

**BEFORE THE
STATE OF CALIFORNIA
OCCUPATIONAL SAFETY AND HEALTH
APPEALS BOARD**

In the Matter of the Appeal of:

**BHC FREMONT HOSPITAL, INC.
39001 Sundale Avenue
Fremont, CA 94538**

Employer

DOCKET 13-R1D2-0204

DECISION

Background and Jurisdictional Information

BHC FREMONT HOSPITAL, INC. ("Employer") is a private behavioral healthcare facility which provides care to psychiatric patients. On July 5, 2012 through December 12, 2012, the Division of Occupational Safety and Health (the Division), through Associate Safety Engineer Susan Eckhardt, conducted an investigation at 39001 Sundale Avenue, Fremont, California. On December 19, 2012, the Division cited Employer for one alleged violation of the occupational safety and health standards found in Title 8, California Code of Regulations¹:

<u>Cit/Item</u>	<u>Alleged Violation</u>	<u>Classification</u>	<u>Penalty</u>
1-1	§3203(a)(6) [Lack of effective communication system to summon help during incidents of patient violence]	General	\$560

Employer filed a timely appeal of the citation. The appeals contested the existence of the alleged violations and whether the changes required to abate the alleged violation were unreasonable.

This matter came on regularly for hearing before Mary Dryovage, Administrative Law Judge for the California Occupational Safety and Health Appeals Board, at Oakland, California on August 14 and 15, 2013. The Employer was represented by Thomas B. Huggett, Littler Mendelson, P.C. The Division was represented by Shelly Gregory, Staff Counsel, Division of California Occupational Safety and Health. Each party presented testimony

¹ Unless otherwise specified, all references are to Sections of California Code of Regulations, Title 8.

and documentary evidence. The matter was submitted for decision after the submission of closing arguments and reply briefs. The ALJ extended the submission date to January 29, 2014 on her own motion.

DOCKET 13-R1D2-0204

Citation 1, Item 1, §3203(a)(6), General

Summary of Evidence

BHC Fremont Hospital is an in-patient and out-patient medical facility that provides care to psychiatric patients. The focus of the investigation was the 96 bed in-patient units, which are housed in a three-story building. The in-patients are individuals who have been medically deemed to be a danger to themselves or others.

The patients are housed in five non-forensic units, A through E. “Non-forensic” means that the patients are not under the jurisdiction of the criminal justice system or have no criminal record. Units A and B on the third floor house the patients that are most acutely ill with a psychiatric condition. The second floor has Unit C, for adolescent patients between the ages of 12 and 17 with diagnosed psychiatric conditions and Unit D, which houses adult patients with less acute psychiatric conditions than on the third floor. Unit E on the first floor is for adults with psychiatric conditions who need more assistance with activities of daily life or daily living. Units A, B, C, and D have 20 beds and Unit E has 16 beds. There are two beds per room.

The layout of the second and third hospital floor is a “V” shape with two units on each floor and a nurses’ station in the vortex. Off each hallway is a day room, consult rooms, exam room, and ten bedrooms, housing 20 patients. At the end of the hallway are a multipurpose room and an emergency exit. The doors to these rooms are normally kept locked. The doors on the patient rooms are kept open during the day. In each bedroom, the doors have been taken off the bathrooms, for safety reasons and instead the bathrooms have curtains, for privacy. There are “panic buttons” near the desk of the staff person in the rooms in which the patients meet with staff, family members, or court personnel. Each unit has a metal detector hand wand which is used when a newly admitted patient arrives and changes into a hospital gown.

At the times of the inspection, there were 279 employees including registered nurses (“RNs”), licensed vocational nurses (“LVNs”), licensed psychiatric technicians (“LPTs”), mental health technicians (“MHTs”), and case managers, who are social workers. Employees who don’t have direct patient care responsibilities but work throughout the facility include housekeeping, building maintenance and dietary department employees.

The MHTs have the most direct contact with patients and do periodic checks on patients every fifteen minutes. In cases where close observation is required, the patient is checked every five minutes. The rounds are done by the MHT alone and there is no policy which requires staff to use a “buddy system” when going into a patient room.

Associate Safety Engineer Susan Eckhardt (Eckhardt) was assigned to conduct an inspection at BHC Fremont Hospital in response to a complaint about potentially unsafe or unhealthy conditions. She conducted the opening conference on July 5, 2012 with Frances Fentzke, Director of Risk Management, Mark Chapman, Human Resources Director and John C. Cooper, the Chief Executive Officer (“CEO”) of BHC Fremont Hospital. Eckhardt returned to inspect BHC Fremont Hospital on October 23 and November 28, 2012. Eckhardt interviewed Barbara Pacifico, Director of Nursing and Sheila Lagoon, Nurse Manager, as well as several employees.

Eckhardt conducted a physical inspection of Units A, B and D. The layout of the units was similar. There was a seclusion room at the rear of the nurses’ station where patients could be brought if they needed to be restrained. All of the rooms have doors which can be locked. Patients can walk freely between their room, the hallway and the day room.

