Cal/OSHA Advisory Meeting
Workplace Violence Prevention in Healthcare
Wednesday, April 1, 2015
Oakland, CA

Welcome: Juliann Sum, Acting Chief
Meeting Chairs: Bob Nakamura, Steve Smith, Kevin Graulich
Notes: Mike Horowitz, Nancy Olsson

MEETING ATTENDEES

NAME	AFFILIATION
Monica Aleman	UNAC/UHCP
Erik Angle	Sutter Health
Terry Baker	CA Dept. of State Hospitals
Jason Barry	University of California
Gail Blanchard-Saiger	California Hospital Association
Millicowt Borland	
Betty Borruso	California Nurses Association
Michael Boyer	CA Dept. of State Hospitals
Lynda Bredleau	California Nurses Association
Mark Brenner	Alvarez Associates, Violence Prevention Academy
Gerard Brogan	California Nurses Association
LaChanta Brown	SEIU
Cecilia Brownlee	Sutter Health
Catherine Bugarin	CNA
Rosa Carcamo	
Melany Carias	CNA
Marilen Castanon	UNAC
Nika Claes	CPMC L&D
Aaron Cramer	San Francisco General Hospital
Wendy Corr	California El Camino Real Association of Occupational Health Nurses (CECRAOHN)
Ingela Dahlgren	SEIU Nurse Alliance of California
Michael Davis	CA Dept. of State Hospitals
Maya Denny	CPMC L&D
Julie De Palma	CA Dept. of State Hospitals
Nonie Devens	CECRAOHN
Kate Durand	Laguna Honda Hospital
Fe Echon	
Amy Erb	CPMC; St, Luke's Hospital SF
Lorraine Feliciano	CNA
Sue Fendley	CNA/NNU
Don Fletcher	
Ashley Flowers	Kaiser Permanente
Debra Gass	CA Dept. of State Hospitals
Deborah Gold	
Suzi Goldmacher	Worksafe
Steven Gonzalez-Lederer	CA Dept. of State Hospitals

Caroline Gordon	Long Beach Memorial, Miller's Childrens
John Haberek	Alvarez Associates
Michelle Hamilton	CA Dept. of State Hospitals
Ed Halsell	CA Dept. of State Hospitals
Michael Hill	Alta Bates, Summit Hospitals
Sherri Hinkle	SEIU NSH
Colbie Hunt	CNA
Tricia Hunter	ANA/C
Janet Jones	CNA
Cynthia Jose	California Nurses Association
David Kernazitskas	Occupational Safety and Health Standards Board
Lindsey Kim	UCLA
Eric Koch	California Nurses Association
Mary Kochie	Cal/OSHA
Martha Kuhl	
Lorna Lentyas	Southern CA Hospital of Culver City
George Levy	
Rita Lewis	CCHCS – San Quentin
Page Lie	CNA
Suzanne Marshall	Chapman Medical Center, IHHI
Mary McDonald	CNA
Alberto Mejio	SEIU 1021
Michael Musser	California Teachers Association
Marilyn Ocampo	CNA
Sgt. Tim O'Connell	Alameda County Sherriff's Dept.
Michael Olisco	UCLA Westwood
Betsy Ortega	
Rochelle Pardue-Okimoto	CNA
Richard Parker	San Joaquin General Hospital
Stephanie Patten	CNA
Dexter Patterson	CNA, SEIU 1021
Mia Pinto-Ochoa	Kaiser South Sacramento
Steve Pitocchi	SEIU Local 1021
Jane Pressman	UCLA/NPH
Eleanor Punzalan	Ronald Reagan UCLA Medical Center
Manny Punzalan	Ronald Reagan UCLA Medical Center
Sandy Reding	
Kimberly Rosenberger	SEIU
Ruby Sloan	Alameda Health System, John George Psychiatric Hospital
Havila Smith	Kaiser Permanente Hospital, San Francisco
Holly Smith	Sutter Health
Anne Stewart	California Nurses Association
Nancy Sumner	Glendale Memorial Hospital
Jeremy Taylor	Sutter Health
Shelly Taylor, for Paul White	Securitas
Caryn Thornburg,	Valley Care Health System
Lyn Tirona	
Terry Tongate	St. Joseph Hospital, Orange
Sean Tracy	CA Dept. of State Hospitals
Kelly Tuttle	CNA
Pierre Ungaro	Dignity Health

Aldrin Valdez	Ronald Reagan UCLA Medical Center
Carl Walter	SEIU USWW
Alison Welsh	CNA
Vickie Wells	CCSF DPH
Dorothy Wigmore	Worksafe
Sandra Williams	Alameda Health System
BJ Wilson	SEIU 1021
Latanshia Wilson-Hall	
Heather Wooten	CNA
Norman Wright	Contra Costa County
Latori Young	SEIU

Juliann Sum, Acting Chief, welcomed the attendees and introduced the Division team working on the rulemaking project – Principal Safety Engineer Steve Smith, Senior Safety Engineers Bob Nakamura (lead) and Kevin Graulich, and note takers Mike Horowitz, Senior Safety Engineer and Nancy Olsson, OT. There will be a few brief statements from CNA. The focus of our time will be spent on what to do constructively going forward in this meeting.

Bob Nakamura polled the group to see who was from management, doctors' offices, labor, and local government. He stated the purpose of the meeting was for editing and to receive final comments on the draft proposal, which was presented at the last meeting. The Division received a number of comments which are posted on the web with the draft proposal. The Division tried to incorporate as much of the comments in this version and wants your final input today if things were left out or unclear. This will probably be the last public meeting for this part of the process. The proposal that we finish will be sent to the Standards Board staff who reviews it to see if it meets the rulemaking requirements that we have to follow with the Administrative Procedures Act for California. Once they think that it's ready and the Division approves it, then it starts moving. We have to work with the timeframe given by SB 1299 and that directs the Standards Board to adopt a standard by next year. It usually takes a year to do the rulemaking. Bob covered the agenda and then opened the floor for brief comments.

Jane Sandoval, RN and California Nurses Association board member, works at CPMC St. Luke's Hospital in San Francisco. They're in support of the proposed regulation that makes it clear that hospitals must have a workplace violence plan. They're not just talking about hospital policies or a web-based program that they require workers to take on a computer for their check-off list. The economic downturn has exacerbated the already marginalized demographic and these are not just psychiatric patients or those influenced by any organic or chemical disturbance. These are patients and visitors that healthcare workers are assaulted by on a regular basis. Hospitals claim they're doing an adequate job but they're not, such as the web-based programs. Most nurses have been a victim where they're bitten, kicked, slapped, kneed, items thrown at them; when they report it, often it's turned around and they ask if there's anything the healthcare worker can do to prevent it. The onus should not be on the hospital personnel; it should be on the hospital to make it safe. The current draft of the regulation has set a model for the nation by emphasizing prevention and it's not about detaining or vilifying the perpetrator. It's about staffing, accountability, education for all. The new regulations are also very comprehensive and cover healthcare workers in any location where healthcare is being provided. As their work environment changes and it moves out of the hospital, the conventional clinic or the hospital has moved out to retail stores and staffs are at greater risk for violence.

Amy Erb ICU nurse at CPMC St. Luke's Hospital. She was a student nurse the first time she was assaulted on the job. It was Christmas eve and she was working at the bedside of a patient

who had a traumatic brain injury and looked up startled, confused and agitated. He lashed out and kicked her hard on the side of her head. The primary nurse that she called for assistance laughed and said to her, "Welcome to our world, honey." Over the years, she's experienced and witnessed that violence toward nurses and other healthcare workers is universally dismissed as just part of the job. There's rarely any training or support for them. Like others, she's been scratched, pinched, punched, kicked, spat at and threatened too many times to count. This happens by patients with psychiatric disorders, medication reactions, dementia or delirium and is not their faults, but it is the healthcare workers' reality. Many nurses have encountered family members or visitors that are stressed to the hilt in these situations and are violent in their reactions, having no coping skills, and are often very threatening. They've experienced being very scared and nervous waiting for security to show up doing their best to protect themselves and their coworkers from various threats. There are those that actually get injured on the job by assaults, such as a nurse and aide that were stabbed by a patient with scissors at their hospital. The hospital's response was to blame the victims, their employees, and said they must have done something wrong. She has not once been offered any adequate training on recognizing, demonstrating or practicing any techniques to diffuse or de-escalate or manage any potentially violent situations. They've only been assigned inadequate computer modules to address this serious issue. Everyone seems to recognize and take seriously the issue of violence and assaults for those working in law enforcement, but studies have shown that nurses and healthcare workers are assaulted more often than police officers. The culture in their workplaces is one of complacency and indifference. They're here to show support for the strongest regulations that would hold hospitals and other healthcare facilities accountable for implementing a violence prevention and protection plan, one that includes interactive training, adequate staffing and security, resources for victims, and systems to report and investigate these incidents.

Michael Hill RN at a medical center in Oakland stated there has been increasing violence in the workplace which includes hospitals and much of it is preventable. He spoke of a nurse that was grabbed by the neck by a mentally unstable patient and lifted up by her neck and thrown to the floor. She was saved by her screams being heard by a passing staff member. Despite the staff calling security for help, they did not arrive for 15 minutes despite repeated calls. Another incident in the ICU nursery where a fight broke out between two families just feet away from fragile infants and despite security being called, the nurses and physicians had to break up the altercation. When security arrived, they stated they were unable to put their hands on the combatants due to hospital policy. Police had to be called because there was not enough security staff and there were multiple incidents going on at the same time in the ER. This has been the norm and nurses many times feel alone fighting this violence. The standard emphasizes prevention which is the key. Hospitals have been unwilling to provide the necessary protections and have inadequate staff due to cutbacks of nurses, ancillary staff and security personnel. This makes nurses even more vulnerable to violence. These regulations can be the standard model for California and the nation and need to be adopted today.

Gail Blanchard-Saiger, California Hospital Association, stated they are committed to working collaboratively through this process and have been very involved since the beginning. They're not discounting any of the concerns raised. Their goal is to create a healing environment for their patients and safe environment for their employees. They need to figure out how to operationalize what's being proposed and hope their comments today will be taken in that spirit. She also gave an update on a development in the legislature that the Emergency Nurses Association sponsored, AB 172, which increases criminal penalties for assaults on staff in the emergency room department. She encouraged others to join CHA and other organizations that are supporting that effort which is another important tool in addressing workplace violence.

Richard Negri, Health and Safety Director with SEIU Local 121RN, told the story of Donna Gross who was violently killed and strangled on the job by a known violent patient at Napa State Hospital in October 2010. When she was laid to rest, the facility said to her colleagues, "What did you expect? Look where she worked." A few weeks after she was killed Cynthia Palomata, a nurse at Contra Costa County Jail, was killed on the job. They petitioned the Standards Board, CNA also petitioned the Board, and SB 1299 came out so the necessity has never been any clearer. He stressed that the onus for a safe and healthful work environment is still on the employer, not the patient and not the nurse.

