



**CALIFORNIA
HOSPITAL
ASSOCIATION**

*Providing Leadership in
Health Policy and Advocacy*

December 2, 2014

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Dear Mr. Nakamura:

On behalf of more than 400 member hospitals and health systems, the California Hospital Association (CHA) respectfully offers the following background information to assist Cal/OSHA as it evaluates the issue of health care workplace violence. CHA appreciates Cal/OSHA's effort to address the issue of violence in health care facilities. California hospitals take very seriously our duty to provide a safe, healthy environment for our patients as well as our staff.

The goal of this submission is to provide general background on the laws and regulations governing acute care hospitals, as well as some external factors at play. This information is important as Cal/OSHA and stakeholders work to develop a solution to reduce health care workplace violence.

Current Compliance Requirements:

1. As we have discussed, current law, Health and Safety Code 1257.7, requires acute care hospitals to develop and implement a hospital-wide security and safety assessment as well as a security plan. The plan must specifically include measures to protect employees as well as patients and visitors. The hospital must track aggressive and violent conduct and examine trends. On an annual basis, the hospital must update the security plan based on the trends it has identified, developments in the area of safety and security or other relevant information.

Employee training is a key component of the security plan. Specifically, Health and Safety Code 1257.8 requires acute care hospitals to provide specific training to employees in the emergency department as well as employees in high-risk areas, as determined by the hospital's safety and security assessment.

The California Department of Public Health (CDPH) reviews the adequacy of the assessment, planning, training, and reporting of security and safety in hospitals through its Patient Safety Licensing Survey. CDPH evaluates hospital compliance with these provi-

sions, investigates and enforces this section of the law. If problems are found, then hospitals are subject to citations and administrative penalties.

2. California Code of Regulations, Title 22 sets forth the regulations governing acute care hospitals. A variety of regulations touch on the issue of workplace violence, including:

22 CCR §70707: Patient's Rights, including the right to receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse a course of treatment, as well as the right to refuse treatment. Patients also have the right to designate visitors of their choosing. While the hospital may limit a visitor if it reasonably determines that his/her presence would endanger the health or safety of anyone in the facility, hospitals must have a strong justification for such a decision; otherwise it would be subject to a claim of discrimination or violation of patient rights.

22 CCR §70717: Hospitals cannot transfer a patient to another health facility unless arrangements have been made in advance for admission to such health facility and a determination has been made by the patient's licensed health care practitioner that such a transfer or discharge would not create a hazard to the patient. Thus, while a hospital may wish to transfer a combative/violent patient, it is difficult to do so because it is difficult to find another health facility that will accept the transfer, or it may create a hazard to move the patient.

3. The Joint Commission, a national accrediting entity for acute care hospitals, requires hospitals to identify and manage security risks through various standards, including:

Human Resources 01.04.01: The hospital orients external law enforcement and security personnel on the following: how to interact with patients; procedures for responding to unusual clinical events and incidents; the hospital's channels of clinical, security and administrative communication; and distinctions between administrative and clinical seclusion and restraint (as defined by the Centers for Medicare & Medicaid Services Conditions of Participation, CFR 482.13);

Environment of Care 02.01.01: "The hospital manages safety and security risks," which include such elements of performance as: (1) The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment; (2) The hospital identifies individuals entering its facilities; (3) The hospital controls access to and from areas it identifies as security sensitive; (4) The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction; and (5) When a security incident occurs, the hospital follows its identified procedures.