Division Exhibit 6, the OSHA Log 300 (Log of Work-related Injuries and Illnesses) for 2011, shows 22 injuries, of which 18 resulted from assaults by patients to staff.² Division Exhibit 5, the OSHA Log 300 for 2012 shows an increase in the number of instances of workplace violence from 2011. Between January 8, 2012 and October 21, 2012, there were 45 injuries, including 39 injuries as a result of patient assaults to staff. None of the entries on these logs state the location of the patient assaults or whether any employee other than the injured employee was present at the time of the assault.

Employer provided various documents to the Division in response to a written request to show steps taken to address the safety hazards. The Fremont Hospital Staffing Guide, Division Exhibit 3 shows the number of MHTs who are assigned to the unit, which varies, depending on the number of patients who were housed in that unit. The staffing levels are specified for each shift, AM, PM and nocturnal (NOC). A resource nurse and additional float MHT are assigned to work on the nocturnal shift in the adult unit.³ While it is not

² Examples of employee injuries 2011 include a nose/facial bone contusion due to patient punching employee, bruising, deep bite marks with no bleeding to right forearm from patient bite, scratches to right side of face due to patient attacking employee, bite on right ankle due to patient bite, face/scalp/neck contusion due to patient kicking patient, face/scalp/neck contusion, cervical strain, and head injury due to patient punching employee in head multiple times.

³ Guards on duty during the evenings are tasked with controlling the influx of visitors who come to visit patients and preventing the introduction of contraband into the units. The extent

clear from the evidence in the record if or when the staffing levels were increased, there was a lack of sufficient staff at the scene of the reported incidents to prevent patients' violent outbursts from causing harm to employees.

Fremont Hospital Injury and Illness Prevention Program Policy No. 9.4 ("IIPP"), effective December 18, 2011, has several generic sections which address the correction of workplace hazards. (Division Exhibit 7) The Fremont Hospital's Workplace Violence Policy, revised December 18, 2011, does not address the issue of employee safety regarding acts of violence by patients, but rather focuses on potential incidents involving violence between employees or involving their family members and associates. (Division Exhibit 8)

Employer refused to provide to the Division documents that it described as "root cause analysis" reports. A "root cause analysis" report is an investigation done by Employer when a serious injury at work involving a patient or an employee occurs. (8/14/13 HT 10)⁴ Cooper and Fentzke refused to provide these reports to the Eckhart based on "confidentiality" objections.

The Fremont Hospital policy "Code Green: Team Support", revised November 2009, addresses potential violence by patients. (Division Exhibit 9) It allows an employee who feels threatened by a patient to call for help verbally by requesting a "Code Green." The policy then provides that an employee who is trained in Crisis Prevention Intervention ("CPI") will come to the aid of the employee who requests help.⁵ The "Code Green" procedures provide that:

1. Staff will page a Code Green - location" repeating three times, when a. the patient is combative, b. the patient a threat to self and others, c. there is immediate breakdown with now time for interventions, d. all least restrictive interventions have failed.

This procedure says nothing about what the staff does, before the "Code Green - location" page is issued. Frances Fentzke told Eckhardt that the means of summoning the CPI-trained employee was not specified in the written policy. Examples of the methods used by the Employer include paging someone over the intercom, yelling "help", pressing the panic buttons, or using the "Code Green" procedures.

to which they were available to prevent patient assaults on staff is not in the record.

⁴ References to the unofficial hearing transcript are designated by the date, HT, page number, e.g. "8/14/13 HT ___". The official record is the audio recording maintained by the Appeals Board.

⁵ CPI training was given to the RNs, the LVNs, the LPTs, the MHTs and the clinical case managers, as well as some administrators.

The Code Green system involves a broadcast over speakers throughout the facility, stating the area of the hospital where the behavioral emergency is occurring. When a nurse or other staff member learns of an assault, the RN on the unit issues the Code and is the lead person. All staff that are available and trained in CPI are expected to report to the scene of the code. If indicated, medicines which were authorized by the physicians' treatment plan are available and the patient is encouraged to take them voluntarily. There is an involuntary mechanism to administer the medications, if needed. After a Code Green incident, the staff debriefs to evaluate what occurred, but the Employer did not introduce the meeting minutes or any evidence of corrections made as a result of the evaluations.

The panic buttons are mounted on the walls that trigger an audible alarm and a strobe light outside of the room where that panic button is located and result in the Code being called. These buttons are located in the exam rooms, the consultation rooms used for discussions with family members and the patient, or for civil court hearings. There are no panic buttons in the hallways, patient rooms, day rooms or nurses' stations. (8/14/13 HT 33) Portable radios are on each unit, kept on a charger.

The managers who Eckhardt interviewed told her that personal alarms were made available to employees for use to summon help, but their use was not mandatory. These personal alarms produce a noise estimated at 130 decibels when activated. After the Cal/OSHA inspection in July 5, 2012, Employer discussed the personal alarms at a staff meeting in October, 2012 and notified employees that personal alarms were available, by including a newsletter with a safety reminder about personal alarms in employee's paycheck envelop. (Division Exhibit 10, dated November 9, 2012) Employees at new employee orientation talks were also told about the personal alarms. Other than these paycheck notices, there was no written information disseminated to employees regarding the use of the personal alarm units. Based on the Employer's assertion that no employees requested an alarm, Eckhardt inferred that personal alarms were not in use by any employee.

