Cal/OSHA Advisory Meeting
Workplace Violence Prevention in Non-Hospital Healthcare
Thursday, November 13, 2014
Oakland, CA

Meeting Chairs: Deborah Gold, Bob Nakamura
Notes: Grace Delizo, Kevin Graulich

MEETING ATTENDEES

NAME	AFFILIATION
Maribel Amezcua	Self
Jason Barry	University of California
Gayle Batiste	SEIU121RN
Christian Bobadilla	Staff at College hospital
Gerard Brogan	California Nurses Association
Yvonne Choong	California Medical Association
Cindy Conner	LA County Sheriff's Dept.
Samantha Contreras	SEIU-ULTCW
Cory Cordova	SEIU121RN
Melvi de la Cruz	SEIU 121RN
Ingela Dahlgren	SEIU Nurse Alliance of California
Pam Dannenberg	California State Assoc. of Occupational Health Nurses (CSAOHN)
Brandon Dawkins	SFDPH Tom Waddell, SEIU 1021
Steve Derman	MediSHARE Environmental Health & Safety Services
Denise Duncan	UNAC/UHCP (United Nurses Associations of California/ Union of Health Care Professionals
Kate Durand	SFDPH Laguna Honda Hospital
David Fleming	SEIU1021
Jennifer Gabales	California Association for Health Services at Home (CAHSAH)
Surit Goldmacher	Worksafe
Lisa Hall	California Association of Health Facilities (CAHF)
Dominique Hamilton	SEIU
Katherine Hughes	SEIU121RN
David Kernazitskas	Occupational Safety and Health Standards Board
Risha Kraal	SEIU121RN
Rita Lewis	CCHS – San Quentin, SEIU 1000
Christina Lockyer-White	Lifehouse Parkview Bakersfield, LTCW SEIU
Alma Martinez	SEIU-ULTCW
Shemiaka Meitzenheimer	Home health aide
Alberto Mejia	SEIU1021
Leslie Morrison	Disability Rights California
Michael Musser	California Teachers Association
Richard Negri	SEIU 121RN
Rob Newells	UCSF Benioff Children's Hospital Oakland
Alvan Philipp	Federal OSHA
Steve Pitocchi	SEIU 1021

Jennifer Rios	SEIUW
Cynthia Romero	ULTCW
Kimberly Rosenberger	SEIU
Jeff Roschko	DSH Napa State Hospital
Salina Savala	SEIU 121RN
Glenn Shor	CA Dept. of Industrial Relations
Ruby Sloan	Alameda Health System
Sarah Springer	SEIU121RN
Michael Tou	Providence Health & Services
Jora Trang	Worksafe
Vickie Wells	San Francisco Dept. of Public Health
B.J. Wilson	Alameda Health System

Deborah Gold, Deputy Chief for Health and Engineering Services, welcomed the attendees and introduced Division staffs that are working on the rulemaking project – Senior Safety Engineers Bob Nakamura, Grace Delizo and Kevin Graulich, and Principal Safety Engineer Steve Smith.

The Division is holding these advisory meetings because two healthcare worker unions petitioned the Board to adopt a new standard that would address workplace violence in healthcare. Petition 538 was filed by the Service Employees International Union Local 121RN and Petition 539 was filed by the California Nurses Association. Copies of the petitions, the Board and Cal/OSHA (Division) staff evaluations, and the Standards Board decision were made available.

This meeting is the second of a series of meetings that the Division is holding on Workplace Violence Prevention. The first was held on September 10th and there will be a meeting next week on the role of facility security and law enforcement on November 19th.

Cal/OSHA has been working on the issue of workplace violence for over 20 years. In 1993, Joyce Simonowitz, Nurse Consultant for the Cal/OSHA Medical Unit, had drafted the first guidelines on preventing workplace violence. Cal/OSHA has done a number of inspections on workplace violence in many different types of healthcare operations and our experience is summarized in the Division evaluations of Petitions 538 and 539.

The Occupational Safety and Health Standards Board is the only agency in CA that's authorized to adopt occupational safety and health standards. At the June 2014 Board meeting, the Board adopted a decision which requested the Division to convene an advisory meeting on this issue and in that decision, they stated that it had determined that the necessity for improved workplace violence protection standards has been established.

We are therefore using this advisory process to determine what should be included in a workplace violence standard – to include how workplace violence is defined, what types of workplaces should be included, and how the issue of workplace violence can be addressed in the different environments.

The legislature passed and the Governor signed a bill addressing workplace violence in healthcare, SB 1299, which was specifically focused on certain hospitals (general acute care hospitals or acute psychiatric hospitals), but which also gave permission for the Standards Board to include other types of healthcare operations in proposed standards.

The rulemaking project required by SB 1299 will be rolled into the process that was already started regarding petitions 538 and 539 and will consider those issues as well as the issues raised in the petitions, these advisory meetings or through this process.

When petitions 538 and 539 were submitted, Cal/OSHA requested a review of WPV injury reports submitted through the workers' comp system. The results of this analysis can be found in the Division's evaluation of Petition 538. In it, there was a table done doing a keyword search in the WC system during a 3-year period. We have WPV identified against HCWs in a lot of different kinds of facilities other than hospitals, as well as hospitals. Dr. Lipscomb's presentation also addressed some of the other environments which WPV is known to be a hazard.