4. The Centers for Medicare & Medicaid Services (CMS) enforces a plethora of requirements for hospitals participating in Medicare and Medicaid (all hospitals in the state). In particular, CMS sets forth the following requirement with respect to patient safety: (1) The patient has the right to personal privacy; and (2) The patient has the right to receive

care in a safe setting. This has been interpreted to limit the activity of hospital staff, including hospital security staff. The following is an excerpt from Interpretive Guideline §482.13(e):

CMS does not consider the use of weapons in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term weapon includes, but is not limited to, pepper spray, mace, nightsticks, Tasers, cattle prods, stun guns and pistols. Security staff may carry weapons as allowed by hospital policy and by state and federal law. However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention. CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion. 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. The use of handcuffs, manacles, shackles, other chain-type restraint devices, or other restrictive devices applied by non-hospital employed or contracted law enforcement officials for custody, detention and public safety reasons are not governed by this rule. Such devices are considered law enforcement restraint devices and would not be considered safe, appropriate health care restraint interventions for use by hospital staff to restrain patients. 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 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).

5. EMTALA requires hospital emergency departments to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with an emergency medical condition. Injuries often happen when trying to accomplish the assessment/stabilizing activities. The requirement to assess and stabilize exists regardless of whether the patient is uncooperative, agitated or combative.
6. California Probate Code §4650 provides that "in recognition of the dignity and privacy a person has a right to expect, the law recognizes that an adult has the fundamental right to control the decisions relating to his or her own health care." All individuals have the right to give or refuse consent to medical diagnostic or treatment procedures and to make medical decisions about what physician's advice they choose to follow.
7. California Confidentiality of Medical Information Act (California Labor Code §56.10 et. seq.) prohibits hospital employers from disclosing patient medical information, except under limited circumstances. Patient information "may be disclosed to providers of health care, health care service plans, contractors, or other health care professionals or facilities

for purposes of diagnosis or treatment of the patient.” This exception is narrowly construed, and hospitals have been fined when patient medical information is disclosed to individuals who do not need the information for purposes of diagnosis or treatment.

8. California law requires that hospitals discharge patients to a safe place. Health and Safety Code §1262.5 requires that hospitals have a written discharge planning policy and process in place for all patients. The policy must ensure that arrangements for post-hospital care — including but not limited to care at home, in a skilled-nursing or intermediate care facility, or from a hospice — are made prior to discharge for patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning.

Particularly in areas with a high homeless population, finding a “safe place” can be challenging and, therefore, hospitals are “housing” homeless patients past the point of needing acute care. According to OSHPD data, because hospitals lack safe and appropriate discharge options for their homeless patients, they stay at the hospital an average of four days longer than necessary.

External Factors Impacting Health Care Workplace Violence:

1. Reduced mental health funding and community services have resulted in a significant increase in the number of mental health and high-risk patients in general acute care hospitals. The number of inpatient psychiatric beds in California has decreased significantly in the last 15 years. Many communities have no inpatient psychiatric services, and outpatient services are minimal as well (see attachment). Thus, when a behavioral health patient presents at a hospital emergency department, the hospital has to manage that patient until an appropriate placement is found. In many counties, individuals having an acute psychotic episode are brought to the emergency department from county mental health for a "medical screening," even when the individual does not have a medical issue. Once these patients are on the hospital campus, the hospital is responsible for them.
2. The patient population is changing. With the aging of the population, more Alzheimer and dementia patients are hospitalized. These patients are at increased risk for aggressive behavior. Similarly, patients suffering from traumatic brain injury, particularly returning veterans, are at increased risk for aggressive behavior.
3. With expansion of health insurance coverage, more individuals are seeking treatment. Unfortunately, there is a shortage of many health care providers, from physicians to laboratory technologists and imaging specialists. This often results in long wait times, which increases the stress level of patients and their family members. This, in turn, is more likely to lead to aggressive behavior.
4. Reduced local law enforcement funding may limit support provided to hospital staff and may also result in more violent/aggressive individuals being brought to the emergency department.