Universal Health Services, Inc., the parent company for BHC which operates Fremont Hospital, did a safety inspection for Unit A, on or around November 1, 2012. (Division Exhibit 11) Under one of the categories, "Patient Assault", the box "MET" is checked for "Staff are carrying personal alarms, radios per policy", indicating that the standard has been met. This assertion is inconsistent with the existing BHC Fremont Hospital policies, which were provided to Eckhardt during her investigation. Employer CEO John C. Cooper admitted during his testimony that this item should have been marked "not applicable" rather than "met". In fact, there was no policy at the facility for employees who perform direct patient care to carry personal alarms or radios. (8/14/13 HT 52).

Testimony of Chris Kirkham

Senior Safety Engineer Chris Kirkham has worked for the Division for fourteen years. Previously, he held positions as assistant industrial hygienist, associate industrial hygienist, associate safety engineer and senior safety engineer. Kirkham earned a bachelor degree in biochemistry from U.C. Davis and a master's in public health from U. C. Berkeley, with an emphasis on industrial hygiene. His training regarding workplace violence includes two-day training by the Crisis Prevention Institute on the escalation cycle and physical containment techniques, as well as one day training by California Pacific Medical Center on "managing assaultive behavior". Kirkham has also participated in two webinars provided by Federal OSHA, one on the violence directive (Division Exhibit 14) and the other on the Guidelines for preventing workplace violence regarding health care workers (Division Exhibit 13).

Since working for the Division, Kirkham has conducted about 400 inspections, seven of which involved mental health facilities. Nine inspections involved workplace violence and twenty involved non-formal inspections concerning issues of workplace violence. Seven inspections involved in-patient, acute psychiatric treatment facilities. Two of the nine involved facilities that were not dedicated to providing mental health services - the country jail and a geriatric long-term care unit. He assessed the security risk factors as part of the inspection, including the ability of employees who are in direct contact with patients to summon assistance during an episode of violent behavior by a patient.

Kirkham reviewed the case file after the citations were issued. Based on a review of the injury logs (Division Exhibits 5 and 6), Kirkham observed that the patterns at BHC Fremont are consistent with the experience of other mental health service facilities, in which physical assaults which result in less severe injuries are more frequent but tend to predict the potential for less numerous but more serious injuries.⁶ Kirkham's opinion is that the Employer was not effectively correcting the hazard of assaults by patients, which increased in April, May and June 2012, compared with 2011.

Kirkham testified that the information that he gathered during his investigations of psychiatric in-patient facilities shows that many assaults happen in isolation. Based on the lay-out of this facility, there are many locations with potential visual isolation in which screaming for help would not likely be effective.

⁶ Kirkham discussed the "pyramid of injuries", whereby the less severe accidents are more numerous and the most serious are least frequent. The range of severity of injuries resulting from violence by patients in in-patient facilities ranges from scratches, psychological trauma, bruises, to death.

In the four strangulation cases which Kirkham investigated, the employee was not physically able to yell for help, e.g. the patient wrapped his hands around the staff member's mouth, or punched an employee in the stomach, or held the employee in a bear hug, so that the employee could not fill his abdomen to scream. In cases he investigated, employee responses included the following: some people froze, lost their voice, could not be heard due to a soft voice, or were weak from a recent illness.

Kirkham testified that panic buttons are frequently not accessible to the employee in a psychiatric facility, due to the location of the buttons. The use of groups of employees during shift change inspection protects employees at that time, but does not prevent other incidents, when an employee works in isolation with the patients. In this case, employees do not wear a personal alarm system, which would insure effective communication for help. In addition, some facilities, including the California state hospitals, not only provide personal alarms, but require their use by all employees who go into the unit. Based on Kirkham's investigation in a fatality at Napa State Hospital, the failure to have a personal alarm played a role in the incident in which a patient strangled the physician with the physician's scarf. The physician was unable to reach the wall button because the patient was between the physician and the panic button.

Kirkham recognized that BHC Fremont has taken some steps to address violence, but testified that the increased staffing at night or other requirements in the staffing guide will not prevent all assaults of employees who are in isolation. Kirkham opined that while an alarm will not prevent an assault in all situations, it prevents some assaults from happening by acting as a deterrent, and by enabling an employee fearing an assault, or being assaulted, to obtain help in a timely fashion. Kirkham testified that there was insufficient information on the injury logs in this case to determine whether the employee whose injury was reported in each instance was isolated or not.

Testimony of CEO John C. Cooper

For the past two and a half years, John C. Cooper, CEO of BHC Fremont has worked for Universal Health Services ("UHS"). He has extensive experience with psychiatric patients.⁷ Cooper has a bachelor's degree in music therapy from the University of Georgia, a master's degree in clinical counseling from University of South Florida and a master's degree in health care administration from Nova Southeastern University.

UHS has 198 behavioral health facilities in the US, in addition to medical facilities. Cooper testified that none of the institutions he has worked for made

⁷ Cooper has served in management positions in hospitals in Arizona and Florida and as a therapist for emotionally disturbed children.

wearing a personal alarm mandatory, including UHS.

