of $50 per hour for emergency services/patient transport entities, the first year cost[4] for establishing and implementing the Plan is $1,090,000 and the ongoing cost of maintaining the Plan is $218,000 per year.

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[7] http://www.cpf.org/go/cpf/?LinkServID=86C34E47-1CC4-C201-3E156C299B32F183 and http://www.the-caa.org/docs/Calif-EMS-Safety-Net.pdf

Calculations: Initial Program Cost = 40 hours * $50/hour * 545 = $1,090,000

Annual Program Cost is 8 hours * $50/hour * 545 = $218,000

### 3.4 Plan Costs for Outpatient medical services to the incarcerated (category 1.17 from the scope)

The Board identified 123[8] county jails and court holding facilities operated by local government in California. The Board estimates that the initial cost to establish a workplace violence prevention plan for these facilities is approximately 40 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the recordkeeping requirements is approximately 8 hours per year. There is no reporting requirement for employers that provide outpatient medical services to the incarcerated. Assuming an administrative cost of $50 per hour for emergency services/patient transport entities, the first year cost[4] for establishing and implementing the Plan is $246,000, and the ongoing cost of maintaining the Plan is $49,200 per year.

Calculations: Initial cost = 40 hours/facility * $50/hour * 123 facilities = $246,000

Annual cost = 8 hours/ facility * $50/hour * 123 facilities = $49,200

### 3.5 Training Costs (for all local government entities covered by the regulation)

There are approximately 120,000[6] employees in local government covered by the regulation. The cost of establishing the training program is included in the cost of establishing the Plan, calculated above. The Board believes this cost should be minimal, as it is currently required by Title 8 section 3203. The Board estimates that annual training, which is not required by section 3203, will cost approximately one hour of employee time per year. Assuming employee time at a cost of $25 per hour, the training cost to local government agencies is $1,750,000 per year.

Calculation: Annual Training Cost = 1 hour * $25/hour * 120,000 = $3,000,000

[8] http://www.ppic.org/main/publication_show.asp?i=1061

### 3.6 Total Local Government Costs (all numbers rounded to the nearest thousand):

| Table 3. Total Local Government Cost | | |
|---|---|---|
| **Category** | **Initial Setup Plus First Year Cost**[4] | **Annual Cost Thereafter** |
| 3.1 Plan Cost Hospitals | $384,000 | $192,000 / year |
| 3.2 Plan cost Non-Hospital licensed facilities | $110,000 | $22,000 / year |
| 3.3 Plan Cost for Emergency Medical Services | $1,090,000 | $218,000 / year |
| 3.4 Plan Cost Correctional Settings | $246,000 | $49,000 / year |
| 3.5 Training Cost for all Entities | $3,000,000 | $3,000,000 / year |
| **TOTAL LOCAL GOV COST** | **$4,830,000** | **$3,481,000 / year** |

There are a total of 787 local government employers covered by the proposal:

Calculation: Total number of local government employers =

64 hospitals + 55 licensed non-hospitals + 545 emergency response-patient transport + 123 outpatient medical services to the incarcerated = 787 employers

## 4.0 PRIVATE SECTOR COSTS

Private sector costs are divided into the following:

- Plan costs for hospitals (categories 1.1, 1.2 and 1.6 of the scope)
- Plan costs for licensed non-hospital licensed entities (categories 1.3 - 1.5, 1.7 - 1.14 and 1.16 of the scope)
- Plan costs for emergency medical services or patient transport (category 1.15 from the scope)
- Plan costs for outpatient medical services to the incarcerated (category 1.17 from the scope)
- Training costs for all local private entities

### 4.1. Plan Costs for Hospitals (categories 1.1, 1.2 and 1.6 from the scope):

There are 409[1] private general acute care, acute psychiatric or special hospitals covered by the regulation. The Board estimates that the first year cost[4] to establish and implement a workplace

violence prevention plan required by the proposal is approximately 80 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the reporting and recordkeeping requirements is approximately 40 hours of administrative time per year. The Board estimates the cost of the reporting requirements is approximately 20 hours per year per hospital. Assuming an administrative cost of $75 per person-hour for hospitals, the first year cost[4] for establishing and implementing the Plan for the 409 private hospitals is $2,454,000 and the ongoing cost of maintaining the Plan is $1,227,000 per year.