- a. Several hospitals have reported that when local law enforcement identify a disruptive person in the community, the officer will ask the individual (who may be under the influence of drugs or alcohol) whether they want to go to jail or the emergency department. Law enforcement then brings the individual to the emergency department for “medical screening.”
 - b. The impact of AB 109 on hospitals has been significant. AB 109 provided for the realignment of funding and supervision for certain low-level offenders, adult parolees, and juvenile offenders from state prisons and institutional facilities to the local jurisdiction, e.g., county probation and sheriff departments. While the realignment intended to make available services and supports to facilitate rehabilitation and assimilation into the community, adequate support, particularly for parolees with mental health issues, is not available. With one-third of the state’s prisoners having a mental health diagnosis, these parolees often end up in the hospital emergency department.
 - c. Many hospitals reported that local law enforcement will not take a report for patient-on-staff violence, and some may not respond.
5. Several hospitals contract with local prisons and jails to provide medical services. This necessarily brings increased risk of violence into the acute care hospital setting. While most such hospitals have locked units, those units pose increased risk due to the inmate-patient population. Other risks are posed when a female inmate is admitted to deliver a baby. Security and allowing visitors is often a challenge. Additionally, regardless of whether the hospital has a locked unit, guards assigned to inmate-patients are not accustomed to working in a hospital environment.
 6. Recently released prisoners with medical issues are brought from the prison or jail directly to the hospital. Thus, while these individuals are no longer in custody, they have only been recently released and may not be prepared to live in the community. Similar to the issues posed with homeless patients, these individuals cannot be discharged without a safe place to go to.
 7. Increased violence in the community is spilling over into the hospital. For example, when hospitals treat a gang member, the risk of gang violence erupting in the hospital increases. Similarly, when victims of domestic violence are treated at the hospital, the perpetrator may very well be a visitor.

The Acute Care Hospital Experience:

While health care workplace violence has been a topic of concern for many years, there have been few studies to evaluate what techniques and strategies are effective in reducing the incidence of workplace violence. As noted by Jane Lipscomb, the speaker at the September 10, 2014 Cal/OSHA Advisory Meeting, studying this issue is challenging as the patient population is not fixed and there is no standard definition or data collection protocol.

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 di-

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verse backgrounds of those involved in the issue. While some individuals have a clinical background, others have a military or law enforcement perspective. Further, as noted in a recent study, “hospitals’ efforts to reduce workplace violence are hampered by the lack of standardized surveillance of violent events and knowledge of why such violence occurs.”¹ Finally, as noted above, hospitals face a variety of safety and security challenges, including but not limited to gang violence, insufficient support from local law enforcement and increased utilization of emergency departments by behavioral health patients.

Conclusion:

Given the lack of empirical data on specific actions that are effective in reducing workplace violence and the multitude of external factors impacting this issue, we believe that, at this stage, Cal/OSHA regulations should: 1) create a standard definition of workplace violence; 2) create a standard reporting mechanism focused on workplace violence²; 3) align with the requirements of Health and Safety Code 1257.7 and 1257.8; and 4) incorporate an incident response/analysis component. This initial regulatory framework would set the foundation to obtain data, allowing Cal/OSHA and health care providers to evaluate the effectiveness of various strategies and techniques.

Moving forward, CHA is ready to assist Cal/OSHA as it develops regulations and enforcement policies in an effort to provide employees with a safe work environment. Thank you for the opportunity to submit this information. We look forward to working with you.

Sincerely,



Gail M. Blanchard-Saiger
Vice-President, Labor & Employment

Attachment

Cc: Deborah Gold, Deputy Director for Health, Cal/OSHA
C. Duane Dauner, President/CEO, California Hospital Association

¹ (ARNETZ J. E. , HAMBLIN L., ESSENMACHER L., UPFAL M.J., AGER J. & LUBORSKY M. (2 0 1 4) *Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports*. Journal of Advanced Nursing 00(0), 000–000. doi: 10.1111/jan.12494).

² The current Cal/OSHA Log 300 does not allow for identification and tracking of workplace violence incidents. Moreover, as the current Log 300 only captures actual injuries/illness, incidents of workplace violence that do not result in injury are not captured.