At BHC Fremont, there are panic buttons in the consultation rooms used for discussions with family members and the patient, or for civil court hearings. The panic buttons sound an alarm, activate a strobe light, and result in the Code being called.

Video cameras are located in the nurses' station and seclusion restraint or time-out room in the back, in the hallways, day room, multipurpose room, cafeteria, gymnasium, hallways and entrances/exits to the hospital. There are two sets of monitors for real time review. Each set has sixteen cameras. One set is in Cooper's office and the other is in the clinical services unit. Each nurses' station has a pair of monitors for the units on their floor. Those panels show the back room, the hallways and the day room. However, from the nurses' station, one cannot see into the patient's rooms.

Cooper testified that the live feed video cameras are not staffed. There are no cameras in patient rooms or bathrooms. Cooper testified that "all of the staff members are required to monitor the video system", but that he did not spend time watching the monitors in his office and no one was specifically tasked with real time monitoring of the video system in the clinical services unit.

In April 2012, a therapist in the out-patient department complained about the lack of personal alarms, because she was being followed to her car by a patient. After receiving this report, BCH Fremont purchased several personal alarm devices and made them available for staff use. They are kept on the first floor in the safety officer's office and the nurses' staff office. Employees were informed about the availability of personal alarms through staff meetings and the November 2012 newsletter.

The reasons why the personal alarms are not required, according to Cooper are: (1) staff has not stated that they would feel more secure with a personal alarm; and (2) staff would have to be disciplined if they violated the rules. He was not able to determine if any of the assaults were caused by isolation of staff, or whether the incident would have been "absolutely prevented had there been a personal alarm".

Cooper reviews the incidents reports sent by Frances Fentzke (Fentzke), Director of Risk Management at BHC Fremont Hospital. These reports provide information on the type of incident, what the staff did as a result of the incident, and the additional follow up needed. The root cause analysis reports also contain information about patient assaults on staff and were not produced to the Division.

Employer Exhibit A is the CPI nonviolent crisis intervention participant workbook which instructs employees on the safe management of disruptive

and assaultive behavior. The CPI training is required for RNs, LPNs, LPTs, MHTs, case managers, activity therapists, and security personnel. Other employees are offered the CPI training, when the space is available. Page 14 instructs them on the release techniques to be used when an employee is getting choked or bitten.

The “Workplace Violence” policy (Division Exhibit 8) which contains a zero tolerance policy, applies to the staff, and not the patients. Cooper testified that BHC Fremont addresses workplace violence associated with patient assaults by collecting data on these incidents, analyzing the data, and taking corrective action immediately. However, there was no documentation regarding what actions were purportedly taken or the dates on which the corrective actions were taken. BHC Fremont does not have a policy regarding personal alarms, radios or phones. Cooper admitted that it is possible for a staff member to be in a patient room, alone and for the door to be closed by the patient. Staff have been trained to never allow the patient to stand between them and the door, but Cooper admitted that it is not inconceivable that this could occur.

Fentzke has been the Director of Risk Management for the past three and a half years. She participates in the monthly safety risk management committee meetings with the licensed staff, but she is not a clinician and has no training with regard to direct patient care. When “something negative happens” involving a patient and staff, Fentzke is alerted through an incident report called the Health Care Peer Review (HPR). The employer’s human resources staff also creates Employee Accident Reports (EAR), which focuses on the injured employee and do not contain any patient information. The Root Cause Analyses reports are completed by her when there is a “tragic event”, which she defined as a loss of consciousness, fracture or death of an employee or patient. The Employer’s forms do not specify whether the employee was isolated when the injury occurred. (8/15/13 HT 134)

Mark Chapman (Chapman) has been the BHC Fremont Hospital Director of Human Resources since November 2011 and is responsible for managing the Employer’s personnel functions. Chapman provided Eckhardt with the OSHA 300 logs for 2011 and the first ten months of 2012 (Division Exhibits 5 and 6) which he prepared. These logs are based on employee accident reports he reviewed or conversations he had with injured employees.

Chapman testified regarding the forty-six employee injuries reported between January and October 2012, including thirty-nine patient assaults on employees and seven involving other types of work-related injuries. (Division Exhibit 5)⁸ Four employees were assaulted by patients in January 2012.⁹

⁸ The Employer withdrew Employer Exhibit C, the complete OSHA Log of Work-related Injuries for 2012 based on the Division’s objection that it was not provided in discovery. The two additional injuries in November and December 2012 are therefore not considered as part of

Incident No. 3 and No. 4 were both OSHA reportable incidents: one involved a contusion to the shoulder region caused by patient pushing the employee into the door frame and the other described as “contusion: wrist strain: shoulder/upper arm” caused by a patient slamming the door to the dayroom onto an employee’s hand. In February 2012, there were three patient assaults to staff. Incident No. 7 is an OSHA reportable injury which involved a security guard who was struck in the eye several times, after being called to the scene to break up a fight between patients. It is described as “contusion: fact/neck strain: mandible, TMJ, Head Injury.” There was one patient assault to staff in March 2012, three in April 2012, ten in May 2012, six in June 2012, two in July 2012, one in August 2012, one in September, 2012, and eight in October 2012.