The purpose of this meeting is to determine which healthcare workers, other than general acute care hospitals and acute psych, have workplace violence hazards, the nature of those hazards, the control measures that are currently in use or that could be proposed, and any barriers to implementing those control measures in these environments. By non-hospitals, we mean everything from facilities licensed by the Department of Public Health as skilled nursing facilities and intermediate care facilities through home through emergency medical services, we will ask stakeholders to elaborate on this.

Ms. Gold referenced H&S code 1257.7 and 1257.8 which are the safety and security plans that apply to certain hospitals in California. These laws are not enforceable by Cal/OSHA but they do provide information about what has been done so far on this issue.

Ms. Gold described the OAL rulemaking chart and the Administrative Procedures Act that governs how agencies can adopt regulations. California has a process for adopting regulations that will then be enforced by state agencies. In California, that responsibility for the OSHA regulations adoption is given to the Standards Board while the enforcement is done by Cal/OSHA. The Division is providing advice and then will make a rulemaking proposal to the Standards Board, who will then vote on the proposal and conduct rulemaking activities. So the Standards Board has the authority, which is granted by the legislature, to adopt regulations for occupational safety and health. We are meeting in the state building and conducting pre-rulemaking activity. Once we get through these advisory processes we will write a proposed regulation, and send it over to the Standards Board who will review it and send it to the Office of Administrative Law, who will issue and publish a notice of proposed rulemaking. There will be a public hearing by the Standards Board, there will be a written comment period as well. There may be some changes done through other public notices and eventually the Board will vote on the proposal. Ms. Gold emphasized that we're still in the early stages (state agency part) talking with stakeholders to figure out what's best to put in the regulation. There will be other opportunities for public comment but this is the chance we have to develop collaboratively the regulation that will provide better protection to employees at work.

Bob Nakamura then solicited input on the different types of health settings that should be included in this rulemaking. He started off with skilled nursing facilities.

Lisa Hall, California Association of Health Facilities, stated that she was surprised that they ranked #2 on the stats and stated they also represent the residential intellectual developmental disability facilities. A lot of this is a change in the environment. The residents that are being discharged into the facilities have behaviors. They are highly regulated on how they can control their behaviors in the facility. She sees room for additional training to help with this.

Risha Kraal stated their building is a skilled nursing facility (SNF) but they are a behavioral health building. They are also a forensics unit so they have a lot of inmates in their building and have a lot of patient to nurse and staff violence where they are bit, hit, kicked, spit every day. There is a great need for a regulation for buildings like theirs. They have a nurse suffering from neurological disorders and seizures because a resident kicked her and stomped her head into the ground because they didn't do proper screening before the patients were brought in. They get training on the restraints they use but they are not allowed to put their hands on a resident. The first step is verbal redirection, so if they hit someone in the face 3-4 times and they are told to stop and they do, that's where it ends. They're not allowed to put their hands on the resident from there. Management is pushing away from restraining residents. Workers will be under investigation for using too much force so people are just getting hit and there's no in between.

Kate Durand, SF Dept of Public Health – Laguna Honda Hospital (180 bed SNF), has a fair amount of workplace violence that has somewhat increased recently due to changes in patient population. They try to screen on admission to not accept patients that have behavioral issues that will lead to workplace violence but that doesn't always work. They train all staff on SMART training, which is a recognition and de-escalation strategy for staff but that doesn't always work either because there's not always sufficient warning to de-escalate and a lot of the violence is random and fast. The SMART training came out as a response to one of their state surveys where they had a particularly bad incident of workplace violence.

Samantha Contreras, United Long Term Care Workers, represents 5,000 nursing home workers in California and stated some members were in attendance to give their perspectives.

Cynthia Romero, Genesis Behavioral Health, works with workplace violence on a daily basis – kick, spit, hit, everything you can think of. They do proact but it doesn't always work, so they just deal with it on a daily basis and need more staffing. When they bring them in, they need to assess them better.

Jora Trang, Managing Attorney at WorkSafe, has done work around workplace retaliation and they've conducted meetings all across California and have found that workplace retaliation is a huge part of the workplace environment. Not only are workers experiencing workplace violence, they are experiencing a situation where they feel there is no way to report for various reasons. There are disincentive programs, disciplinary procedures that are taken against them and are unfair. There's a workplace culture that believes is is part and parcel of the work – they're going to experience workplace violence so just deal with it. There's a lack of a clear standard and prevention policy. There's a cultural perspective where they've had to go out and train workers and tell them their body is more important than their job.

Deborah Gold clarified later there will be opportunity to discuss barriers to implementation, but would still like input on what other facilities should be included.

Bob Nakamura asked if there was anyone from home health operations.

Pam Dannenberg, California Association of Occupational Health Nurses, mentioned there are clinics that deal with behavioral issues as well as daytime group health, senior home care facilities, residential homes that house people that are no longer able to care for themselves.