Calculations: Initial program cost = 80 hours/hospital * $75/hour=$6000/hospital * 409 hospitals = $2,454,000

Annual program cost = 40 hours/hospital * $75/hour=$3000/hospital * 409 hospitals = $1,227,000

Reporting Cost per hospital = 20 hours * $75/hour = $1,500

### 4.2 Plan Costs for Private Non-hospital, licensed health care facilities (categories 1.3 – 1.5, 1.7 - 1.14 and 1.16 from the scope)

The Board identified approximately 5000[1] private non-hospital, licensed health care facilities covered by the regulation. The Board estimates that the initial cost to establish a workplace violence prevention plan in a non-hospital setting is approximately 40 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the recordkeeping requirements is approximately 8 hours per year. There is no reporting requirement for non-hospitals. Assuming an administrative cost of $50 per person-hour for non-hospitals, the first year cost[4] for establishing and implementing the Plan in non-hospital private facilities is $10 million, and the ongoing cost of maintaining the program is $2 million per year.

Calculations: Initial program cost=40 hours*$50/hour=$2000/facility*5000 facilities= $10 million

Annual program cost = 8 hours*$50/hour=$400/facility*5000 facilities=$2 million

### 4.3 Plan Costs for Emergency Medical Services (category 1.15 from the scope)

There are approximately 170 private companies[9] that provide emergency medical or patient transport service. The Board estimates that the initial cost to establish a workplace violence prevention plan for these employers is approximately 40 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the recordkeeping requirements is approximately 8 hours per year. There is no reporting

[9] http://www.the-caa.org/docs/Calif-EMS-Safety-Net.pdf

requirement for employers who provide emergency medical services or patient transport. Assuming an administrative cost of $50 per person-hour for emergency services/patient transport entities, the first year cost[4] for establishing and implementing the Plan is $340,000 and the ongoing cost of maintaining the Plan is $68,000 per year.

Calculations: Initial program cost = 40 hours * $50/hour * 170 = $340,000

Annual program cost = 8 hours * $50/hour * 170 = $68,000

### 4.4 Plan Costs to Outpatient medical services to the incarcerated (category 1.17 from the scope)

The Board identified 17[10] private prisons and jails in California. The Board estimates that the initial cost to establish a workplace violence prevention plan for these facilities is approximately 40 hours of administrative time. Once the Plan is established, the Board estimates that the cost of maintaining the Plan and complying with the recordkeeping requirements is approximately 8 hours per year. There is no reporting requirement for employers who provide outpatient medical services to the incarcerated. Assuming an administrative cost of $50 per hour for emergency services/patient transport entities, the first year cost[4] for establishing and implementing the Plan is $34,000 and the ongoing cost of maintaining the Plan is $6,800 per year.

Calculations: Initial program cost = 40 hours * $50/hour * 17 = $34,000

Annual program cost = 8 hours * $50/hour * 17 = $6,800

### 4.5 Training Cost (for all private entities covered by the regulation)

There approximately 550,000[6] employees in the private sector covered by the regulation. The costs of establishing the training program is included in the cost of establishing the Plan, calculated above. The Board believes that this cost should be minimal as it is currently required by section 3203. The Board estimates that annual training, which is not required by section 3203, will cost approximately one hour of employee time per year. Assuming employee time at a cost of $25 per hour, the training cost to the private sector is $13,750,000 per year.