OSHA Guidelines for Preventing Workplace Violence

In 2004, federal OSHA issued Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA 3148–DIR 2004 concerning the violence inflicted by patients or clients against staff. (Division Exhibit 13) The Guidelines recognize that the “OSH Act mandates that, in addition to compliance with hazard-specific standards, all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harms.” (*Id.* at p. 2) The seriousness of the problem was also noted in the 2004 federal OSHA Guidelines: “[Bureau of Labor Statistics] data shows that in 2000, 48 percent of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services.” Risk factors include “solo work, often in remote locations with no backup or way to get assistance, such as communication devices or alarm systems.” (*Id.* at p. 3)

The federal OSHA policies and procedures were expanded when U.S. DOL OSHA Directive CPL 02-01-052, Enforcement Procedure for Investigating or Inspecting Workplace Violence Incidents, was published, and made effective on September 8, 2011. (Division Exhibit 14) “Workplace violence has remained among the top four causes of death at work for over fifteen years, and it impacts thousands of workers and their families annually.” (*Id.* at p. 4) Healthcare and social service settings were identified as high-risk industries.

this decision. (8/15/13 HT 142 and 150)

⁹ Chapman’s recollection of the circumstances surrounding the patient assault incidents was vague and contradictory. (8/15/13 HT 140-150). On cross-examination, he admitted that his recollection was refreshed by reading Exhibit 5 and he had no independent memory of the location of some of the incidents. (8/15/13 HT 151-152) Chapman testified that he could not determine whether the employee who suffered a contusion to the knee in Incident No. 32 was alone when the employee was kicked by the patient. Nor could he recall if there were other employees present when a patient head-butted an employee in Incident No. 33.

Working with unstable or volatile persons in certain healthcare settings, such as in-patient psychiatric facilities, working alone or in small numbers and history of workplace violence are among the known factors which inform the decision by OSHA inspectors to conduct an inspection. Under this directive, if inspectors determine that a serious workplace violence hazard exists because the employer failed to keep its' workplace free of hazards to which employees were exposed, a citation alleging a violation of the general duty clause would be warranted. (*Id.* at p. 16-17)

The Cal/OSHA Guidelines for Security and Safety of Health Care and Community Service Workers, March 10, 1998, as well as the federal OSHA guidelines, recommend the use of personal alarms for psychiatric hospitals and in-patient facilities. (Division Exhibit 12 at page 12, Division Exhibits 13 and 14)¹⁰ The Cal/OSHA Guidelines suggest that after the employer conducts an identification of security hazards, it should “determine if risk factors have been reduced or eliminated to the extent feasible. Identify existing programs in place and analyze effectiveness of those programs, including engineering control measures and their effectiveness.” (Exhibit 12 at p. 10) With respect to the use of engineering controls in psychiatric hospital/ in-patient facilities:

Alarm systems are imperative for use in psychiatric units, hospitals, mental health clinics, emergency rooms, or where drugs are stored. Whereas alarm systems are not necessarily preventive, they may reduce serious injury when a client is escalating in abusive behavior or threatening with or without a weapon.

- a. Alarm systems which rely on the use of telephones, whistles or screams are ineffective and dangerous. A proper system consists of an electronic device which activates an alert to a dangerous situation in two ways, visually and audibly. Such a system identifies the location of the room or action of the worker by means of an alarm sound and a lighted indicator which visually identifies the location. In addition, the alarm should be sounded in a security area or other response team areas which will summon aid. This type of alarm system typically utilizes a pen like device which is carried by the employee and can be triggered

¹⁰ Employer’s claim that these guidelines do not mention the personal alarm as a reasonable abatement is not accurate. See, e.g. Division Exhibit 14, Appendix B – Potential Abatement Methods, “Implement Engineering Controls, such as: Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones and private channel radios where risk is apparent or may be anticipated. Arrange for a reliable response system when an alarm is triggered.”

easily in an emergency situation. This system should be in accord with provisions of California Title 8, GISO Section 6184, Emergency Alarm Systems (State of California, DIR GISO). Back up security personnel must be available to respond to the alarm.

(Exhibit 12 at p. 10) The work practice controls section recommends:

- b. Personal alarm systems described under engineering controls must be utilized by staff members and tested as scheduled.

(Exhibit 12 at p. 15)

Findings and Reasons for Decision

The Division established that the employees were exposed to assaults and workplace violence by patients, the hazard was known to the employer and the Employer failed to maintain an effective Injury and Illness Prevention Program, in violation of section 3203(a)(6). Employer's Appeal from this item is denied.

The factual allegations of Citation 1, Item 1 are:¹¹

During and prior to the Division's inspection, the employer failed to implement an effective IIPP in that the employer did not correct an identified unsafe working condition by taking appropriate steps to ensure that an effective communication system was in place for all employees to summon help during violent behaviors by patients, including assaults on employees. Panic buttons were located in various areas, but these may not be accessible to an employee experiencing an assault. Screaming or whistling by employees is not to be relied on to communicate an emergency due to the potential failure for this type of communication to be heard by other employees.