Bob Nakamura began the review of the proposed draft with the scope and application. The Division appreciated the comments received on better identifying health facilities that would fall under the scope. There were no comments on scope and application, so he moved on to the definitions section and mentioned that drug treatment programs were inadvertently removed and will probably be added back.

Elsa Monroe, RN at San Quentin State Hospital and SEIU Local 1000, stated that she comes from a land where they make weapons out of Jolly Ranchers, toilet paper, bagging from magazines. She stated that nurses were lost by being hit with lamps, thrown to the ground/asphalt, and dirt stuffed in a nurse's mouth. These were not weapons "designed for violence" and she would like the definition of dangerous weapon to be revisited.

Richard Negri stated that an instrument doesn't need to be designed to become a weapon. A set of teeth and a ballpoint pen are able to inflict serious injury and many in the room can talk about being bitten or stabbed by a pen. SEIU recommends removing "designed to be" from the definition of dangerous weapon.

A nurse with UNAC/UHCP agreed that removing those words would make the definition clearer. She's also been a victim of violence and was carrying a 3-month old baby and a visitor tried to throw a chair at her. If the chair had hit the child, there could have been a death or someone else could have been hurt. They've had nurses hit with IV poles, cardiac monitor cords. She thinks the definition of dangerous weapon should be more specific.

Michael Musser, California Teachers Association, thinks that the definition of dangerous weapon is too limiting and that anything can be a weapon. He feels that the definition should be broadened by striking the language, "designed to be."

Gail Blanchard-Saiger, appreciates the comments on the definition of dangerous weapon, but points out where other items such as a chair and IV pole would fall under the definition of workplace violence as "the threat or use of physical force." The idea is not to exclude those as violence, but trying to be clear on how to report a situation. If somebody comes in with a gun or a knife, regardless of what they do with it, the mere fact that they have it creates a reportable situation or recordable situation depending on what we're dealing with. Where somebody picks up a chair, using that as a weapon, that too would be reported or recorded. They're just trying to put things in the right bucket, especially for hospitals that are having to report these things that they know when and what they have to report.

Dorothy Wigmore, Worksafe, gave an example of someone working at a psychiatric ward where a piece of Plexiglas was used as a Frisbee and his only protection was a mattress. She stated that dangerous weapons depend on the circumstances, but the point is dangerous

weapons can be a whole lot of things and not just things that are designed to be dangerous. She encourages Cal/OSHA to go back to the original definition and take out "designed to be."

Jorge Cabrera, SoCalCOSH, urges that the definition be brought back to include any object that could potentially hurt or kill a healthcare worker – "dangerous weapon" means an instrument capable of inflicting death or serious bodily injury.

Pierre Ungaro, CNA, concurs with Mr. Cabrera and stated that any weapon is a weapon. He referenced the California penal code that uses ADW, assault with a deadly weapon, which could be a piece of wood.

Leslie Morrison, Disability Rights of California, recommends adding a definition for "serious bodily injury" since it's referenced in the draft. Bob Nakamura responded that it may be complicated to do that.

Rob Newells, UCSF Benioff Children's Hospital Oakland, supports Gail's comments on the definition and as we move a few pages forward to the definitions of reportable workplace violence incident and workplace violence, it makes sense to have a specific definition of dangerous weapon. It doesn't exclude any other weapons.

Bob Nakamura pointed out that part of the thing that's driven us is to use the definitions that we were given by SB 1299. This is basically part of that definition, so the definition of dangerous weapon is embodied in what a hospital has to report to the Division for incidents. In that context, we weren't really sure what the intent was as far as who recommended that exact language in SB 1299 and what the driving force was for that. If anyone has comments about that, it would help us to decide on the regulatory language.

Ashley Flowers, ER RN at Kaiser Permanente South Sacramento, stated we need to redefine the definition of a weapon as well as be mindful of materials used in their department that are accessible by patients. This year their ED had many violent incidents, but one patient took the framing off a mirror in the restroom and made a shank and attempted to attack a nurse with it.

Suzanne Marshall, Local 121RN, agrees with making the definition of dangerous weapon broader because she's been physically attacked twice, sustained physical injury, spent thousands of dollars on repairs and therapy because she was afraid to go back to work and had no one to protect her and no adequate security. The two patients that attacked her were themselves the weapons – their fists, their arms, and their feet. They didn't have to fashion any instrument; their bodies were the weapon so that has to be taken into account.

Katherine Hughes, RN with SEIU understands what others are saying about the definition of dangerous weapon and having it be this is what it was designed to be. But at the same time if you're looking at that makes everything that's used in a facility that wasn't designed to be a weapon reportable, the reality is under the reportable workplace violence incident, if anything is used and it is threatening and it can result in or does result in injury, it's going to be reportable. Let's call it like it is, a dangerous weapon is something that's being used that's capable of inflicting injury. Even if we kept that language in there, the reality is if they use a chair or a frame of a mirror, it's going to be reportable so we're just splitting hairs over something where everyone here can recognize that anything can be used as a weapon.

An anonymous person stated that in SB 1299, there is language in the bill signed by the Governor that specifically states that this section does not limit the Standards Board does not

limit the authority of the standards board to adopt standards to protect employees from workplace violence. There's additional language that says you don't have to stick to this bill in order to protect them.

Bob Nakamura pointed out that the Division didn't put that language in there to omit the use of improvised weapons and that it was just a distinction for the actual reporting. If someone uses the bed pole off his bed and starts swinging at someone, that's obviously a violent incident and should be reported. The distinction was how to categorize the reports that are turned into the Division.

Gail Blanchard-Saiger stated that CHA absolutely agrees that anybody that's using anything, whether it's a chair an IV pole or piece of glass, and comes at an employee whether they physically touch them or not, that is reportable and that is use of physical force or the threat of physical force. Her point in defining dangerous weapon as "designed to be used" is, and she thinks the legislative intent is the fact that the legislature used firearm as its example, if someone comes into a hospital with a gun, pulls a gun out and does nothing else so no physical force, that standing alone would be reportable. From a statutory construction perspective, "a" and "b" have to be something different and that's the distinction in her mind. They're not trying to get out of reporting anything and everyone all agrees on the IV pole and the chair that's used as a weapon would be reportable.

Nancy Sumner, Glendale Memorial Hospital, has worked 37 years in the emergency room. She doesn't agree with the definition of dangerous weapon as "designed to be capable of inflicting death or serious bodily injury" because you could have trauma, especially with veterans coming back and retired military personnel. You could have PTSD or other trigger in a nurse here that's already been assaulted and never reported it and you're going to have problems that people will not report it if they think that it's only a weapon. Anything and everything is a weapon. She suggested using "designed to be or capable of inflicting death or serious injury" in the definition. She recommends not using the term "bodily" because you can be traumatized and not show a physical scar like the veterans are showing.

An ER nurse with Kaiser Permanente Hospital and UNAC/UHCP asked that the term dangerous weapon be defined to include fists. She asked a patient to vacate from her bed because she was being transferred to a psych facility and she was very combative and lunged at her with her fists. A security officer came by and the patient punched him instead and he was knocked out.

Hector Alvarez, security consultant and police officer, stated that he would like to see an additional definition that expands around the improvised weapon because it makes a difference if someone crafted or found something when they got there versus they came with and brought that weapon with them. He's okay with dangerous weapon as defined if there was another definition to include or expand improvised weapon. It would be helpful for assessing the effectiveness of a program if they saw that overall the majority of attacks were improvised weapons versus dangerous weapons.

Dorothy Wigmore, noted the use of firearm is distinguished from other dangerous weapons in (e)(1) of the draft as particularly urgent and requires reporting within 24 hours and that other things are reportable within 72 hours. So yes things get reported if it's improvised, but it could be that you're going to be reporting it a lot later and that might make a difference in terms of prevention activities, taking it seriously, etc. Having either the reporting requirements all be the same in terms of time and that would make the definition not matter much or if the two different

reporting timeframes are kept, then it has to be clear that improvised weapons fall into the urgent or emergent threat or as a dangerous weapon.

Sandra Williams, Alameda Health System, asked if we're reporting all the injuries and Bob Nakamura replied yes. A registered nurse from Kaiser Oakland asked Bob to repeat his clarification. Bob replied that the reporting requirement in (e) on page 13 comes from SB1299 but the Division staff is not clear on what was the intent behind that; we want to see what the goal of that specific reporting requirement was.

David Kernazitskas, Occupational Safety and Health Standards Board, asked if the definition of dangerous weapon can be modified to "an instrument designed to be capable of or improvised to inflict death or serious harm" to incorporate some of the concerns brought up during this meeting. He asked if he ripped molding from a mirror and made into a shank would that be considered as designing it be a weapon. It's important to get that correct because on page 5 of the draft where if (B) of the workplace violence definition includes hands, teeth and pencils as dangerous weapons, then whether or not an employee is injured every time you use your hands, teeth or a pencil, you just had workplace violence. It's important to clarify the definition of dangerous weapon and maybe include improvised in there so that would take into account the use.

Mia Pinto-Ochoa, Kaiser South Sacramento, stated that dangerous weapon should be defined as "forceful use or threat with or without an object with intent to cause any injury or harm."

Bob Nakamura proceeded with reviewing other definitions.

Gail Blanchard-Saiger noticed that "disruptive behavior" was added in later in the regulation and it would be helpful to have a definition for that since it's used.

Dorothy Wigmore noted comments she prepared from WorkSafe, the word "hazard" is used later in the proposal instead of "risk factors" and there is a difference between the two. If you want to be accurate, what you're talking about in the definition of environmental risk factors are hazards. When you're talking about patients, you're dealing with risk factors. Hazards are the inherent property of things and that's what we want to get at if we want to prevent things; we don't want to argue about what are the odds of something happening. What occupational health and safety is about is dealing with the hazards and preventing them.

Nancy Sumner referred to the collection of money in the definition of environmental risk factors where it's huge in pharmacies nowadays. So you might want to give a couple of examples but you're limiting what type of environmental risk factors. Bob Nakamura replied that we actually didn't want to limit it and left it pretty open.

Elizabeth Hawkins, UNAC UHCP, recommends that the environmental risk factors include pharmaceuticals and administering procedures.

Gail Blanchard-Saiger requested that the language from the Safe Patient Handling regulation about distinct parts/skilled nursing facilities be used in the definition of general acute care hospitals. She maintained that it's not a coverage issue and that distinct part skilled nursing facilities would still be covered just like standalone skilled nursing facilities. She just wants to clarify the distinction between general acute care hospitals and distinct part skilled nursing facilities. Bob Nakamura asked Gail if this was about reporting. Gail replied that it's just about the definition of acute care hospital and that it could impact reporting but the members that

she's talked to said they'd still report skilled nursing because operationally it would be too difficult to separate out.