Calculations: Annual Training Cost = 1 hour * $25/hour * 550,000 = $13,750,000

[10] http://www.cca.com/locations?state=CA#filters and http://www.geogroup.com/maps/index/1

### 4.6 Total Private Sector Cost

Table 4 Total Private Sector Costs

| **Category** | **Initial Setup Plus First Year Cost**[4] | **Annual Cost Thereafter** |
|---|---|---|
| 4.1 Plan Costs Hospitals | $2,454,000 | $1,227,000/ year |
| 4.2 Plan Costs Non-Hospital licensed facilities | $10,000,000 | $2,000,000 / year |
| 4.3 Plan Costs Emergency Medical Services | $340,000 | $68,000/ year |
| 4.4 Plan Cost Correctional Settings | $34,000 | $7,000/ year |
| 4.5 Training Cost for all Entities | $13,750,000 | $13,750,000 |
| **TOTAL PRIVATE SECTOR COST** | **$26,578,000** | **$17,052,000 / year** |

There are a total of 5,596 private sector employers covered by the proposal:

Calculation: Total number private sector employers =

409 hospitals + 5000 non-licensed hospitals + 170 emergency response-patient transport +

17 outpatient medical services to the incarcerated = 5,596 employers

# 5.0TOTAL COSTS TO ALL SECTORS

| Table 5 Total Cost to All Sectors | | |
|---|---|---|
| **Category** | **Initial Setup Plus First Year Cost**[4] | **Annual Cost Thereafter** |
| State Government | $5,325,000 | $4,758,000 / year |
| Local Government | $4,830,000 | $3,481,000 / year |
| Private Industry | $26,578,000 | $17,052,000 / year |
| **TOTAL** | **$36,733,000** | **$25,291,000 /year** |

There are a total of 6388 employers covered by the proposal.

Calculation: Total number of employers =

1 (State of California) + 787 (local government) + 5,596 (private sector) = 6,384 employers

## 6.0 QUANTIFIABLE ECONOMIC BENEFITS

The majority of economic benefits of the proposal are not quantifiable. Occupational fatalities occur from workplace violence in California and have an immeasurable financial impact on the family of the victim. Fatalities will be prevented by the proposal, but such benefits, which are not quantifiable, are not included in the economic analysis.

Workplace violence incidents which do not result in an injury with days lost from work are also not included in the economic analysis because there is a lack of data on the number of such incidents and a quantifiable cost for such incidents. These incidents have an economic impact as they result in reduced employ productivity and increased employee absenteeism. The number of workplace violence incidents that do not result in an injury with lost days from work are believed to exceed the number of reported workplace violence incidents with lost work days by orders of magnitude and number in the tens of thousands of incidents per year for the employers covered by the proposal.

The quantifiable benefit of the proposed regulation is determined by multiplying the number of lost time injuries that will be prevented by the proposed regulation by the cost of an average injury resulting from workplace violence.

The number of injuries now occurring to employees covered by the proposed regulation is calculated by multiplying the annual workplace violence injury rate in the healthcare industry in California by the number of employees covered by the proposal. The annual injury rates are expressed as the number of nonfatal occupational injuries and illnesses involving days away from work per 10,000 full-time workers. The most recent data available is for 2014.

There are two categories of employees in the healthcare industry: (1) Healthcare practitioners/ technical operations and (2) Healthcare support occupations.

For healthcare practitioners/ technical operations, the workplace violence annual injury incident rate is 7.0[11] (after removing animal and insect related events) per 10,000 full-time workers.

For healthcare support occupations, the workplace violence injury incident rate = 16.0[11] (after removing animal and insect related events) per 10,000 full-time workers.

In California, there are 749,930[12] employees in the healthcare practitioners/technical operations category and 352,700[13] employees in the health care support category. There are 1,102,630 total employees in healthcare in California (both categories combined)

The combined annual injury rate for healthcare in California is

$$\frac{(749{,}930\ employee * 7.0\ injuries\ per\ 10{,}000\ employees) + (352{,}700\ employees * 16.0\ injuries\ per\ 10{,}000\ employees)}{1{,}102{,}630\ employees}$$

= 10 lost day injuries per 10,000 full time employees per year in the California healthcare industry

The direct cost (medical treatment and lost wages) of each injury from violence resulting in days away from work is approximately $3,000[14]. The indirect cost (lost productivity, increased absenteeism, training of replacement employees, etc.) of each injury is approximately 1.6[15] times the direct cost or $4,800 per injury. The total direct and indirect cost of each violence injury is approximately $7,800.