Employer was cited under Section 3203(a)(6), which reads as follows:

¹¹ Division's motion to amend citations to change the violation from Section 3203(a)(3) to Section 3203(a)(6) was granted on August 13, 2013. There is no change to the alleged violation description, other than the underlined portion and the section cited.

(a) Effective July 1, 1991, every employer shall establish, implement and maintain an effective Injury and Illness Prevention Program (Program). The Program shall be in writing and, shall, at a minimum:

(6) Include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely manner based on the severity of the hazard: (A) When observed or discovered; and, (B) When an imminent hazard exists which cannot be immediately abated without endangering employee(s) and/or property, remove all exposed personnel from the area except those necessary to correct the existing condition. Employees necessary to correct the hazardous condition shall be provided the necessary safeguards.

Division has the burden of proving a violation under the preponderance of the evidence standard. (*Howard J. White, Inc.*, Cal/OSHA App. 78-741, Decision After Reconsideration (June 16, 1983).) Here, to prove a violation of §3203(a)(6), the Division would have to prove that the employer failed to “implement and maintain” an “effective” IIPP that provides “for correcting unsafe or unhealthy conditions . . . in a timely manner. . . when observed or discovered.” More specifically, the question would be whether Employer took appropriate steps (“implemented and maintained” an “effective” IIPP) when it observed the hazard, consisting of frequent and increasing number of patient attacks on employees within the facility.

Section 3203(a)(6) requires the Employer to provide proof of the action taken to correct the known hazard, once an unsafe condition is found. (*BART*, Cal/OSHA App. 09-1218, Decision After Reconsideration (September 6, 2012).) In *BART*, the Appeals Board held:

The safety order requires employers to establish, implement and maintain such procedures. Thus, a written plan that states "action shall be taken on reported unsafe conditions" may satisfy the requirement to establish a written plan. Such, however, does not show the plan was implemented. Rather, proof of implementation requires evidence of actual responses to known or reported hazards. Conversely, proof of failure(s) to respond to known or reported hazards establishes a violation of this section through a failure to implement a plan. (*Los Angeles*

County Department of Public Works, Cal/OSHA App. 96-2470 Decision After Reconsideration (Apr. 5, 2002) [employer's failure to train employee in accordance with its own sufficient written training program was failure to implement the training portions of an IIPP as required by 3203(a)].

1. Unsafe working conditions were well known to Employer.

Repeated and numerous patient assaults on employees, increasing in frequency in 2012, were known to Employer throughout 2011 and 2012, through the time of the October 2012 inspection. Employee injuries as a result of patient assaults on staff averaged one per week in the first ten months of 2012, an increase from 2011. A number of injuries were caused by patients who were assaulting the employees who had been called to the aid of other employees or patients. Even if the injuries were caused when one or more other employees were present, it appears that there was an insufficient amount of staff present at or near the incident to de-escalate the situation in a timely manner. The high frequency of patient assaults within the hospital, many with serious consequences, constitutes a significant employee hazard, regardless of the specific circumstances in which they occurred.

The Employer's knowledge of its' employees exposure to violent patient behavior and the ongoing exposure to the risk of violence by patients in its in-patient facility is well established.¹² CEO Cooper admitted that he reviewed the detailed reports of incidents of violence and was aware of the hazards caused by the patient assaults on staff. In addition, Fentzke and Chapman, both of whom were in responsible management positions, were aware of the continuing patient assaults against employees.

2. Lack of timely correction when the hazard was discovered.

As noted above, once the employer is aware of the safety hazard, the employer is required to develop a program for preventing similar or more serious incidents in the future. *BART, supra*.

There is no written documentation of the changes to procedures or engineering controls implemented in response to the increase in employee injuries by patients. If, as a result of the reports and interviews of the percipient witnesses by Fentzke and Chapman, they made corrections or changes to the Employer's procedures, these changes should have been documented in writing. They testified that they had knowledge of details of

¹² "Lack of employer knowledge" is a defense to a serious classification and is not relevant here. (*Tomlinson Construction, Cal/OSHA App., 95-2268 Decision After Reconsideration (Feb. 18, 1998).*)

these incidents, but did not specify what changes were made or when the changes were made.

BHC Fremont Hospital holds monthly safety risk management committee meetings with the licensed staff whose jobs involve direct patient care. Cooper testified that a number of strategies were enacted to provide a safe environment for the employees, including additional staffing and guards in the evenings, mandatory CPI training for those employees involved in direct patient care, installation of panic buttons in some locations, video cameras and the Code Green policy. The specifics are not in the record, such as the date the changes went into effect or changes to the written policies.

None of the detailed reports maintained by the employer, such as the "root cause analysis reports," incidents reports (called "Health Care Peer Reviews") and Employee Accident Reports (EAR)) were introduced at the hearing or provided to the Division during the investigation. These reports presumably contained the facts surrounding serious injuries caused by patient assaults.