Jennifer Gabales, CAHSAH, represents hospice and home health providers in the state, knows they're on the list and that the Division's report has included incidents of safety issues in their

settings. They are unique in that they provide care in the patient's home so there's not a lot they can do with facility, but both federal and state regulations allow them to discharge for cause that includes safety issues. So if a nurse or a home health aide or another worker is in the home and they feel unsafe due to the patient's condition or their family members that are present, if they report that to their supervisor they are allowed to discharge for cause. It's their recommendation to their members that they include the reasons for allowable discharge in their admission agreements and they train staff on how to report safety concerns to their managers. She mentioned at the last meeting there was a report of a home health nurse that was physically assaulted and then became deceased after caring for a mental health patient. That is not typically the home health care they provide. There isn't a mental health – home health ordered in California. It's typically post-hospital discharge. There are some ongoing nursing home health provided through various Medi-Cal waiver programs and hospice is usually end of life care, but all home health in the State is required to be ordered by the physician, so that's typically medical and not mental health.

Lisa Hall, California Association of Health Facilities, stated that skilled nursing is different and highly regulated on how or when a resident can be discharged from a facility. They have to be given 30-day notices, they have a 7-day bed hold and have to be offered one if they are discharged. They also have to be given the first available bed back. There are a few reasons a facility can discharge, but the resident has the right to a hearing and most of the time, the resident comes back to the facility. So that's a big barrier in that facilities can not just discharge a resident out. There are a lot of regulations that protect the patient's right to stay in the facility.

David Fleming, SEIU 1021, San Francisco General Hospital, stated that psychiatric populations and the downsizing of acute care units, patients are being discharged into residential areas that are not really skilled nursing facilities, but more like hotels. There is violence that goes on in the hotels where patients are placed, so the workers at the hotels are subject to violence but also the people that live there. He's not sure what category that would fit in. Bob Nakamura asked who employs the hotel workers. David replied that it is the City of San Francisco and non-profit organizations, Progressive House, Baker House, and a few other units.

Katherine Hughes, SEIU Local 121RN and Nurse Alliance of California, also represents home health workers in the LA County who do home health, public health, working in group homes, working in boarding care, which are very small and privately owned. They're not in a skilled nursing facility, but they're in the same kind of care. Their home health nurses are telling them they work alone in areas that are very dangerous. They don't have a reliable means of communication when they feel they are in danger, don't have any alarm or GPS systems which would allow them to be located, or any policies in place where there is a check-in, check-out process so people know where they are. They find they're being disciplined for being in the home too long and they have such a tremendous case load that they need to get in and out very quickly. She suggested an advertisement that is put on a car door so that people in the neighborhood know they're with home health and not CPS or law enforcement. It's not something employers are willing to address.

Richard Negri, SEIU Local 121RN, listed facilities that should be included: long term care, outpatient, ambulatory including doctor's offices, OB-GYN, abortion clinics, same day surgeries, pharmacies, home health care, corrections, pysch and mental health, state mental health, hospice, senior health care. They believe these facilities are in this category based on asking people in the state who work in health care to provide their story about workplace violence and have a large collection of data. He shared that a public county hospital employee felt more unsafe at the parking lot more than anywhere else.

Bob Nakamura clarified that he plans to go through the specific hazards of each environment right after going through the list of operations.

Samantha Contreras represents 170,000 in-home supportive services workers that, don't work that work in facilities, work part-time as CNAs. Wants to stress that protections be extended to every worker in every single work environment because some workers work minimal hours as a home health aide or as a CNA at a nursing facility.

Kathy Hughes added that assisted living is often part of a skilled nursing facility but they require different levels of care, so assisted living might be more like a residential care but it's a different term that is used out there in industry.

Steve Pitocchi, SEIU Local 1021, stated that a number of classifications in different work settings, they found that when requesting information from the employer regarding batteries and assaults that the employer would only report on employees that filed workers' comp. What needs to happen is that they need to be able to get information on occurrences because there are many occurrences of battery and assault in the field as well as inpatient, but there's not a tool to get that because the employer relies on the fact that if someone didn't file a workers' comp claim, then it didn't happen. Or for incidents that go unreported to the health system because the manager or supervisor who may know of an incident failed to inform the employer, therefore the representatives of the employees were not able to get accurate information on exactly what's happening. Because the employer doesn't report, the employee doesn't feel they can report for fear of retaliation.

Brandon Dawkins, SEIU Local 1021, San Francisco Dept of Public Health, Tom Waddell Urban Health Clinic, is a community clinic but they also have a huge umbrella of facilities including respite care, have nurses in their hotels in various locations. They are located in an underserved community in San Francisco, tenderloin, where they provide direct patient care to the homeless and mental health population. When their mental health patients don't get their meds, they snap at their nurses and the frontline staff and sometimes get physical with the medical providers. They're not allowed to touch the patients and instructed to call the police and half the time, the police don't show up. They don't have deputy sheriffs in their clinics. They have private security that are also not allowed to put their hands on the patients if they get physical and are instructed to call the police as well. They have also had shootings in their hotels as well as drugs on the steps of their clinics. He wants to know what can be done about that, especially on the state level, to ensure the safety of not only their patients but the staff as well.

Denise Duncan, United Nurses Association of California, also represents home health RNs, physical therapists, and nurse practitioners in southern California. They report that they are walking into domestic violence situations in the home and they have no prior knowledge until they walk in the door. They've been assaulted with equipment in the home, everything from a cane to a walker, by a family member. There are more and more demented patients they're caring for, drug deals going down the hall in the home, more people having weapons pulled on them as well as one RN was chased to her car and fell and broke her wrist. These are their concerns and it appears from their testimony to be escalating.