### 6.1 State Government Benefit

The total number injuries involving days away from work among 112,000 state employees covered by the regulation

[11] http://www.dir.ca.gov/OPRL/Injuries/Demographics/2014/PrivateIndustry/2014Table18-PrivateIndustry.pdf
[12] http://www.bls.gov/oes/current/oes290000.htm
[13] http://www.bls.gov/oes/current/oes310000.htm
[14] https://www.osha.gov/Publications/OSHA3826.pdf
[15] https://www.osha.gov/SLTC/etools/safetyhealth/mod1_costs.html

$$= 112{,}000\ employees * \frac{10\ injuries}{10{,}000\ employees}$$

= 112 injuries with lost time per year to state employees covered by the proposal

The cost of injuries resulting in days away from work due to workplace violence:

= 112 injuries * $7,800 = $873,6000 / year – current cost

Assuming 50% of injuries are prevented by implementation of the proposal, the savings would be

=873,600/year * 50% = $436,800 / year – benefit
Lost Time Injuries Prevented = 100*50% = 56/year

## 6.2 Local Government Benefit

The total number injuries involving days away from work among 120,000 local government employees covered by the regulation:

$$= 120{,}000\ employees * \frac{10\ injuries}{10{,}000\ employees}$$

= 120 injuries with lost time per year to local government employees covered by the proposal

The cost of injuries resulting in days away from work due to workplace violence

= 120 injuries * $7,800 = $936,000/year – current cost

Assuming 50% of injuries are prevented by implementation of the proposal, the savings would be:

=936,000/year * 50% = $468,000/year – benefit
Lost Time Injuries Prevented = 120*50% = 60/year

## 6.3 Private Sector Benefits

The total number injuries involving days away from work among 550,000 private sector employees covered by the regulation:

$$= 550{,}000\ \text{employees} * \frac{10\ injuries}{10{,}000\ employees}$$

= 550 injuries with lost time per year to private sector employees covered by the proposal

The cost of injuries resulting in days away from work due to workplace violence

= 550 injuries * $7,800/injury = $4.29 million / year – current cost

Assuming 50% of injuries are prevented by implementation of the proposal, the savings would be:

$4.29 million /year * 50% = $2,145,000 / year – benefit

Lost Time Injuries Prevented = 550*50% = 275 injuries/year

The total quantifiable benefits for the proposal are shown in Table 6 below:

Table 6: Total Quantifiable Benefit to All Sectors

| Category | Lost Time Injuries Prevented | Annual Benefit |
|---|---|---|
| State Government | 56/year | $437,000/year |
| Local Government | 60/year | $468,000 / year |
| Private Industry | 275/year | $2,145,000 / year |
| **TOTAL** | **391/year** | **$3,050,000 / year** |

## 7.0 PRIVATE SECTOR SMALL BUSINESS DETERMINATION

A small business is defined in Government Code section 11342.610[16]. The private employers included in the proposed regulation would be a small business if their facility does not have more than 150 patient beds or 1.5 million in gross annual receipts. The Board estimates that nearly all employers within the scope categories 1.3 – 1.16 (approximately 5000 employers) are small businesses and nearly all employers within scope categories 1.1, 1.2 and 1.17 (approximately 500 employers) would not be small employers. As a result, approximately 91 percent of the private businesses covered by the regulation would be small businesses.

Calculation: Percent Small Business $= \frac{5000 \text{ small businesses}}{5500 \text{ total businesses}} * 100\% =$ 91% small business

## 8.0 COST AND BENEFITS OF ALTERNATIVES TO PROPOSAL

[16] http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=GOV&sectionNum=11342.610.