Lorna Lentyas, Southern CA Hospital of Culver City, works at a 72-bed inpatient psychiatric care facility and has the most violent patients from LA County hospitals. She stated that nurses also operate outside the hospital as psychiatric emergency teams (PET) at her hospital so she suggests that PET teams be included in the field operations definition.

Elsa Monroe referred to the correctional treatment centers, the county facilities, CDCR facilities where it's not just one treatment center but where the inmates are all getting their medications and there have nurses going to the cell blocks by themselves. She wants coverage for correctional settings where medical personnel are providing services.

Jane Pressman, UCLA/NPH, works at an acute psychiatric hospital and stated there is partial hospitalization programs after hospitalization as well as outpatient hospitalization programs and doesn't see those covered. Bob asked for clarification and Jane replied they are day treatment programs.

Richard Negri stated that the "general acute care hospital" definition is different than that in the Safe Patient Handling regulation because the latter might limit reporting and the idea was to go beyond SB 1299 and broaden it as wide as possible to affect the majority of workers. SEIU is okay with this definition but might need some clarification on it.

Cory Cordova, SEIU121RN, represents an acute psychiatric facility in Cerritos and referred to mobile clinics in the "field operations" definition. One of the things that happens when you're a stand-alone psychiatric facility is that you have to be transported via ambulance or van owned by the facility. If a person is in restraints, they have to be accompanied by a registered nurse by law. however College Hospital has no policy and procedure, no resources available if they have a code gray in that vehicle. We need to add something to include transportation of those patients, not just specific to treatment because sometimes they're en route to get medical treatment from a psych facility to a medical facility. Bob Nakamura replied that we don't intend to omit that issue and doesn't know if it's actually not covered but the Division will look at it.

Bob Nakamura addressed the question of outpatient care for psychiatric procedures, he asked the commenter to look at the definition of acute psychiatric hospital to see if it's covered.

Katherine Hughes stated there are often times when patients are medically transported from one facility to another and they're not necessarily psychiatric patients and could be transferring for any number of reasons. She's not sure that the "field operations" definition covers that. There could be a critical care transport where she works at a trauma center but now she has a cardiac patient that's going to be transported to a facility that specializes in cardiac where she doesn't work. So covering transportation is not a bad idea and is something they forgot. Bob asked if this involves someone going with a patient to another facility and Katherine agreed.

Lorna Lentyas stated the majority of hospitals in LA County transport their psychiatric patients with their own staff via taxi, van, or ambulance to the ward and most of those patients are violent and they don't have procedures or any security measures for violent patient attacks.

Gail Blanchard-Saiger stated the issue of transporting patients would seem to be covered as the hospital sending out its employee at a different location and would be responsible, but that needs to be thought through.

Lorna Lentyas stated that it would be advisable for the hospital to have a clear policy and emergency procedures for the safety of the staff transporting the patient. Bob Nakamura replied that the Division will consider the issue in more depth.

Bob Nakamura referred to the list of facilities under the "health facility" definition and asked for comments on those.

Vickie Wells, City and County of San Francisco Dept. of Public Health, asked what the Division is including as "congregate living health facilities" on page 3. Bob replied that we were using the lists we had from Licensing and asked if Vickie didn't think they were a source of violent incidents. Vickie said she can't respond because she doesn't know what is meant by the term and that it needs clarification. Bob said that the Division will need to reconsider whether to include it or not.

Gail Blanchard-Saiger stated that this definition is a little bit confusing and paring it down might help. She gave the example "or for any one or more of these purposes, for one or more persons, to which the persons are admitted for a 24-hour stay or longer" and explained there are things listed which would not require a stay for 24 hours or longer like pediatric day health and respite care. She gave another example, "for the purposes of this Section, a health facility includes hospital based outpatient clinics (HBOCs)" as something that's already previously stated and not needed. Gail offered to provide more clarity on this definition.

Sandra Williams stated that the definition or reference to congregate living health facilities can be found on the CDPH website.

Suzi Goldmacher, Worksafe, stated that home health seems to be missing from the list. Richard Negri stated that SEIU didn't think it needed to be there because they didn't consider it as a facility, but that it's covered under the scope.

Bob Nakamura continued with the list of definitions and explained that the definitions for "local health officer" and "medical specialty practice" were deleted because they weren't references used later on in the draft proposal. He also explained that the term "patient classification system" was added because it's part of the Labor Code.

Gail Blanchard-Saiger looked up the term "patient classification system" in T22 Section 70053.2 and based on that recommends that the sentence should end after the word "shift." Bob Nakamura responded that the Division will consider it but he thinks the whole definition is included in the Labor Code. An anonymous commenter replied that she disagrees with Gail and that it should be based on the assessment of the individual patient and that should be up to the RN to make that assessment and that language should not be removed.

Katherine Hughes stated the definition looked paraphrased and so she copied, pasted and read out loud the actual definition from Title 22. When they're talking about determining the amount of nursing care needed for each category of patient, that is based on the nursing assessment and the fact that they have to use the patient classification to determine the patient's acuity so that's exactly the assessment of individual patients by a registered nurse. She would like to say determine nursing care requirements because it's bigger than staffing. It's actually the kind of nursing care that's required, but that doesn't really apply to workplace violence so she left it alone.

A Kaiser Oakland RN stated that she thinks it's a slight paraphrase but that's why it's crucial that all of the language be included because it says "as specified in Title 22 General Acute Care Hospitals."

Richard Negri stated that he agrees with the previous commenter.

Latanshia Wilson-Hall, works in the ICU at Saint Bernadine Medical Center in San Bernardino, deals with a large number of violent patients and visitors. When they deal with what's going on 50% of that patient classification has to deal with the violence, the combativeness, how much the person is fighting, do they have them in 4-point restraints. Last week it took 6 nurses to hold a patient down until they could get a physician in the room and at the same time there were 3 nurses in the next room fighting with another patient. The patient classification is crucial in determining whether the patient needs one-to-one or needs sitters because they deal with this all the time and need the determination to say they need a higher nurse to patient ratio, provided they're actually using the system and listening to them and providing the staffing that is called for. She's been off work for the last 5 days because she's been traumatized by being threatened and assaulted more than 4 times in 1 ½ weeks. She recommends the definition not be stricken because it makes them look to see if they need more staff to address the needs of these patients and what's going on with it.

Gail Blanchard-Saiger is not suggesting omitting the definition and also recognizes it's in the statute. The citation she provided is what Katherine Hughes just read from so recommends either defining patient classification system and lay out the whole entire thing or just say "as set forth in Title 22 Section..." She's concerned that the paraphrase provides something different. Bob Nakamura replied that the Division will try to determine which would be better.

A nurse with Santa Monica UCLA Medical Center stated that the patient classification system should be removed because it does not fit the nurse at the bedside.

Rosa Carcamo, Saint Francis Medical Center, agrees with the nurse that was traumatized by the events that took place. Two days ago in her ED, they were holding 8 psychiatric patients for 60 hours with 2 sitters. One of them ran out of their department and they were chasing them down the street trying to get them back on a 5150 hold. They told their organization that they needed more staff and that the acuity level was too high and that it was dangerous, so this language should have exactly what Title 22 says.

Gail Blanchard-Saiger stated, in reference to the "patient contact" definition, that other action that ... "allows" direct physical contact is vague and is concerning as far as the standard. Bob replied that we're talking about potential.

Kate Durand, Laguna Honda Hospital, agrees that the "patient contact" definition needs work. There are employees whose job is to have patient contact and there are many other employees whose job is to not have patient contact, but they are in situations that allow for patient contact. She's not sure if the language is trying to separate it out or covering only those employees who are doing procedures that are meant to be direct patient contact. She gave an example of a food service worker delivering a meal where there's absolutely the possibility of patient contact, but that's not the intention of their assignment. She feels that the definition needs clarification because she feels that the food service worker needs to be covered. Bob Nakamura responded that is the idea that the Division is trying to get at.

Jeannie King, SEIU121RN, suggested using the wording "therapeutic contact with or without physical contact with the patient." Bob Nakamura replied that the Division is trying to get at situations where an employee can be hit by a patient.

Kate Durand added that she says the definition is not clear because there's a focus on clinical procedures. In their facility, there's an opportunity for patient contact in the cafeteria where somebody works in the billing department. The definition needs to be broadened to include possibility of contact with any employee.

A commenter had concern about broadening the definition because the training programs would be designed specifically for people who have contact versus somebody that has incidental contact. He suggested removing "allows" that could lead to something for people who just happen to walk on to a hospital or healthcare grounds versus somebody who's intentionally and specifically providing care. That program would be developed uniquely for them versus somebody who's in the cafeteria and just somebody who wanders in. There needs to be distinction between incidental contact and intentional contact for the purposes of tracking incidents and training programs.

Sandra Williams stated the emphasis should be on employees. When talking about injuries and people getting hurt, all employees should be included and no classification should be excluded. She gave an example of a patient affairs officer dealing with patient complaints, there's a potential for exposure to the hazards of that patient's and/or their family members' aggression. They also have other employees who come into contact with a patient and we should not segregate; we should be inclusive when we're talking about injury in terms of preventing and/or mitigating the exposure to the hazard of injuries.

Gail Blanchard-Saiger can't find where the term "patient contact" is actually used and she agrees with Sandra that it's really the risks and the hazards rather than the classification whether it's clinical or not. She suggests putting into context where it's actually used because maybe we don't even need it if we frame it in that way. Bob Nakamura replied that the Division would re-evaluate that.

Elsa Monroe stated that she feels comfortable with the "patient contact" definition the way it is because she looks at the broad scope with correctional facilities and state mental health facilities where this is what happens where the nurses have gotten killed and LPTs have died. They were innocently walking from clinic to point B and they were assaulted.

Richard Negri suggested removing "workplace" from the definition of "patient specific risk factors" because he doubts that anyone would know that a patient or any individual in front of them has a history of "workplace violence" specifically as opposed to "violence." He also suggested removing "the use of drugs or alcohol" because where it says psychiatric condition or diagnosis, any condition or disease process that would cause confusion and/or disorientation, there are many of those beyond the use of drugs or alcohol and they would all be encompassed with the statement "any condition or disease."

Ms. Chan, Santa Monica UCLA Medical Center, likes the "patient specific risk factors" definition and feels it covers everything and is appropriate for nurses at the bedside.