Bob Nakamura asked if there was anyone from emergency medical services.

Cory Cordova, SEIU Local 121RN, represented nurses where they've had to fight to get someone discharged from a sub acute unit. One of the pushbacks they get from employers is the un-predictableness of the violence. One patient at a psych facility will be a patient somewhere else, but the nurses at a hospital ER will have no idea that this person is a volatile patient but they might have been discharged from a previous facility because they were volatile. There's nothing that tracks that, nothing gets reported to law enforcement or an agency, to let them know they're getting a patient that's probably going to try to stab you when they get there. There should be some coordination with law enforcement so they have data so that when a patient shows up at an ER, they know that this patient could be volatile.

Risha Kraal, Genesis Healthcare, the problem with tracking is that most of them are conserved patients from counties. When they are reviewing packages they are covering nursing notes so they don't know the patient is receiving 3-4 PRNs a day. By the time they get to their facility, they're good for 2-3 days because they are super-drugged up but as soon as the PRNs wear off and they are dealing one to one with the patient, they don't know what their behavior will be until they explode on them. She feels the counties need to be more responsible too because they're shuffling patients from building to building and people don't want them and the counties are covering up what type of patients they're sending.

Cindy Conner, Lieutenant with Los Angeles County Sheriff's Department, works with LA County Department of Health Services. Law enforcement can't share criminal information as much as they'd like to. With AB 109, there are a lot of releases that come out of custody but there's a psychiatric hold placed on them because they've been treated by a custodial facility by their department of mental health. They encourage mental health within a custody facility to communicate with mental health workers as to where that patient is being released and to indicate their knowledge of the patient/inmate upon their release but they're trying to come up with something they can legally do to identify these people.

Bob Nakamura then asked if there was anyone representing primary care and medical offices.

Yvonne Choong, California Medical Association, represents 40,000 physicians. She raised a couple of issues. Physician offices are not licensed, physicians practice in a wide range of settings ranging from one office to physicians that are practicing in offices that are leased as part of a larger medical campus. It's not clear how standards would apply to offices because they are not licensed, physicians practice under their own medical license and the types of facilities they are working in are so varied and a lot of facilities are not in their control. There's also a different type of staff mix in every office, different physician specialties. One of the specialties that have experienced the most violence is urologists. The last 3-4 shootings of physicians have been urologists but they're not who you'd imagine would have mental health, so you could have co-existing conditions and have someone come in for a broken leg and you would have no reason to worry about what their mental state is. She emphasized that it could be the patient's family or caregivers. There are HIPPA issues that they've run into with being able to share information to create an alert system or contacting law enforcement. She feels that guidance is more effective than standards because uniform standards that would apply to all physicians' offices would be extremely difficult. Ms. Choong also pointed out that the majority of ambulatory surgical centers are not licensed. They may be accredited or certified by CMS so there is some oversight but they're not necessarily licensed by CDPH. In addition to physician offices, there are also other health practitioners such as dentists, physical therapists, and allied health professionals such as chiropractors where the patient pool may be very similar.

Katherine Hughes, RN with SEIU Local 121RN and Nurse Alliance of California, recognizes that doctor's offices are not licensed but pointed out they still employ healthcare workers so there still should be some kind of plan in place, also some education and training on how to recognize a patient that might be escalating and de-escalation techniques. There also needs to be some level of protection, granted it might be very different than an acute care hospital, but there still needs to be a plan and policies, and education and training in place for the employees and the doctor, just like they have policies and procedures for everything else – absentee policies, late policies that the employees need to be educated on.

Richard Negri, SEIU Local 121RN, stated that the settings are going to be varied so the standard should call for something site-specific.

Rob Newells, UCSF Benioff Children's Hospital, stated their biggest problem in their outpatient clinics is from threats and intimidation from coworkers and supervisors.

Bob Nakamura asked if there was anyone from correctional healthcare operations.

Rita Lewis, RN at San Quentin State Prison, felt what was most lacking was consistent follow-up after a violent event. There doesn't seem to be any protocol. She stated that a nurse got locked into one of the hospital rooms with a patient because the custody officer didn't see her and locked the door. There was no post-meeting, even at least on the floor she was working, on how to prevent the incident from occurring and there's an expectation that you're just going to deal with it on your own.

Elsa Monroe, San Quentin State Prison, stated that it was not only traumatic for the nurse that was held locked with an inmate who had committed murder, and despite her yelling for help there was none. The second issue was they were understaffed. She was performing LVN duties, involved in giving insulin injection and she was focused on giving the correct amount of insulin. The officer on duty was making fast rounds shutting each door of each cell very quickly and when the nurse realized she had been locked in she started calling for help and there was none. The message from administration was that she should've had her whistle, questioned why was she doing that in the first place and the whole premise was that it was the nurse's fault. Another nurse, LVN, was in the condemned area (administrative segregation) with inmates that are highly violent and giving medication through the food port which is a metal door that opens up where the inmate gets their tray for food. Normally the inmate comes out to get their medication but because of the situation the nurse was compelled to give it through the port. Unfortunately the inmate "gassed" her with body fluids (urine and feces) and it landed on her face, hair and chest. When she asked for help, there was no protocol and the officers didn't know how to handle this. The nurse was paraded throughout the facility and transferred her to Marin General Hospital because she was an employee and could not be helped onsite. The nurses there didn't want to help her because they were grossed out and had the attitude that she was a prison nurse. It's like they are second class health care providers by society. She had to be treated like she was being decontaminated. The supervisor asked her to come back so she could complete giving medications. There was no debriefing and no sense of compassion for her.