### 8.1 Alternative 1: Take no Action
**Cost = $3 million/year and 385 Additional Lost Time Injuries per Year. Benefit = $0**

Taking no action or dropping the current proposal would be in direct violation of California Labor Code section 6401.8. The costs and benefits of such an alternative are analyzed for comparison purposes.

The cost of taking no action would be the loss of the benefits of the current proposal. The current proposal is estimated to prevent 391 lost time injuries per year, thousands of violent incidents per year, and a small number of deaths. The quantifiable economic benefits of the proposal to employers are estimated at $3 million/ year. The Board lacks data to calculate the economic benefits to employees. There are no economic benefits to taking no action

### 8.2 Alternative 2: All Outpatient Medical Offices and Clinics, Field Operations and Ancillary Health Care Operations Retained in the Scope of the Proposal
**First Year Cost = $102 million, Annual Cost Thereafter = $42 Million. Benefit = $3,830,000/ year and 491 Lost Time Injuries Prevented per Year.**

A previous version of the proposal covered a much larger number of employers and employees and included outpatient medical offices and clinics, field operations and ancillary health care operations. The Board estimates that the increased scope would include approximately 30,000 additional non-hospital licensed facility employers and 200,000 additional employees than the current proposal.

#### 8.2.1 Alternative 2 Cost

Applying the same cost assumptions used for the proposal (40 hours of administrative time to establish the Plan; 8 hours annually to maintain the Plan thereafter at $50/hour), the additional cost to establish and implement the plan for this alternative for the first year[4] is $60 million and the ongoing cost of maintaining the Plan is $12 million per year thereafter.

Calculations: Initial program cost = 40 hours * $50/hour * 30,000 = $60,000,000

Annual program cost = 8 hours * $50/hour * 30,000 = $12,000,000

Appling the same cost assumptions used for training, the additional training cost for this alternative is $5 million per year.

Calculations: Annual Training Cost = 1 hour * $25/hour * 200,000 = $5,000,000

The total cost of this alternative is shown in Table 7

| Table 7 Total Costs of Alternative 2 | | | | |
|---|---|---|---|---|
| **Category** | **Current Proposal** | **Additional Cost of Alternative 2** | **Additional Annual Training Cost of Alternative 2** | **Total Cost of Alternative 2** |
| First Year[4] Cost | $36,733,000 | $60,000,000 | $5,000,000 | $101,733,000 |
| Annual Cost Thereafter | $25,291,000/year | $12,000,000/year | $5,000,000/year | $42,291,000/year |

### 8.2.2 Alternative 2 Benefit

Using the same lost time injury rates used for the proposal (10 injuries per 10,000 full time employees per year), the additional quantifiable benefits of this alternative is calculated as follows:

Expected injuries in outpatient medical offices, clinics, ancillary health care operations and field operations $= 200{,}000 \text{ employees} * \frac{10\ injuries}{10{,}000\ employees}$

= 200 injuries with lost time per year

The cost of these injuries resulting in days away from work due to workplace violence:

= 200 injuries * $7,800 = $1,560,000/year

Assuming 50% of these injuries are prevented by implementation of the Plan, the additional savings would be:

=1,560,000/year * 50% = $780,000 / year – benefit

Lost Time Injuries Prevented = 200*50% = 100

Total Benefit of Alternative 2 = $3,050,000 / year (current proposal) + $780,000/year (additional benefit from expanded scope) = $3,830,000/ year

Total Lost Time Injuries Prevented = 391 (current proposal) + 100 (additional benefit from expanded scope = 491 injuries/year

## DETERMINATION OF MANDATE

These standards do not impose a mandate on local agencies or school districts as indicated in the Initial Statement of Reasons.

## ALTERNATIVES DETERMINATION

The Board invited interested persons to present statements or arguments with respect to alternatives to the proposed standards. No alternative considered by the Board would be more effective in carrying out the purpose for which the action is proposed or would be as effective as and less burdensome to affected private persons than the adopted action, or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law. Board staff were unable to come up with any alternatives or no alternatives were proposed by the public that would have the same desired regulatory effect.