Latanshia Wilson-Hall agrees with keeping the "patient specific risk factors" definition because when they perform nursing assessments or admission assessments, one of the things they look at is whether a patient has a history of substance abuse, alcohol abuse. She had a patient in

the field where they had to fight the man to get him in the truck, they fought him in the ER and had to paralyze him and put him on propofol and in restraints. His history of alcohol and drug abuse was automatically part of his admission assessment and information on his intake that let them know he had a tendency to be combative. As they removed him from his drugs and woke him up, that helped them to understand and be able to staff for his needs and what he was going to present as they brought him out of being on paralytics, propofol, etc.

Bob Nakamura asked Richard Negri why he suggested removing "the use of drugs and alcohol" from the definition of patient specific risk factors. **Richard Negri** explained that he thought it would be encompassing the language that's below it. If nurses say they want this language there, then he wants what nurses want.

Kate Durand suggested changing the word "use" to "abuse" in the definition of patient specific risk factors. Bob Nakamura asked if there's an issue about a patient being a drug user. A registered nurse from southern CA added that instead of narrowing it down to confusion and/or disorientation, suggested "alteration of thought process;" it could be due to anything.

Hector Alvarez asked if the definition of patient specific risk factors also addresses things around the patient (why they were brought in, is this gang-related, etc.) that contributes to violence or is it captured someplace else. Bob replied that it's covered in another section but we're trying to consider what to include for that process.

Cory Cordova stated in response to Bob's question about whether to take into consideration the abuse that if it's someone's first time taking Vicodin or some other drug, they may flip out even using it as prescribed.

Elsa Monroe understands where Richard is coming from with regards to removing "workplace" because patients can have a history of violence of any kind, not specifically workplace violence but still a risk.

Bob Nakamura continued on with definitions and explained that PLHCP definition was removed because it wasn't used later in the draft. He also added that "for the purposes of complying with subsection (e)" was added to the "Reportable workplace violence incident" definition because not everyone is going to report to the Division. General acute care hospitals will have to report, but other facilities won't and we're trying to keep with the Labor Code as far as what's reported and that particular process.

Katie Moore, Kaiser Oakland, recommended using the <u>threat or</u> use of physical force and removing the word "hospital" in (A) of the reportable workplace violence incident definition; so it would read "the threat or use of physical force against an employee" because you're including much more than just a hospital employee. Bob Nakamura clarified that only hospitals would be reporting to the Division to be consistent with SB 1299. He also explained that the words "threat or" aren't in the definition provided by SB1299.

Richard Negri stated that SEIU agrees with the previous commenter that the word "threat" should be included and be reportable. It is a mechanism that could be used to prevent an issue from occurring and that the idea is to put in as many mechanisms of prevention possible to prevent something from occurring that goes farther than a threat.

Vickie Wells acknowledged that the Division wants to stick with what's in SB1299, but requested clarity for what is meant by physical force. There are incidents that happen that

involves physical force that are accidental that they might not benefit from reporting to Cal/OSHA. She gave an example of a patient in a wheelchair bumps into an employee in the hallway and runs over their feet as an incident that shouldn't necessitate a report to Cal/OSHA. **Bob Nakamura** replied that it's difficult to separate intent in an act or action from something that just occurs, so we're still wrestling with that idea. He requested that Vickie send the Division recommended language about that.

Latanshia Wilson-Hall agrees with adding threat because people make threats and oftentimes they're real. She was working and someone told them that if something happens to his mother, he's going to kill everybody in here. As a result, that person was not allowed on the facility premises for two days without a police escort and he punched several holes in the walls, he threw chairs. The same thing happened the following week with a different person. Often, administration can be alerted so they can put in preventative measures in place and deal with that person accordingly. **Bob Nakamura** reiterated that we're talking about things that are supposed to be reported to the Division and a lot of the things will be reported after the fact and he doesn't know how the Division will be able to utilize the information about threats. He also pointed out that threats are covered under recording and is part of the violent incident log so the Division is not saying that threats don't have to be considered by the hospital or other employers. All we're saying is that a threat doesn't necessarily have to be reported to the Division as part of that process.

Grace Corse, RN SEIU Local 721, asked if it's reportable when management is abusing a worker psychologically or physically to OSHA. **Bob Nakamura** replied that workplace bullying is actually not within OSHA's traditional scope of control and that there are certain processes in the state that are trying to deal with workplace bullying. Grace added that she's also talking about harassment and retaliation, which as far as she knows are not legal in the state of California. **Steve Smith**, Principal Safety Engineer, explained there are existing laws that protect people from that and this plan does talk about covering those types of harassment and intimidation, but all we're talking about here is this particular definition (reportable workplace violence incident) and the related subsection (e) at the end of the standard that we'll talk about in more detail that talks about what needs to be reported to the Division by the hospital. It's a smaller subset of all the items that are supposed to be in the Plan and there's a larger subset of items that are recordable for the hospital itself in their log of incidents. But this subset is just those that are reported to us in the Division. This definition is right out of the law.

Ruth Calderon, Coastal Community Hospital, said that we should keep "threat" in the definition. She gave an example of a gang member who was paralyzed and couldn't do anything himself but had access to other gang members and tried to extort money from their employees.

Hector Alvarez thinks we should keep "threat" separate under something that is recordable versus reportable because he doesn't want the process clogged up with things at a lower level. There is a broad range of what threats are and it doesn't mean they're not going to get looked at. This is about taking something that's a serious incident by definition and then reporting it to the Division. He's concerned that if low level threats get included that the process will get clogged up and we'll lose the effectiveness.

Marilen Castanon, Saint Francis Medical Center and UNAC UHCP, stated that workplace bullying should be a reportable incident. Peer to peer or management to subordinate bullying is a common occurrence in the workplace and has gone unreported for a long time. Managers threaten nurses with reporting incidents and take retaliatory measures such as assigning them jobs to a night shift or weekend shift when it's not their turn. The effects of unreported violence

can take a toll on healthcare workers and can reflect on their work performance, such as healthcare issues, job satisfaction, and ultimately absenteeism. Bullying can be a risk for patient safety and patient care if not reported.

Susana, Kaiser Permanent Oakland Hills, works in the ED and wants to include in the "reportable workplace violence incident" definition a perceived threat or attempt to injure, attempt to harm a healthcare professional in the workplace as stipulated in this document. She referred to the definition of workplace violence in the draft which means any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. She and her colleagues are threatened every single day in the ER. There was an incident where a man threatened her, and came back the following day and threatened another coworker, the 3rd day threatened 2 coworkers and the 4th day there was a death that resulted from this. **Bob Nakamura** repeated that the Division is not saying not to have those things recorded internally as part of the violent incident logs but we're saying not to report it to the Division.

Gail Blanchard-Saiger stated that CHA supports the distinction between reportable events as defined and recordable events which under the workplace violence definition would include threats.

Rob Newells wonders about the limiting of reportable incidents to violence committed by patients or people accompanying patients and where does that leave family and friends of employees that come and get into a fist fight in the lobby. Is that not reportable to OSHA? **Bob Nakamura** responded that his understanding would be that the example given would be included if it involves an employee and is reportable.

Katherine Hughes stated that we're getting confused between the reportable stuff which falls under SB1299, which is what you took the language out of; what she keeps telling her members is that everything else is covered under the definition of workplace violence and it's covered under the reporting part farther along in the draft where it talks about threats (c)(2)E.2. She tells her members that if they have managers that are harassing them, intimidating them or other threatening disruptive behavior towards them, that is a Cal/OSHA file able complaint when this becomes final. That's where the bullying for them comes into play and they're looking forward to the definition of workplace violence and the recording mechanisms in the violent incident log to have everything else they need in it.

Bob Nakamura continued the review of definitions and explained that the Division added the definition for special hospitals but learned that there aren't any right now. Many people also recommended that we include the typology of violence and that's why we have the Type 1, 2, 3, and 4.

Richard Negri suggested changing the word "organization" to "employer" in the Type 2 violence definition because organization could imply a non-profit organization, association or union. We're talking about customers, clients who do business with or at their employer and not at their organization, so it's critical to replace the word organization with employer.

Katherine Hughes suggested using the words "who is known to" instead of "has a personal relationship" because she might not have a personal relationship with someone but she might know them in passing or they might be a neighbor or a stalker or someone coming in. We need to look back to the actual definitions and make sure we're not paraphrasing.

Gail Blanchard-Saiger agrees with Katherine's comments. She also added with respect to Type 3 violence thinks "former employee" seems to fit Type 4 and that it might be a deviation from what the original definitions were. With Type 3 violence, there are other laws that deal with retaliation and unlawful harassment. She doesn't see a fair use of these types throughout the rest of the document and would like to reflect further on clarifying particularly the Type 3 violence.

Marilen Castanon stated with regards to types of violence, to her violence is violence. It should not be tolerated whether if it's an outsider, insider or lateral and shouldn't be used unless they're going to be used in codes against the types of violence listed.

An anonymous commenter stated that it's a bit naïve to think that this doesn't happen. She has a unique situation that she hopes is in the minority. She's been harassed, detained in the storage room, held hostage in an office. She's filed police reports because she has very abusive supervisors. It's not physical but psychological and this needs to be included in the document somewhere. It's a career destroyer and needs to be recognized by OSHA, needs to be a violation and needs to be punished. There need to be safe havens for employees who are victims of abuse by an employer. **Bob Nakamura** asked if she was referring to Type 3 violence and whether the definition was good enough. She replied that it needs to remain in the draft but needs to be expanded.

Ms. Chan stated that she likes the Type 2 and 3 definitions and there is nothing wrong with them.

Elsa Monroe agrees with Richard Negri about the Type 2 violence definition and that "organization" is replaced with "employer." They have a lot of contractors coming in and out, especially traveling nurses. She feels the word "threat" in the workplace violence definition allows room for them to be able to report management that verbally threatens and takes punitive measures against professional nurses. She stated there was a professional nurse who committed suicide after he was threatened by management about failing to make probation.

LUNCH

Bob Nakamura reconvened the meeting and reminded attendees to sign in so that they will receive important notifications about the rulemaking project. He addressed the question that Vickie Wells asked earlier about why congregate living health facilities were listed and he stated that they came from a CDPH list that they use for licensing. This definition is distinguished from the earlier definition, as opposed to the definition for reporting to the Division of violent incidents.

Gail Blanchard-Saiger is concerned that the language "includes, but is not limited to" in the workplace violence definition is a vague standard and encourages removing "not limited to" and if there are other things, then specify them because otherwise it's vague. CHA is okay with the addition of "the threat" and stated that "the threat or use of physical force against an employee by a patient or a person accompanying a patient" might be too narrow because it could just be a visitor or somebody off the street. She stated they may have provided language on that.

Millicowt Borland suggested the wording "who provides services to the organization" instead of "any others for whom an organization provides services" in the Type 2 violence definition.

Jorge Cabrera favors maintaining the language "includes, but is not limited to" in the workplace violence definition because we don't want to restrict ourselves to these definitions and there's

going to be a lot of learning going forward in terms of reporting and improving the regulation. So it's important that we keep the definition as broad as possible.