Katherine Hughes, SEIU 121RN, represents thousands of corrections and detentions nurses in county and state correctional facilities. She stated that in San Diego, they are often working alone due to staffing cuts so they're segregated from anyone that can help them; there are poor alarm systems, poor education and training. Their biggest problem is working alone and for state facilities they don't feel they have to follow the same set of rules that actually do apply to

them, telling them there were no bloodborne pathogens when the nurse was gassed, there was no follow-up to see what diseases she might have contracted from the inmate. Their biggest issues are that they're working alone, there are not adequate safety systems in place, and that they're not receiving education and training.

Rob Newells, UCSF Benioff Children's Hospital, stated they manage the clinic at Alameda Juvenile Justice Center. He is concerned that their workplace violence policy will not fly at the county jail. There are Children's Hospital staff that work at the county facility, so he has concerns about protecting his staff that work at a different location.

Deborah Gold asked if there was anyone else that wanted to discuss the issue that county jails that have contracted with other providers for health care services. The Division is currently investigating a similar situation. One of the precipitating events was the killing of a nurse at the Contra Costa County jail who was maybe employed by another agency and the issue of working alone was raised there.

Cindy Conner, LA County Sheriff's Department, prior to being assigned to work with the LA County health systems she was a watch commander at LA County Twin Towers Correctional Facility. The LA County Sheriff is the largest jail system in the world and one of the towers is the largest forensic inpatient facility for inmates with mental disorders and has the largest distribution of psychotropic drugs. She stated that it would be unfair to say that what happened in San Quentin is the general rule and that it sounds like there was inadequate leadership there. Their prevailing rule is the safety of their staff and nobody is left alone and everyone is monitored. Those situations are debriefed and root cause analysis is done to what occurred. She is shocked and sorry to hear about what happened but feels that it is an isolated incident and not systemic across the state.

Ingela Dahlgren, nurse and Director of SEIU Nurse Alliance of California, spoke of a psych tech at Napa State Mental Hospital that was strangled in 2010 outside the building because they had taken an old facility that was not built to house violent criminal patients and were housing very violent patients. The leadership had omitted to make sure that everyone had working personal alarms and there was a prevailing knowledge among all the staff that they work there and they had to take whatever was coming at them. If Donna's personal alarm had worked, she might have been saved but everyone knew the alarms didn't work outside and staff had to go to different buildings. There was no update and Donna's family was told at her funeral by administration that she knew what she was hired for.

Cory Cordova, SEIU 121RN, previously represented RNs at Twin Towers stated there are inconsistencies in the level of safety whether it's manpower, equipment, policy and procedure. It's night and day from comparison to what the deputies get compared to what the RNs get. The issues that arise, whether it's a disconnect with employers or a disconnect with staff, the RNs feel segregated in regards to policy and procedure and security needs, they also feel segregated in regards to camaraderie because they work alone most of the time. So a lot of the stuff that if I have a fellow deputy in trouble I high-tail it over there to make things happen it doesn't happen for RNs. So the gassing situation would have been handled differently for a deputy than it was for the nurse.

Jeff Roschko, RN at Napa State Hospital, stated they have HPOs which are essentially officers that don't go in until after a weapon is brandished. Therefore nurses and psych techs and other medical personnel have to go hands-on and are frontline. They are not equipped and are not allowed to have flashlights. Patients pick up chinks and chairs and staffs have suffered broken

bones and permanent brain damage. Donna Gross' incident was a horrible incident and no safety measures have come from that. There are 44 patients and 5 staff and officers might walk by once or twice a shift if you're lucky. When there is a patient death, that's when the policy and procedure changes which is understandable, but when there's an assault rate over 1 per calendar day or 400 assaults per year, it's a daily basis and it doesn't seem there's anything being done for it. The Department of Justice stepped in for a while and they were recently released from their jurisdiction. They only have reactive measures and never proactive measures, and that's why there are always assaults and violence.

Bob Nakamura asked if there was anyone from community-based in-patient or outpatient mental health, addiction services, drug treatment, sub-acute and geriatric psych facilities.

David Fleming, SEIU 1021, San Francisco General Hospital, stated that there are 365-day shelters that are a collection point for anybody that may be outside the normal support systems that exist – homeless individuals, individuals who are out of prison, individuals that have no resources. This would include respite care or people who walk in off the street. There are high levels of violence in their shelters. There are even those in halls that don't want to go to the shelters because there is a lot of violence there, and the people who work there are subject to violence as well as the EMS personnel when they have to respond to an incident at the shelter. That is a category of non-profit organizations that support the community and are subject to a high level of violence.