Employee Exposure

Employee exposure is required for each alleged violation. "Exposure" has been defined as "reliable proof that employees are endangered by an existing hazardous condition or circumstances." *United Airlines*, Cal/OSHA App. 00-2844, Decision After Reconsideration (April 30, 2009) citing *Santa Fe Aggregates, Inc.*, Cal/OSHA App. 00-388, Decision After Reconsideration (Nov. 13, 2001). "There must be some evidence that employees came within the zone of danger while performing work related duties, pursuing personal activities during work, or employing normal means of ingress and egress to their work stations." (C.A. *Rasmussen, Inc.*, Cal/OSHA App. 96-3953, Decision After Reconsideration (Sept. 26, 2001); *Santa Fe Aggregates, Inc.*, *supra*).

Employees of BHC Fremont Hospital were exposed to patient assaults, including 18 incidents in 2011 and 39 incidents in the first ten months of 2012. (OSHA 300 logs, Division Exhibits 5 and 6) (Chapman, Eckhardt, who interviewed other employees, and Kirkham) The types of injuries which occurred during this period included contusions to the shoulder region, the wrist, the shoulder/upper arm, the neck, the mandible, and head injuries. The cause of the injuries included a patient slamming a door to the dayroom onto employee's hand, a patient kicking an employee, punching an employee in the face, ear, temple or other body part, choking an employee, using table and chairs to strike employees, and various struggles which occurred when employees were putting patients in four-point restraints.

The Division established a violation of Section 3203(a)(6) by showing that the Employer was required to implement a plan to protect its employees from the known or reported hazards in a timely fashion and it did not do so.¹³

Adequacy of the actions Employer took to protect employees

Employer argues that the steps it took to reduce the hazard to employees should be viewed as an adequate response to the observed hazard.

Employer maintains that its IIPP, which has been in effect since December 18, 2011, addresses the unsafe conditions and satisfies the requirements of Section 3203(a)(6) (Division Exhibit 7). Employer's IIPP requires hazard inspections to be performed and documented at least monthly, as required by Section 3203(a)(4). However, Section 3203(a)(6) requires hazards which are discovered to be corrected in a timely manner.

The Employer established procedures for investigating work injuries and maintaining reports, in addition to the OSHA 300 Log. The Code Green Policy No. 205 was last revised on November 2009 and it mandates CPI trained staff report to an incident of violence in the workplace as soon as possible, but does not specify how this is to be done. (Division Exhibit 9) A comprehensive Injury and Illness Prevention Program should include elements which implement the post-incident analysis and corrective action, as discussed below. This piece is missing. If there were further changes to Employer's written policies since 2011, which address the hazard of frequent assaults on staff by patients, they were not made part of this record.

Although Employer took certain steps to minimize the hazard, it is apparent from the evidence that these steps were not adequate. In Jan. 2012

¹³ The use of personal alarms by employees is not specifically mandated by the safety order. However, once a hazard is identified, the Employer must develop the methods or procedures for correcting the unsafe condition. Kirkham's testimony and the documents that he referred to in his testimony, which identify the use of personal alarm devices as a useful method of countering the observed hazard, are sufficient to establish that use of such devices would be one useful approach to employee protection. It is not necessary for the Division to prove that use of such a method would be the only way to protect employees, or that it would be provide perfect protection.

Kirkham testified credibly that while a personal alarm is not a preventative device, it serves as a deterrent which could cause a patient to refrain from violent conduct.¹³ Kirkham was established as an expert, based on his specialized knowledge, skill, experience and training, including seven investigations of facilities which provide mental health services and twenty investigations involving workplace violence. (Cal. Evidence Code 720). His opinion regarding the utility of requiring staff to use personal alarms to prevent or minimize the harm caused by assaults on staff is reasonable and trustworthy. *Sargon Enterprises, Inc. v. University of Southern California, et al.* (2012) 55 Cal.4th 747.) Kirkham's opinion that the Employer could require employees to wear a personal alarm is well founded.

there were four assaults, in February, there were three, and then the number was down in March and trending upward in April. There were ten in May, six in June, then down again during July-August-September, but eight more occurred in October. (Exhibit 5 and testimony of Chapman) Employer chose not to implement an additional action that is well recognized as a useful preventive measure. Rather than requiring use of personal alarm devices - or some other comparable system - Employer eventually made personal warning devices available to employees but their use was not mandatory. Even this action was taken at least four months after the investigation began and at least six months after the pattern of continued and increasing frequency of assaults began.

Employer's "Code Green" policy cannot be implemented if the vulnerable employee is not able to summon adequate and timely assistance to prevent the patient from assaulting the employee. Weaknesses in the engineering controls which were known to Employer include the fact that the live feed video cameras are not staffed and no real-time monitoring exists to provide timely assistance.

Employer's contention, in effect, is that it did enough to prevent attacks without requiring employees to wear a personal alarm. It argues that none of the incidents would have been avoided or minimized by the protection that a personal alarm would have afforded. This argument is not well supported by the evidence.

Employer had detailed "root cause" reports which were not provided to the Division. There is a strong inference that these reports would have likely supported the Division's analysis that a personal alarm or other device for summoning others would have helped to prevent injury to the employees. By the failure to produce these reports, employer's assertions that personal alarms would not have made the workplace safer in those instances are questionable. (Evidence Code sections 411 and 412¹⁴) Even the sparse details of patient assaults in the OSHA logs show that there was a lack of sufficient staff at the scene sufficient to contain the patients' violent outbursts. At least some of the harm caused by these violent incidents would have been prevented or minimized by the use of a personal alarm.