Nancy Sumner stated that one of the challenges is that hospitals have so many contracted employees, e.g. housekeeping, so who's going to keep them accountable and train them; verbiage is needed if they're not employees of the hospitals, but contractors. **Bob Nakamura** asked if she meant as a source of violence and she agreed.

Jorge Cabrera mentioned a bill that recognizes joint liability for organizations that directly employ people doing work for them or also contract the services out so ultimately the responsibility falls on the employer and the contractor.

Kate Durand stated that it's very confusing to have the 4 different types of violence subsets of workplace violence, because the definition of workplace violence really only includes Type 1 and Type 2. Maybe we don't need to reference those types and don't need those definitions. Bob Nakamura replied that we should probably modify (A).

Dorothy Wigmore stated that the typology comes from a variety of places and the definitions do link to workplace violence. She's okay with the statement that it's "any act or threat of..." but how is worksite defined? She suggests using during the course of employment because there are plenty of examples of where people work away from their main place of employment and things that happen on the grounds. There are phrases that are used in other regulations that state the topic of being in a course of employment. With regard to "including, but not limited to" the focus is on the most dramatic Type 1 and Type 2. She's not certain that's helpful when we know that workplace violence is much more than the use of physical force and we've certainly heard that today. She will give the Division examples of definitions used in other jurisdictions that might be helpful.

Elsa Monroe feels that when classifying Type 1, Type 2, etc. it's pertinent. Otherwise it wouldn't be there. She feels that the hospital association is already covered under SB1299. This regulation is including public workers, like her or others that work in correctional settings. She feels this is very important especially when you're talking to an inmate's league of lawyers that are trying to get away with their client.

Ms. Chan stated that the classifications are clear and nothing is wrong with them.

Bob Nakamura continued the review of the draft and noted the change on page 7, (c)(2)(F).

Gail Blanchard-Saiger stated that they don't always have control at their leased spaces, so how much control the employer actually has over their location (ex. going out into the community) needs to be taken into account. **Bob Nakamura** replied that the Division realizes that an employer doesn't necessarily control some of the risky areas but we think there's a minimum duty to inform employees of where there are problems and what problems they might encounter and see what they could do about it.

Katie Moore, Kaiser Oakland, stated that it's actually more crucial that we have the kind of training and support to deal with workplace violence that occurs in a home setting. Evidence shows that nurses who go out to the public are more at risk for workplace violence and for assault than they are in the more controlled hospital setting. Holding the employer accountable for making sure that nurses and other healthcare providers have the correct training, the ability to have protection so staffing is very important because if you're going into a place where you

have a potentially violent situation you may need more than one person. Employers will generally send one person in and not have that person have protection. These kinds of protections in an outpatient setting, especially the homes, are crucial. The language needs to hold there.

Richard Negri suggested adding "working alone" as one of the factors stated in (c)(2)(F)1.a. He's been told by many nurses that when doing an assessment procedure for identification or evaluation of risk you have to start at the top and go over working alone conditions.

Dorothy Wigmore supports Richard Negri's recommendation and part of the reason is that her own experience dealing with the issue of violence actually started with people who were working alone and having a regulation in Manitoba where the very first time a working alone regulation was used was by social workers who feared for their lives as they were expected to enter a particular building, and they used the working alone regulation because of fear of violence. There are a variety of documents and evidence on how to deal with this and that isolation is only one kind of working alone. She thinks this is a really important one to make a change on.

Richard Negri commented on (c)(2)(F)1.d. and recommended removing the words "during hours of darkness" because it doesn't matter whether you're in an outside area during daylight, twilight or darkness, that use of an outside area is one that should have assessment procedures and an evaluation.

Nancy Sumner also represents Schaefer Ambulance Service and commented on doing CCT transports (c)(2)(F)4. There's a big discrepancy when they have patients that are on 5150's or restraints with ambulance companies and hospitals don't apply restraints. Communication is important and we really need to look at this because they will be in restraints and they don't get holds and documentation and paperwork. Nurses in the ER don't want them on restraints but ambulance procedures sometimes say they have to be put in restraints. She's seen patients run out of the ER that are being transferred to gurneys. This is a problem because patients do jump out of the back of ambulances. **Bob Nakamura** asked Nancy to send the Division ideas about what should be covered.

Dorothy Wigmore clarified that what we're talking about is the prevention plan and when particular types of violence are supposed to be assessed. What she's trying to figure out is why we're only talking about particular types (1 and 2). **Bob Nakamura** responded that we're trying to deal with evaluating the patient-specific factors in (c)(2)(G).

Katherine Hughes stated that the original language in (c)(2)(I)1 about procedures to ensure that sufficient staff is trained used the wording trained "in appropriate disciplines." Their previous comments recommended "trained in appropriate disciplines, is <u>assigned and</u> available." The importance of that is people have to be specifically assigned to respond to emergency codes. At Napa State Hospital, everybody hears the alarm and everyone is expected to respond and they had an incident where nobody responded because people are busy at work and they know everybody's going to show up so they continue with their work. So people need to be assigned to do this so we know specifically who's going to respond, just like they assign a code blue team and they know who's doing code blue that day. It's not necessarily the same people every day. SEIU also suggested that it include managers and supervisors because they should be a part of this response and be a part of the whole procedure.

Gail Blanchard-Saiger said there should be a definition for disruptive behavior in (c)(2)(G). Also some of the things listed in (c)(2)(I), procedures for the correction of workplace violence hazards in a timely manner, are not really corrective actions but should really be part of the plan. She gave an example of procedures to ensure that sufficient staff is trained as something that is not a corrective activity, and that should be part of the plan. CHA requests that "Corrective measures shall include" be changed to "Corrective measures may include" because some of these things should be moved to the other section where it should be part of the plan and you should do that. There's mixing of what should actually be in the plan and what are corrective measures depending on the circumstances. Bob Nakamura replied that we'll look again to see what's not a corrective action but the training was intended to be training for if people didn't know what to do.

Richard Negri stated that from their perspective, they look at policies and procedures as corrective measures.

Hector Alvarez stated that those two are blended together. When they conduct security assessments, vulnerability assessments they look at the threat. Then they would look at some of the configuration of the room, patient's access to the employees which would involve mitigation factors. When he takes the threat, the vulnerabilities and the mitigation they actually put in place that's what gives him his risk. He agrees the way we have it looking at the configuration of spaces in corrective action, they would be looking at that as the first line assessment. If an incident occurred they would then go back and look at how effective or ineffective those were, but this is not how it's done in the field right now from a risk assessment perspective. These are blended and we need to look at how they're lined out. **Bob Nakamura** replied that we should look at rewording the title of the section.

Elsa Monroe agreed with adding the procedures to ensure that sufficient staff for each shift, including managers and supervisor, and they should be specifically assigned and available. She stated that during the night, there's only one RN taking care of 20 mentally ill patients, one LVN, and licensed psych tech. In order for there to be accountability when there is a nurse that's been violated, the language in the standard is going to be protecting that nurse.

Ms. Chan stated that (c)(2)(I)1. Procedures to ensure that sufficient staff should always be the number one priority. She doesn't like the language that "Staff is not considered to be available..." and feels it should be removed.

Nancy Sumner stated that she doesn't see the word "security" in this and that's the problem, that we don't have enough security at any of our hospitals. They are not union so security personnel can only do so much. Also if hospitals don't have seclusion rooms, that presents a problem. It's unrealistic to say you're going to identify the hazards in 7 days. It should be identified and dealt with immediately. If you have a lot of Type 1 and Type 2, your HVA should identify that you need security fulltime in the ER on both shifts. **Bob Nakamura** replied that some of that is covered under (c)(2)(I)9.

Sandra Williams stated that corrective actions generally happen after an event where you're identifying and reviewing your policies and processes, the adequacy of the response, and identifying additional hazards. Some of the language in (c)(2)(I) would be better suited for another section. With regard to staff, staff should be all inclusive of those who are trained. To state that the manager should be part of the response, they do not work 24/7 but there should be some leadership that is present that does respond as they would do with the other codes that are generally used in an acute care setting.

Dorothy Wigmore stated that WorkSafe provided earlier comments and some of those deal with design issues. Regarding (c)(2)(I)3. "...employee access to doors and alarm systems cannot be impeded," you don't always have doors but what you really need is an exit so you may be restricting yourself by just using the word door. People need to be able to get out and that's what the design should be for. Design also needs to account for things like color, sound and lighting and she doesn't see guidance being given about that. She also wanted to support others' comments about being assigned as well as being available because if you're assigned you know what you're supposed to be doing and you need to know who's doing what when you have a scary situation. She offered help on language regarding design.

Katherine Hughes stated that SEIU's security union was here earlier and they drafted comments together which will be submitted formally. Under training, they should have interactive training and "the involvement of security staff should be an integral part of the entire process like any other employee." They also recommend that they participate in the training that the security code responders receive, especially since if there is security onsite they would be expected to respond. They suggest that, if an employer does hire or contract with some form of security service or have a designated head of security, someone that's actually physically employed by the facility and not just a contractor, these provisions should apply to security staff or have an expectation of participation. So where you say employees are involved in developing the plan, evaluating the plan, etc. there's an expectation of participation for whatever kind of security the facility may or may not have in place.

Suzanne Marshall doesn't know if she agrees with the assignment of staff unless we define what kind of staff is being assigned. After being attacked twice and trying to take both of her cases to court, and being told there's not enough evidence to sustain an arrest or conviction it seems like the system is set up to protect the patient beating up the nurse and not the other way around. So she would not want to be assigned because even though she goes to AB508 training because it's expected of her, she wouldn't ever go on a code gray because of her experiences. They have no security in her hospital and the first time she was attacked the security that came was a 65 year old woman that walked with a limp and she was one person for the entire hospital. She's had 4 surgeries and multiple injuries, including a broken jaw.

Elsa Monroe restated her recommendation to include managers and supervisors should be assigned and available.

Grace Corse asked if the expectation is that security, police, and/or sheriff personnel who are in the facility will provide assistance rather than stand around twiddling their thumbs when a nurse is being attacked, which is happening in her facility. Bob Nakamura replied that the Division has an expectation that something will be worked out so that appropriate security is provided but he doesn't know how all those contracts are set up.

Latanshia Wilson-Hall stated that when patients come in with knives or guns, their security tells the workers that they don't take them and that the healthcare workers have to take them from the patient and then turn them over to security. When patients are upstairs fighting in the rooms, security doesn't come in the room and deal with that. After the Boston bombing they had a man threaten to bomb their hospital and he did start a fire in the hospital, but it fell to the nurses. Her issue is would this be assigned to the nursing staff when they have security staff who is trained in dealing with people. Nurses already take training to deal with combativeness and are on the front lines. They need that secondary line of defense and know that someone else is coming. They have code team, stroke team where every day 3 nurses are assigned to

answer codes. These nurses are assigned to these tasks on top of taking care of their own patient assignments. It takes them away from patient care and takes them away from jobs that they are already assigned. They need the secondary line of defense to nurses the support and backup when they get into these situations. **Bob Nakamura** asked if this deals with patient classification system. Some commenters said that patient classification system deals with staffing.