Melanie de la Cruz, SEIU Local 121RN, has experience in an acute care psych facility at College Hospital in Cerritos. They range from dual access patients such as autistic or mental retardation to depressive patients, bipolar, also geriatric, adolescent and adult patients. There is a disconnect between the actual training, the management and the staff. There is no safety within their walls. Her coworker has been bitten six times in the past four years and at the end of the day, he's blamed for it. She's heard management tell them that it's part of the job and they know what they're getting into. If it's part of the job it can be prevented. Workplace violence not only ranges from visitors and patients. It also comes from coworkers and administration. Before they can be treated, they're investigated to see if they're the ones at fault. Luckily she's never experienced being physically hurt, but she has experienced emotional and mental damage. The word disgusting is an understatement of what goes on in these facilities. They've been spit at, gassed, hit, and punched. She knows of a therapist that was hit with a chair and needed spinal surgery. She knows of someone that needed to undergo HIV testing because the patient that assaulted her was HIV positive. And at the end of the day her colleague was the one blamed for it. If you can predict it, we're a psych facility. They receive Management of Assaultive Behavior (MAB), Crisis Prevention and Intervention (CPI) training which focus on verbal de-escalation which can only go so far. A lot of employers focus on patient safety and not the staff.

Christian Bobadilla, College Hospital in Cerritos, has been bit 6 times and has also worked with a dislocated shoulder after a patient assaulted him. He wasn't able to leave the unit because they were short-staffed. If he'd leave, there would only be females left to work with 12 highly assaultive males. People who have come from prison come into their facility, and one of the patients had a piece of glass attached to his leg and used it to stab one of their mental health workers 6 times who almost died. The hospital ended up firing the worker accusing him of being at fault. Things need to change because they want to help but don't want to get hurt and blamed for it.

David Fleming, SEIU Local 1021, stated that he sees the same thing happen in a lot of the facilities where he represents employees in disciplinary processes where the patient has come at the employee and the employee put his hand up, the patient runs into the patient's hand and falls on the floor yet the employee is charged with assault against the patient. There was a case where the employee was terminated and they fought to get the person back. What the employer wants them to do is cover up or run, but that might endanger everybody else. You're not allowed to defend yourself because that's against their rules and regulations.

Richard Negri, SEIU Local 121RN, stated that College Hospital has been cited by Cal/OSHA for $47,000 of violations and they are in the appeal process. During that time, they don't have to abate what they were cited for. While that's occurring, multiple issues are still occurring and they had to open up a whole new case against this facility. He was told that one of the reasons for the violence was that the patients have zero to do and it was suggested that patients be provided magazines to read or exercise mats to stretch. One of their represented employees was told by management that they'll wait until there's a regulation, so they don't have to do anything until they have a regulation. Another employee told him that she was alone on the floor with a large patient population and a patient was slamming his fists together and threatening her. These scenarios are happening every day and they can't file enough complaints to Cal/OSHA.

Katherine Hughes, SEIU Nurse Alliance, represents a lot of the healthcare workers in the LA County area. They're seeing inmates released from the corrections system and then showing up at their outpatient psych facilities and they have some history of violence and they don't have enough protective mechanisms in place. Cal/OSHA doesn't have any control over releasing inmates and cutting their sentences short, and they're very violent or have a drug history and they might act out because they need the drug and they don't have it, or coming off of it and become violent. They're being told there aren't any specific policies, effective policies, or reporting they can do. You're going to hear the same things, the need for education and training, the fact that they're working alone, and that employers aren't recognizing the propensity for the violence in these areas because they're in the outskirts. As soon as you get into the periphery of the non-traditional stuff, the controls are fewer and less enforced. The workers don't always have the same level of empowerment and the same level of protection to be able to speak out about retaliation. Those are the kinds of things they're finding in peripheral health care settings.

Christian Bobadilla, College Hospital, gets punched 12-15 times per day and also gets kicked, bit, spat on, scratched but there's nothing in place to keep track of how many times it's happened per shift to everybody. The hospital only wants to track when workers get sent to emergency because that's what goes on the OSHA 300 log. If there is any other type of work-related injury they say, "What could you have done better, then change that so you won't get punched or kicked."

Risha Kraal, Genesis Healthcare, stated that anytime the resident touches them they write an incident report. But if you refuse any type of treatment, even if you got to the ER, the only thing they're reporting is if you were prescribed medication like ibuprofen. Nobody knows how many times the healthcare workers are getting hit and kicked. It's always about patient rights but what about the workers' rights. It's okay for them to not take medication or not to take a shower and they can't be forced to do anything. Their company closed down a unit and opened a forensics unit. After getting a huge contract from LA County and their building is probably 80% forensics unit now and they didn't give workers any kind of training. They were told the company was bringing in people to deal with the inmate population and they have no idea who they're dealing

with. She was a correctional officer with the LA County Sheriff's Department and already had that type of training. When you give these types of patients, convicted criminals and mentally ill, forks, spoons, plates, trays and chairs they can be triggered by one word or a look someone gives them and it will cause all 70 people will go off in the dining room. There are only 6 workers in the dining room with them.

Melanie de la Cruz, SEIU Local 121RN, stated that there is one to one staffing when the patient presents with grave danger to themselves or other people or is unable to provide their own care. They're assigned their own personal staff. Any use of assistive devices is an extension of yourself. There is an unwritten rule that administration calls one with dignity where workers have to stay at arm's length away from patients so they are an easy target for patients to reach. Staff have been fired for protecting themselves from being hit because they were outside of the arm's length reach. It's about patient rights, but what about theirs?