Employer's opinion that personal alarms should not be required is based on assertions that 1) nobody asked for one, after personal alarms were purchased, and 2) the employer would have to discipline employees for not wearing them, if the policy were put into effect. The suggestion that compliance

¹⁴ Evidence Code Section 211 provides: "Except where additional evidence is required by statute, the direct evidence of one witness who is entitled to full credit is sufficient for proof of any fact." Evidence Code Section 412 provides "if weaker and less satisfactory evidence is offered when it was within the power of the party to produce stronger and more satisfactory evidence, the evidence offered should be viewed with distrust."

may be inconsistent does not alleviate the employer's obligation to implement and enforce measures to address known safety hazards as they arise in the workplace. Employer's failure to require use of personal alarms or other devices constitutes a failure to correct unsafe or unhealthy conditions, work practices and work procedures in a timely manner based on the severity of the hazard.

Employer admits that the use of personal alarm devices was identified as a possible safety measure. The UHS safety inspection report form for BHC Fremont incorrectly credited the employer as meeting this requirement. It had no policy requiring staff to carry personal alarms or radios. Such a policy would not be difficult or costly to implement, given that the Employer purchased personal alarms and made them available for use upon request by the employees. The fact that none of the employees use or requested to use a personal alarm is not a sufficient justification for failing to set up a policy requiring employees to use a personal alarm or other device to request assistance.

**Employer's argument based on whether a deficiency is
"essential to the overall program"**

In its' Post Hearing Brief, the Employer cites *Keith Phillips Painting*, Cal/OSHA App. 92-777, Decision After Reconsideration (Jan. 17, 1995) for the proposition that the Division fails to establish that the IIPP violated the safety order if the citation is based "on the ground of one deficiency, [unless] that deficiency is shown to be essential to the overall program". (Employer Post Hearing Brief, p. 11.) The Board's decision in *Keith Phillips Painting, supra*, upheld the finding that the IIPP was deficient, as it was missing certain essential elements, most notably the training and instruction required for all new employees and all employees given new job assignments. It did not discuss the requirements of Section 3203(a)(6), which requires that the unsafe conditions be corrected in a timely fashion. The Appeals Board has long held that the Division may establish a violation of Section 3203(a)(6), if the IIPP in question lacks any one of the minimum elements required. (*Tomlinson Construction*, Cal/OSHA App., 95-2268 Decision After Reconsideration (Feb. 18, 1998).) In this case, taking appropriate steps to correct known hazards is "essential to the overall program" and is required to maintain an effective IIPP. (*Keith Phillips Painting, supra.*) Section 3203(a)(6) requires that the steps taken must be memorialized by a written policy. The IIPP fails in that regard.

The Proposed Penalty

Employer did not dispute the \$560 proposed penalty including whether it was calculated in accordance with the regulation, the reasons for the classification of general and credits given. The Division appears to have granted the Employer all available credits, and to have applied the initial severity

classifications of most benefit to the Employer. Therefore a penalty of \$560 is appropriate and assessed against Employer for the violation.

Decision

It is hereby ordered that Citation 1 is sustained, and the appeal is denied, as indicated above and set forth in the attached Summary Table.

It is further ordered that the penalty indicated above and set forth in the attached Summary Table be assessed.

Dated: February 28, 2014

MD:sp

MARY DRYOVAGE
Administrative Law Judge

SUMMARY TABLE DECISION

In the Matter of the Appeal of:
BHC FREMONT HOSPITAL, INC.
DOCKET 13-R1D2-0204

Abbreviation Key:	Reg=Regulatory
G=General	W=Willful
S=Serious	R=Repeat
Er=Employer	DOSH=Division

Site: 39001 Sundale Avenue, Fremont, CA 94538

Date of Inspection: 07/05/12 – 12/12/12

Date of Citation: 12/19/12

IMIS No. 316562701

DOCKET	C	I	SECTION	T	Y	ALLEGED VIOLATION DESCRIPTION MODIFICATION OR WITHDRAWAL AND REASON	A	V	PENALTY PROPOSED BY DOSH IN CITATION	PENALTY PROPOSED BY DOSH AT PRE- HEARING	FINAL PENALTY ASSESSED BY BOARD
	I	T		P	E		F	A			
	T	E					F	C			
	A	M					I	A			
	T						R	T			
	I						M	E			
	O						E	D			
	N						D				
13-R1D2-0204	1	1	3203(a)(6)	G		[Failure to ensure effective communication system was in place for all employees to summon help during violent behaviors by patients.] ALJ affirmed violation.	X		\$560	\$560	\$560
Sub-Total									\$560	\$560	\$560
Total Amount Due*											\$560

(INCLUDES APPEALED CITATIONS ONLY)

NOTE: Payment of final penalty amount should be made to:

Accounting Office (OSH)
Department of Industrial Relations
PO Box 420603
San Francisco, CA 94142
(415) 703-4291, (415) 703-4308 (payment plans)

*You will owe more than this amount if you did not appeal one or more citations or items containing penalties. Please call (415) 703-4291 if you have any questions.

ALJ: MD
POS: 02/28/14