Cory Cordova stated that the employer will decide who's on the response team, but we need to make a clear delineation between if you're not going to be on the response team and have direct patient contact, you can't be counted as part of the response team. Typically what happens in a healthcare situation is that you're part of a team, but if you're one of the folks that don't have an actual role or duty and you're standing around then all of the responsibility goes on the nurses with direct patient contact. So if there's going to be a requirement for a response team, they don't want employers to say they have 5 people on the response team and 2 of them are security and they're not allowed to touch the patient and they shouldn't be counted on the response team.

Katie Moore commented on (c)(2)(J)7. 7. Solicitation from the injured employee and other personnel involved in the incident of their opinions regarding the cause of the incident, and whether any measure would have prevented the injury. She suggested adding language that none of the information the employee provides can be used for disciplinary purposes. When they have employees injured in their facilities, they have a team that surrounds them and grills them about the cause of injury. They will ask the nurse over and over again, "What could you have done differently?" The nurse may try to come up with something to satisfy that question and when they do, that is used against them to then say this was your fault for having been injured. OSHA already has recommendations and says that no employee shall be disciplined for reporting workplace violence and she suggests similar language in this section that it shall not happen. This becomes a way of blaming the victim again and we're already seeing that. This is about identifying things that may have led to the incident in order to prevent it for the future, not to blame the person who was injured.

Bob Nakamura then moved the discussion on to the violent incident log (c)(2)(J)8. and explained the reason this section is so long is if you put a form into the regulation, it's much harder to change it than it is to change a list of things that have to be on that. If we wanted to change something down the road about what should be put in or taken out, it's much easier to do that with a list than it is to have the whole form put up for review again. We previously had a simpler list of items that had to be on the log and there were many comments that it left out too much information from what we needed to see. One model for this was the sharps injury log so that should be something that everyone here should be familiar with. The concept is to provide a form that is easy to understand that gives you all the likely combinations of what might have happened, what might be involved in a given incident so you can check off the box that's appropriate for that particular incident. He suggested to some that part of the list can be marked off to show what things needed to be reported by hospitals so that there aren't that many different forms floating around (i.e. one form can be used for different purposes).

Dorothy Wigmore said that people have different definitions of a log. Some people expect to see a summary like what you get from the log 300. Others expect to see something more like an incident report which she would support and is detailed here and has recommendations. She asked why this is called a log when we're really talking about a report because she thinks we need both. You need a report of what happened, you need a report from the person who had to deal with the violence, you need a report from the supervisor and then you need some

kind of tally that can be used by joint health and safety committees, violence prevention committees, inspectors etc. She's not sure that this draft achieves that and suggests trying for both and getting people's recommendations for what needs to be in a log and what needs to be in a report.

Gail Blanchard-Saiger discussed privacy concerns and stated that what the list has for the incident report is part of the plan so that anybody that has access to the plan, whether it's the safety committee or any employee that asks for a copy of the plan, is going to see every single incident report and all of that employee information. What's really helpful for reviewing the plan and evaluating risks and taking corrective action is to know the trend, so there should be a form to allow that to happen. The only comments that she has on the specific elements is post-incident stress and she doesn't think that information will be available right after the incident and the question about whether security or law enforcement was contacted, she wants clarity on security and does that mean internal security and that's really two different things. **Bob Nakamura** asked if it's true that not all hospitals have security and that there are different ways to contract for security services and attendees agreed, so we'll need to consider that when we try to describe the interaction.

Vickie Wells stated that a number of items listed are duplicative of what employers are already required to keep on the OSHA 300 log. We should avoid duplicating requirements, such as whether time was taken off work and for how long. That's not something you're going to know immediately when you enter that information on your workplace violence log but you're going to track that on your OSHA 300 log. Asking the employer to track it in both places becomes onerous because if someone's off work as a result of a workplace violence injury, that's going to be a recordable injury and you're going to track lost and restricted workdays on your 300 log. You shouldn't have to track it as well on the workplace violence log. You should simply reference the case number back to the OSHA log and same thing about medical treatment. In many of these cases, the time off work doesn't happen immediately after the incident they might think they're fine and go off work sometime later, so they have to go back and update the 300 log and the workplace violence log with the same information. That doesn't make sense. **Bob Nakamura** replied that we'll look at some of these items.

Richard Negri stated that SEIU agrees with Gail Blanchard-Saiger about the patient's individually identifiable medical information not being included on the log and referred to the note in the draft regarding that.

Bob Harrison, University of California San Francisco, stated that he helped work on this and the data elements. In regard to post-incident stress, he agrees with the comments but we need some way to capture the issue of stress as an injury and that was the best term they came up with. If there are other ways of describing that, it is something we should look at. He also agreed that there's work to do on the confidentiality on how to capture the information without compromising confidentiality. He thinks it's important that reporting be encouraged and be accurate. If an employee feels that the information might somehow be disclosed to another employee or a manager or someone else in the facility that might actually discourage reporting. So that's something we have to figure out, how to capture easily identifiable data but not compromise medical confidentiality. **Bob Nakamura** asked if leaving off an employee's name would be an example. Bob Harrison replied that would be one option or having a form and having a log, some compromise so there's aggregate data, but then there's also a form that's useful for a hospital.

Sandra Williams agreed on having two types of documents and stated that you need to report first on the log and some of the data sets might be similar but everything should not be on the log where it relates to any of the identifiable information for a patient and/or employee.

Nancy Sumner said that she doesn't see on the log whether the person was arrested because we can do citizen's arrest and have people arrested. She feels we need to do that because she's had a couple of people whose patients were arrested. This is very arduous as far as collection of data and that we should look at setting up a team of people that maybe have been assaulted or willing to deal with it. It should be non-punitive and we want people to report it. A lot of them are in fear of their supervisors or their managers because they're afraid they're going to be deemed fearful or that it's more paperwork. If they're identified they should be immediately taken out of the workplace just to take a deep breath and asked if they're okay instead of being told to get back to work, do your job and suck it up.

Dorothy Wigmore asked who is or what entities are going to have to do these reports. Are we talking about all the places that are covered under this? **Bob Nakamura** replied yes. She referred to the Worksafe comments where they raised the issue of confidentiality and proposed some language that comes from one of their lawyers and it's partly based on some of the work they've done.

Pierre Ungaro, Glendale Memorial Hospital, stated that police records aren't confidential so he doesn't really see the argument here as long as they're not abused.

Katherine Hughes stated that the reality is that OSHA 300 logs are not confidential and that any employee can ask for them. It has the employees' names, where they work on those logs unless they're specific privacy cases regarding sharps injuries or sexual abuse. If it's reportable to Cal/OSHA, it's on the 300 logs and employees and their representatives have the right to those records. If there's something we need to put in here that quantifies what is a privacy part and what isn't, then maybe we can look at that. The 300 logs are public to the employees and representatives and we need to know this information, because if we don't know this information, then we can't address not just trends but each specific incident and how we can prevent it from happening in the future.

Richard Negri stated that the note referring to the patient's individually identifiable medical information goes under the assumption that the hazard of violence was borne with the patient. The log, however, is talking about a worker who is a victim of workplace violence whether it was borne from a patient, a coworker, any of the typologies that we've already talked about. If that individual is a patient, there's no reason for that patient's individually identifiable medical information to be on the log. He stated that the log is about a worker who experienced workplace violence and this is what's recorded on the log and asked Bob Nakamura if his understanding was correct. Bob Nakamura replied yes.

Tami Olenik, LAC USC Medical Center, stated that we need to have a safe haven for the victim or removal of the assailant. She filed a police report after experiencing workplace violence and she's unable to get a copy of the report with the deputy's number and suspects that there is a cabala that's formed with the county. They have a number of issues within these organizations and conflicts of interests that also need to be addressed, such as an authority figure making demands on an employee and the employee being the subject of harassment, intimidation and retaliation in the workplace.

Hector Alvarez stated there's a distinct difference between organic violence and targeted violence. Regarding targeted violence, it's extremely important for him to know who he's dealing with and those in the background and less important to know about the background when he's dealing with organic violence. In the interest of protecting patient information but at the same time knowing who the aggressors are, there's a difference between those two types of incidents. A lot of times what they've discovered that have led to incidents of violence have been a reluctance to come forward because of a misunderstanding of certain privacy laws and people not sharing information. He feels that people don't understand what they can and cannot share and this is one of the key areas that should be focused on if we want an effective standard.

Vickie Wells understands why people want this information but also understands why it's difficult to get people to do these reports. They've been trying to get people to report violent incidents where there was no injury and no need for medical treatment using the employer's first report or supervisor's incident investigation report. What they hear back from their employees is that it takes a lot of time to fill out paperwork and they're unwilling to do it for a minor event. By adding to the amount of information you collect, the less likely people are willing to report the minor incidents that we'd like to know about. It's a catch 22 because you want all that information on a larger incident but how much underreporting are you going to get because people are simply not willing to put out the additional paperwork.

Ruby Sloan, John George Psychiatric Hospital, was assaulted and called the Sherriff and when they came, the doctor released the patient but the deputy wouldn't take the person to jail. She wants to know who has the say so and she called the DA to get some answers and they said they had no jurisdiction over the deputy. **Bob Nakamura** replied that it's unfortunately not the Division's area. Katherine Hughes offered to speak with Ms. Sloan afterwards.

Steve Pitocchi, SEIU Local 1021, stated that lack of reporting is a cultural issue and was discussed at previous hearings. This goes back to the accountability of the employer to make moves to be sure that employees' issues are being addressed and are reported, and that incident reports are being done. We need to change that culture of this is just how we work and where we work and we'll accept it.

Bob Nakamura then moved on to (d)(1)(C) Employers shall provide additional training when new equipment or work practices are introduced <u>or when a new, or previously unrecognized, workplace violence hazard has been identified</u>. The additional training may be limited to addressing the new equipment or work practices <u>or workplace hazard</u>.

Rob Newells asked if annual training in (d)(1)(B) is only for employees who provide direct patient care or should that be all employees because everybody doesn't necessarily perform patient contact activities. **Bob Nakamura** explained that goes back to where we talked about the patient contact definition so we'll have to consider both.