Deborah Gold stated that we're trying to focus on non-acute care, non-acute psych hospitals in this meeting. We've mentioned a lot of community based or non-hospital settings, starting from licensed facilities like skilled nursing and other intermediate care facilities. She referred to the list of facilities licensed by CDPH, home health, EMS, other field operations like methadone vans, primary care and medical offices, correctional health care, community-based inpatient and outpatient services, addiction services, sub-acute and geriatric psych. This is a grouping we put together and the list that is in the petition is how things get grouped in the data collection system of workers' comp and it's not an exhaustive list. So we want to hear if we've left out an important environment. We understand there are a lot of distinctions between the different kinds of environments. Doctors' offices are different than behavioral day care centers, or a day care center for geriatric patients. She asked if there are other types of facilities that stakeholders want to talk about.

Brandon Dawkins, SEIU Local 1021, San Francisco Department of Public Health, stated that Laguna Honda Hospital, San Francisco General Hospital, and the primary care clinics of San Francisco all receive the same SMART training. They are advised if the worker is backed into a corner by a patient less than an arm's distance, they are to do anything possible to get out of that corner. There have been deputy sheriffs, nurses, health workers, eligibility workers that were assaulted in their primary care clinics and it they put their hands on the patients, workers are subject to disciplinary action but nothing happens to those patients. Some of those patients have been arrested and let go, some slapped with misdemeanors. The hospital doesn't go out of its way to press charges on patients who assault the workers which is unfair and ridiculous. Workers deserve better protection and no one ever brings up what can be done for them.

Michael Musser, California Teachers Association, has over 325,000 members statewide and only a few members are actually skilled nurses in school districts, some employees are trained as nurses' aides, and also some paraprofessionals who work with handi-capable students who have multiple challenges whether it's physical challenges or medical challenges. These individuals are facing similar things daily like attacks either from the students or the parents. He hopes that somehow, if we're not addressing it at this time, that we look at it in the future and that there are other employees in the state of California that are providing these types of services to individuals in California and they need to also have some type of regulations that the school districts will follow.

Rob Newells also serves on the Board of Directors for the Aids Project of East Bay, which is a community-based AIDS service organization. They have a primary care clinic, social services, substance abuse and mental health program, and a mobile testing unit for HIV testing in the

community. He doesn't know if they fit into any of the categories but suggested they be included.

Dave Fleming, SEIU 1021, stated that as ACA expands, there is a decrease in the size of hospitals and more patients and clients are going to move into multiple community or clinic-type settings. He stated that we need to keep an open mind to where people might be moving to because of ACA, not just one type of clinic. In San Francisco, there are 17 different types of clinics, then non-profit clinics that address significant individual problems that are subject to violence at any given time.

Katherine Hughes, SEIU, asked if blood banks fall under the scope as a community-based setting, as well as mobile clinics where they're providing some type of health care in the community. She stated that blood banks are staffed with health care workers.

Samantha Contreras, ULTCW, wanted to clarify if the list was only for facilities licensed by CDPH. She raised the point that there are other facilities such as residential care facilities for the elderly that are licensed by the Department of Social Services so important to look at other departments besides the Department of Public Health. She also is in solidarity with workers at the psychiatric facilities, but also acknowledged their members here from skilled nursing facilities. Even though long-term care workers are caring for grandparents, these patients suffer from dementia and other problematic disorders, and put workers lives at risk.

Shemiaka Meitzenheimer, RNA/CNA works at a skilled nursing facility and deals with dementia and Alzheimer residents who can become combative when they try to give quality care. They are punched, kicked, scratched. It took her and two other workers to dress a combative resident and they were written up because they were told they should have just backed off and let the resident stay in bed and not be changed and cleaned up. It was a double standard because you have to check on them and change them every 2 hours so you either try to give the care or you don't and still get written up.

Christina Lockyer, CNA works with dementia residents at a skilled nursing facility. They wear ankle bracelets and get violent. You need two workers if you have a combative resident and they don't take into consideration the ratio of patients and most of the time there's not enough staff to attend to a combative resident correctly.

Richard Negri, SEIU121RN, gave an example that if he loses his way and beats up a cop, whether the cop is on-duty or off-duty, he'll face the consequence that it's a felony. If he spits at or kicks a judge, whether or not the judge is on duty, he'll face the consequences. There are a number of other workers that he'll face consequences and believes that health care workers should have the same protections as these other individuals.

Lisa Hall, CAHF, added that many of the categories on the list are not licensed by CDPH such as residential care facilities that are licensed by Social Services. No one wants to see a healthcare worker hurt but the nature of the regulations are there to protect the resident and there are so many regulations on what a facility is and isn't allowed to do. Right now, they feel there are still too many psychotropic and anti-psychotic drugs used in long term care. Patient advocates would like to see it down to zero. There are going to be residents that have behaviors, facilities are funded only to a certain point for staffing and some go over it. As these programs are looked at, funding is going to be an issue and additional funding will be needed for the additional mandates that come out.