Gail Blanchard-Saiger suggested adding to (c)(2)(M) a provision that says something to the effect of "notwithstanding the employer may have a policy requiring an employee to report internally at the same time." The concern that she articulated previously is that there are some hospitals that do have internal security and it would be faster if the employee contacted internal security; or we've heard testimony before where the employee calls and when law enforcement comes they don't necessarily know where to go, so it would be helpful if internal security staff knew that local law enforcement was on its way and could direct them to the appropriate place.

Sandra Williams supports what Gail Blanchard-Saiger stated and it's based on communication and how we operationalize the expectations so she does agree or for those facilities that do not have security, if someone does dial 911 they'll know where to respond who would be the point of contact in the facility so there are no delays.

An anonymous commenter stated she had a problem with reporting to an internal agency. They are contracted out by the employer so she sees a conflict of interest there and a reluctance to share the information with them since they probably wouldn't want to lose their contract, the report-taking might be "iffy."

Dorothy Wigmore stated that in (d)(2)(D) How to report violent incidents to law enforcement, she would just state how to report violent incidents. It's not just law enforcement, people have to know what the rules are if they're a temporary employee and who to report to, if they have to see a supervisor if they're badly hurt. They have to know who to report to about what, and it's not just law enforcement. If people don't know who to report to, they won't fill out any forms and you're going to lose all kinds of information and people are going to get frustrated. She wants to be sure that we retain "interactive training." People learn by doing things, by practicing, and by having conversations based on integrating what they know from their own experience with the new material that they're being presented with. She also pointed out that this is where we talk about hazards and not risk factors and it's her evidence for changing the definition of environmental risk factors.

Jorge Cabrera underscored Dorothy Wigmore's comments about interactive training and that we shouldn't even consider the option of doing online training. Many schools and universities have discarded that option because they understand it's a watered down educational system and it defeats the whole purpose. If we're going to prevent workers from injury and educate them on how to stay safe, interactive education is the best way to go.

Nancy Sumner teaches CPI at her hospital and it has made a big difference but the challenge is that not everyone is mandated to take the training. She feels that everyone should have to take the course, including the doctors.

Ruby Sloan thinks CPI is okay but it doesn't apply to the type of population that they deal with. What they should do is run because they are no match for the population they deal with and she believes that every facility should have law enforcement there.

An anonymous commenter agreed and stated that they're not cops and he's never been trained on being a police officer, make an arrest, or fire a firearm.

LaChanta Brown, Harbor UCLA psychiatric ER, stated they also do CPI training. It's mandatory once a year and it's useless. Half of their staff is out now due to the violent population they deal with and the staff that are still there try to use the CPI are getting hurt on a daily basis. She's raised the question of updating the CPI training to the managers there because it's been the same since she's been there for 27 years. She thinks that it would help to have law enforcement officers come in and teach them different techniques that will keep them from getting injured as much as they are now.

Lorna Lentyas stated that with regard to training, the trainer should have experience in a psychiatry setting and have been a nurse for at least a couple of years because a couple of years ago, their trainer was a new graduate that had not been in a hospital.

Richard Negri noted the language "No less frequently than every 90 days," was removed from (d)(3)(B) and that this subsection is for people who are assigned to respond to incidents of violence in the facility. In speaking with healthcare workers, they have found that it's absolutely necessary for them to be able to have an opportunity to practice the maneuvers a minimum of every 120 days. While there are people working in facilities where they have populations of gangs and others that come in with an increased amount of violence, those healthcare workers may not need to practice as much as those who are working in an entirely different type of environment where it's every once a year when somebody comes in where there's a violent incident. Folks need to be able to be prepared and they all say for frequency of training that it should be 90 days, 120 days at the most because they'll get rusty if they don't use the skills that they learned in the annual training they received. If they're on response teams they definitely need to be able to practice, especially if they don't have a high number of incidents in that particular facility.

Katherine Hughes questioned the addition of the language "after the employer knows or with diligent inquiry would have known of the incident," in (e)(1) with regard to hospitals reporting each reportable violent incident to the Division. She asked if this is speaking directly to the legislation and Bob Nakamura replied yes. Katherine stated that the additional language is not part of the legislation and if we're reflecting legislation then we need to reflect legislation and this doesn't. **Bob Nakamura** explained we have a very similar requirement for reporting to the Division by telephone a serious injury or fatality within 8 hours, which is where they have that language for the reason that an employer can't always know that soon. Katherine asked where the language is found and Bob replied that it's in Section 342 and we wanted to be consistent with that because of all of the issues with an employer being dinged for not notifying us in a timely manner. One of the things that we're most concerned about is a case where someone has been attacked and doesn't report it right away.

Dorothy Wigmore commented on the list of additional training requirements in in (d)(3)(A): 2. Aggression and violence predicting factors, she stated that she doesn't know what it's talking about. She asked if that's talking about hazards. If you're talking about prediction you should know that it's very hard to predict individuals' behavior. But you do know what hazards are and which kinds of hazards are likely setting folks up to deal with violence. She also asked what is the assault cycle in 3. and stated she's never heard of this phrase and doesn't know what it could be referring to. She asked where did the language come from in 4. "Characteristics of aggressive and violent patients and victims," and stated that there aren't characteristics of violent victims and you're blaming the person who was assaulted when you use this kind of language. And in 5. Verbal and physical maneuvers to diffuse and avoid violent behavior, she suggests using the word "prevent." When you talk about restraining techniques, she suggest not just showing restraining techniques but train on when they're appropriate to use and which ones are appropriate for which type of circumstance. She feels there is a lot of work to be done on this training list. She also supports Richard Negri's point about frequency that is particularly important for people who don't have to deal with violence on a regular basis as some others, that they have the training, and that they get the refresher so that they remember when something does happen and they're in a better situation to respond. **Bob Nakamura** replied that we got the language from HSC 1257 and we're open to suggestions on that list.

Richard Negri asked if it was appropriate to include that the training be done on the job as opposed to people having to take it on their own time and on their own dime. He also suggested we have something about frequency of training. **Mike Horowitz** explained that when Cal/OSHA requires training, the Appeals Board has always ruled that provide means that the employer pays for it and it's on company time. There was a decision on that that involved

nurses and bloodborne pathogens training that went to DAR where a temporary agency tried to require their nurse applicants to get their bloodborne pathogens training on their own time and Cal/OSHA cited them and sustained that. Richard added that someone pointed out that it's addressed in (a)(3), 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.

Elsa Monroe emphasized that restraining techniques should remain on the list of additional training requirements for health facilities in (d)(3)(A). In CDCR, the custody officers and now the nurses are very well trained on what the consequences are with a human being who gets physically restrained. In the ER, when you're dealing with a patient that's coming in on meth or a patient that's schizophrenic, you're dealing with a police car coming up the ramp and the guy is kicking out the doors. When they open the police car door, you're going to see a beast coming out that's going to take 5 NFL-types to get this guy. This is why we need restraining techniques to help control this person from injuring others and himself.

Caryn Thornburg ValleyCare Health System, said when we're talking about restraining techniques particularly for general acute care hospitals we need to be sensitive of the requirements under CMS guidelines under §482.13(e). It's pretty clear about restraints and hospitals are being asked to train under this standard and they run the risk of losing their CMS accreditation or finance back from insurance companies. Bob Nakamura asked Caryn to send that information to the Division.

Vickie Wells stated that in many of their outpatient clinics, they do have security onsite and they would never ask their healthcare workers to try and restrain someone in those types of healthcare environments. So requiring training on restraining when it's not something they ever ask them to do doesn't make sense. It might actually even encourage workers to try and restrain someone instead of letting the sheriff do it. She doesn't agree with training on restraints when it's not something that happens in that type of healthcare facility.

Bob Nakamura then moved the discussion to (e) Reporting requirements for General Acute Care Hospitals, Acute Psychiatric Hospitals, and Special Hospitals. He said the Division has a similar requirement in Section 342 for reporting serious injuries, illnesses or death to our closest district office. He's heard concerns about how that information will be presented on the website once we get that information because the Labor Code requires us to establish the number of incidents for each employer and post it on the web in a publicly accessible format.

Vickie Wells asked what are you looking for under (e)(1)G. A unique incident identifier. Is that something the Division is going to create? Otherwise, everyone will have a different system. **Bob Nakamura** explained that we have to keep a tally for each facility and we won't be able to distinguish one report from another unless the employer creates an identifier for each report. We've been talking internally about how this is going to happen and one of the things proposed was to give each hospital an identification number so that when it's reported on a computer it would be easy for the facility to make the report.

Bob Nakamura then moved on to (f) Recordkeeping and pointed out that exceptions that were applicable to Section 3203 based on the size of the employer do not apply. We added the violent incident log to records required in (f)(3) and removed the language after Chief in (f)(4) "of the Division of Occupational Safety and Health and his or her representatives." We followed the same format as the ATD and safe patient handling standards. He also explained the next steps

and that we're going to try to get a draft to the Standards Board in May, so the Division would like your comments in the next two weeks because otherwise we may not be able to review it and incorporate them in time.

Nancy Sumner stated that a lot of this goes through the risk manager. She also stated that you have to keep the training records a lot longer than mentioned. Bob asked for clarification and Nancy stated that HVA is a hazard vulnerability assessment so she's now moving her hospital's HVA up to number 4 to make it a higher priority.

Bob Nakamura thanked the attendees for coming to the meeting and helping the Division with this project. Once it is finished, it will be reviewed by the Division, Department and Agency. Once the proposal gets to the Standards Board, they have to review it to make sure it meets the requirements of the Administrative Procedures Act, they notice it and the notice is published by the Office of Administrative Law. Then there's a 45-day comment period for the initial draft and any subsequent changes are given a 15-day notice but only on the things that were changed from the initial draft. Depending on how many changes we have to make subsequent to the first proposal, we expect that we'll get this done within a year. He then adjourned the meeting.

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MEETING NAME Cal/OSHA Workplace Violence Prevention in Health Care **DATE** April 1, 2015

CHAIRPERSONS R Nakamura, S Smith, K Graulich **LOCATION** Elihu Harris State Bldg 1515 Clay St. Oakland

NEW ATTENDEES: PLEASE BE SURE TO WRITE YOUR NAME, AFFILIATION, AND E-MAIL ADDRESS CLEARLY

NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
STEVE PITOCCHI SEIU LOCAL 1021	steve.pitocchi@seiu1021.org	(510) 350-0653	
HAVILAH SMITH CNA/NNU, Kaiser Permanente Hospital SFO RN III	HAVILAH@NUENA.COM	(415) 632-8277	
mia Pinto-Ochoa, RN IV Kaiser S. Sac PACU/CNA RN	miapintochoa@sbcglobal.net	(916) 803-6338	
Michelle Hamilton DSH-WSH	michelle.hamilton@dsh.ca.gov	(562) 409-7204	
Dorothy Wigmore Worksafe	dwigmore@worksafe.org		

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Tim O'Connell ALAMEDA Co SHERIFF	TOCONNELL@ACGOV.ORG	(510) 437-4973	
Rochelle Pardue-Okimoto CNA	rochellepardue@outlook.com	(510) 524 8069	
Michael Boyce Department of State Hospitals	michael.Boyce@DSH.ca.gov		
Kelly Tuttle CNA	martialartschick@gmail.com	916-849-9707	
George Levy	georgeLS10@yahoo.com		

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ATTENDANCE ROSTER (3)

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Stephanie Patten CNA	stephanie pat@gmail		
Mary Kochie, RN Cal/OSHA	mkochie@dir.ca.gov	(818) 901-5751 (818) 901-5748	6150 Van Nuys Blvd Suite 405 Van Nuys, CA 91401
Dexter Patterson CNA SEIU 1021	bazell103@gmail	323 252 8706	
Page Lie, RN CNA	aggie@pacbell.net	(415) 515-7542	1055 Valencia Way Pacifica, CA 94044
Melany Carías RN CNA	melany1428@yahoo.com	818 239 6581	2224 N. Fraderic St. Burbank CA 91504

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Norman Wright Contra Costa County	norman.wright@RiskM.cccounty.us	925-335-1467	
CYNTHIA JOSE California Nurses Assoc.	cynthia.jose@kp.org	(510) 789-7940	
Nancy Sumner Glendale Memorial Hosp	NMSumner@aol.com	818-502-2344	
ALDRIN VALDEZ RONALD REAGAN - UCLA	rin&rald@gmail.com	818-621-2723	
AARON Cramer SAN Francisco General Hospital	Aaron.Cramer@SFDH.org	707 364 0084	378 Chester st. Daly City, CA 94014

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Steven Gonzalez-Lederer CA State Hospitals	Steven.Lederer@DSH.CA.gov	916-654-3520	1600 9th st. Room 153 SACTO CA 95814
Alberto Mejia	SEIU 1021	415 848-3629	—
LATORI YOUNG SEIU	LATORIYOU@aol.COM	415 6786857	—

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Eric C. Koch CNA	ericdavao@yahoo.com		
Anne Stewart CNA	astewart@calnurses.org		
Holly Smith Sutter Health	smiithh7@sutterhealth.org	916-671-4799	SRMC 1 Medical Plaza Roseville, CA 95661
Gail Blanchard-Sauger Cal. Hospital Assoc.	gblanchard@calhospital.org		
Ashley Flowers Kaiser Permanente/CNA Emergency Dept	ashleypflowers@gmail.com		

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
MICHAEL MUSSER California Teachers Assn	britearth69@gmail.com	805 901 7011	9508 SANTA MARIA ST Ventura CA 93004
Deborah Gold	dgold184@gmail.com		
Sandra Williams	swilliams@alamedahealthsystem.org		1411 E 31st Street Oakland, CA
LYNDA Bredleau CNA			
Sean Tracy	sean.tracy@dsh.ca.gov	916-651-3167	

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Colbie Hunt CNA	Ouchrn@gmail	310 415 1169	
Heather Klooten CNA	Kimberwoobe@yahoo.com	415-505-9658	
Lorraine Feliciano CNA	Lpfrn@yahoo.com	510-220-1270	
LYN TIRONA	nylsurte@yahoo.com	916-474-1965	
FE ECHON	echonfe@yahoo.com	(916)837-8424	

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Janet Jones CNA			
Betsy Borruso, RN CNA	evenlily@sbcglobal.net	510-432-1919	
Marilyn Castanon c UNAC/UHCP	mcastanon90640 @yahoo.com	(323) 867-3005	
Millicent Borland	Milliesjoy@AOL.		
Suzi Goldmacher	Suzi.goldmacher @gmail.com		

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Ruby Sloan	Rubiatu@Yahoo	(510) 467-2091	3683 Maybelle Oakland 94619
Martha Kuhl RN	mlk@mlkuhl.com		
Sandy Reding	miracleornurse@gmail.com		
Mary McDonald RN with CNA	marykmcdonald@hotmail.com	(805)889-4167	PO Box 2981 Camarillo, CA 93011
Carl Walter SEIU-USWW	carl.walter@seiu-usww.org	510 350 6411	

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Debra Gass / DSH	Debra.Gass@dsh.ca.gov	-	-
JINGHA DAHLGREN	DAHLGRENJ@SEIU NACA.ORG		
David Kersnazitskas OSHSB			

CAL OSHA
DEPARTMENT OF INDUSTRIAL RELATIONS

ATTENDANCE ROSTER

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MEETING NAME: Cal/OSHA Workplace Violence Prevention in Health Care **DATE:** April 1, 2015

CHAIRPERSONS: R Nakamura, S Smith, K Graulich **LOCATION:** Elihu Harris State Bldg,1515 Clay St., 2nd Floor, Rm 1, Oakland, CA 94612

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Sue Fendley CNA/NNU	sfendley@calnurses.org	510 316 7301	2000 Franklin Oakland, CA
Jeremy Taylor Sutter Health	taylorjs@sutterhealth.org	916-502-2199	2200 River Plaza Dr. Sacramento, CA. 95833
ERIK ANGLE SUTTER HEALTH	anglee@sutterhealth.org	916.591.8226	ONE MEDICAL PLAZA ROSEVILLE CA 95661
Cecilia Brownlee Sutter Health	brownleca@sutterhealth.org	530-888-4513	11815 Education St Auburn, CA 95602

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ATTENDANCE ROSTER

(13)

MEETING NAME Cal/OSHA Workplace Violence Prevention in Health Care **DATE** April 1, 2015

CHAIRPERSONS R Nakamura, S Smith, K Graulich **LOCATION** Elihu Harris State Bldg 1515 Clay St. Oakland

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
JOHN HABEREK ALVAREZ ASSOCIATES	JHABEREK@ WORKVIOLENCEPREVENTION.COM		
MARK BRENNER ALVAREZ ASSOCIATES VIOLENCE PREVENTION ACADEMY	MBRENNER@ WORKVIOLENCEPREVENTION.COM	(916) 743-1416	
Vickie Wells CCSF DPH	Vickie.Wells@ SFDPH.OR		
WENDY ACORE C.E.CRAOHN	WCORE@ its.jnj.com.	925 855-0802	
TICIA Hunter ANA/C	thunter930@ aol.com	916-837 1620	

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ATTENDANCE ROSTER

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MEETING NAME Cal/OSHA Workplace Violence Prevention in Health Care **DATE** April 1, 2015

CHAIRPERSONS R Nakamura, S Smith, K Graulich **LOCATION** Elihu Harris State Bldg 1515 Clay St. Oakland

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Ed Halsell Dept. of State Hospitals	edward.halsell@dsh.ca.gov		
Julie DePolma Dept of State Hospital	julie.depolma@dsh.ca.gov		
Richard Parker San Joaquin General Hospital	rparker@sjgh.gov		
Shelley Taylor on behalf of Paul White, Securitas USA	Paul.White@securitasinc.com		
Michael G. Davis DSH-Sacramento-OPS	Michael.Davis@dsh.ca.gov		

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ATTENDANCE ROSTER 15

MEETING NAME Cal/OSHA Workplace Violence Prevention in Health Care **DATE** April 1, 2015

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Terry Tonyate St. Joseph Hospital orange	mission2swim@yahoo.com	949-425-9849	
GERRED BROGAN	cbrogan@calem.gov	510-433-22..	
YONIE Devens CECRAUHU	ndevens@gmail.com	415.860.4990	X
latausha wilson-Hall	lat_hall@yahoo.com	(909) 827-4128	
Betsy Ortega	betsyortega@gmail.com	(626)444-6308	

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ATTENDANCE ROSTER 16

MEETING NAME Cal/OSHA Workplace Violence Prevention in Health Care **DATE** April 1, 2015

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Lindsay Kim UCLA	lindsay.kim37@gmail.com	818)288-6311	
Lorna Lontejas Sutter CA Hosp of Culver City	Lornalontejas@gmail.com	714 488 80 70	
BJ Wilson SEIU 021	BJ.wilson@Alameda Healthsystem.org	(510) 535 7202	
Maya Denny CPMC L&D	happylulu@yahoo.com	(510) 301-9195	
Nika Claes RN CPMC L&D	nikacnika@yahoo.com	(415) 699.1473	

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ATTENDANCE ROSTER (17)

MEETING NAME Cal/OSHA Workplace Violence Prevention in Health Care **DATE** April 1, 2015

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Caroline Gordon Long Beach Memorial Miller's Children	missmilly647@skaglobal.net	310 344 7630	
Manny Punzalan UCLA RR med center	mepunzalan@gmail.com	(310) 608-6922	
Michael Olsco UCLA Westwood	chael@hotmail.com	8183982158	
SUZANNE MARSHALL CHAPMAN MED CENTER IHHT	sq4europa@AOL.com	7144039282	
Jane Pressman UCLA/NPH	jane.pressman@gmail.com	310-293-1286	

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ATTENDANCE ROSTER

MEETING NAME Cal/OSHA Workplace Violence Prevention in Health Care **DATE** April 1, 2015

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
ELEANOR S. PUNZALAN - UCLA RL	ESPUNZALANRN@GMAIL.COM	310-218-9909	
RITA LEWIS RN CCHCS - SAN QUENTIN	on file		
Jason Barry Univ. of California			
PIERRE UNGARO RN DIGNITY HEALTH	PAUNGARO@JUNO.COM	626/825-9796	2062 LEWIS AVE ALHAMBRA 91001
Rosa Carcamo	rosamum2004@aol.com		

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ATTENDANCE ROSTER

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MEETING NAME Cal/OSHA Workplace Violence Prevention in Health Care **DATE** April 1, 2015

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Sheri Hinkle SEIU NBH	SSWilherson@aol.com	707-655-8924	101 Rodeo Ct Vallejo, Ca 94589
Monica Aleman UNAC/UHCP	monica.aleman@unac-uhcp.org		
Kate Durand Laguna Honda Hospital	kate.durand@sfdph.org	415-759-3321	375 Laguna Honda Blvd SF, CA, 94116
Kimberly Rosenberger Seizu			
Don FLETCHER	KOMET053@GMAIL	415-253-9338	

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NAME AND AFFILIATION	E-MAIL ADDRESS (for notices of future meetings)	PHONE & FAX NUMBERS	MAILING ADDRESS (optional)
Catherine Bugarin CNA	Cathysrn1962@att.net	916-225-8086	
MARILYN OCAMPO CNA	marilynlei1960@yahoo.com	(916) 505 3210	
TERRY BAKER	TERRY.BAKER@DSH.CA.GOV	(916) 654-3586	
Alisa Welsh CNA	welsh120@comcast.net		
La'Chanta Brown SEIU	MSCANDIB525@ATT.NET	3105674095	