Lunch Break

Deborah Gold reconvened the meeting. She stated that most of the morning discussion was centered on examples of patient to health care worker type of violence (Type II). People talked about the different types of environments and what were the hazards there, from correctional health care and people engaging in intentional behaviors to behavioral health issues, etc. We want to get specific about other types of violence or be specific about other types of violence hazards. She referred to the workplace typology as discussed in Jane Lipscomb's handout from the previous meeting. For example, Type I is stranger violence, Type II is client or patient violence, then Type III and IV. There's patient to healthcare worker violence and then there's patient to patient violence in which healthcare workers get caught up because a patient is assaulting another patient. There's visitor to healthcare worker violence and it's been raised in the past as being a specific issue because visitors as family members have expectations that may be unrealistic of what the healthcare environment is going to deliver. There might not be a good outcome for the patient and the visitors may be upset by that outcome. Then there's visitor to patient violence where, for example, there's someone who's engaged in criminal activity and a visitor on the same side or different side than that person and comes into the ER and the conflict from the streets gets transferred to the ER. The violence follows the patient into the healthcare facility. Then there's the outsider violence where somebody comes into the hospital with a criminal intent e.g. of attempting to get drugs. Then somebody raised the issue of bullying. So we want to make sure we get from stakeholders examples of which these are problems in home health versus long term care because that goes into the next discussion about what control measures are relevant in these different environments.

Richard Negri raised the issue of domestic violence following workers into the workplace (Type IV).

Kathy Hughes gave an example of a Type I incident, where a man was pursued by the police and entered the front door of the hospital past the metal detectors and stabbed a nurse 11 times. Also there was a worker on worker incident where a janitor stabbed a nurse with a pencil. They also have a lot of domestic violence where estranged spouses enter the worksite looking for their spouse and people trying to protect that spouse might get caught up in it as well as the spouse. She stated that parking lots and grounds should also be covered.

Gayle Batiste, RN at Northridge Hospital, Local 121RN stated that workplace violence doesn't know any boundaries and that the standard should cover all HCWs, not just those working in ACHs – non-hospital, long term care, skilled nursing facilities, correctional facilities, home health, psychiatric and state facilities. If we only have standards at acute care facilities, that's saying that the healthcare workers in the state, the prisons, the jails and the county facilities that those acute care workers' lives are more valuable than yours. They're not and all of our lives are valuable and that needs to be addressed.

Rob Newells mentioned that most violence he's tracked at his facilities are type II and type III. His biggest issue is with Type IV – phone threats to whomever answers the phone, also e-mail threats and intimidation which are tricky to handle. Deborah Gold asked Rob what types of hazards, in terms of violence, he sees at the Aids Project of East Bay's operations. Rob replied that they're not tracking anything. He's only been with them for 6 months and his concern is that they don't have any direction at all. They are a community based organization and he thinks they feel that anything counts for them. The patient population is volatile so it's a concern.

Ruby Sloan, John George Psychiatric Hospital, works alone with 50-60 patients. She can't leave the floor because she's afraid that a patient will attack another patient.

Kate Durand, SFDH, Laguna Honda SNF has all types of WPV, patient to health care worker, patient to patient, visitor to healthcare worker, etc. In addition to physical assaults, they also have a high incidence of verbal assaults that result in significant psychological trauma. Deborah Gold asked Kate to describe how they occurred and what could have been done to prevent them. Kate replied that she is trying to come up with ideas to prevent these things from happening and trying to work with the staffs that have been assaulted. They are trying to manage care of the resident where the resident care team comes up with a resident care plan to prevent that specific person from being violent, which is after the fact and after they've already committed one assault. They also do some pre-admissions screening to try preventing people from ending up at Laguna Honda who are going to be violent because it's not going to be the appropriate place for that kind of person. They have struggled with the idea of discharging people who have nowhere else to go because they are the safety net facility. She has no idea on how to prevent verbal assaults. Staff that have been verbally assaulted tell her that it's usually racial slurs.

Brandon Dawkins, SEIU 1021 Tom Wadell HC, stated at their clinics, patients verbally assault the staff every day to the point that it's psychologically traumatizing and workers can't come to work because of the racial epithets and other things said. It could get violent because patients wait outside the clinic until the mental health worker or nurse gets off of work to attack them. He doesn't think there's much they can do because they're tapering patients off controlled substances and patients are upset. He suggested that more presence of law enforcement would be of help.

Cindy Conner, LA County Sherriff's Department, stated that they keep track of the crimes that are occurring in the vast types of health care environments and have statistics. They identify high risk areas within hospitals and clinics, what types of crimes are occurring, and define whether events are preventable or non-preventable. WPV is not isolated to HC, and could happen in an attorney's office or 7-11, and is prevalent throughout CA. First you have to have leadership in place that is willing to take measures to create (safe) environment. Important to debrief after incident to mitigate what occurred.

Elsa Monroe, gave examples of employees that could not use alarm systems because they were attacked from behind. Problem was inadequate staffing and need for more law enforcement.
Five officers take care of them and there would be more injuries if they did not have them.

Dave Fleming, SEIU 1021, overall theme is that they respond to incidents on an individual basis but nothing changes on global basis. So they have SMART training but it only occurs on orientation, not on an annual basis which is needed. He sees that no proactive, preventive measures are taken.

Deborah Gold redirected the discussion to what types of violence are occurring in other environments (e.g. home health). She gave an example of a home health nurse that arrives at a home where domestic violence or criminal activity is occurring and gets entangled in that.

Cindy Conner, LA County Sherriff's Dept., is also a member of private hospital organizations, told how a nurse found out in a file that a social worker had been into the residence before with

a parolee gang member and known narcotics in the house in a crime-infested area without any security mechanisms. If this was a law enforcement issue, she wouldn't send a deputy with a bullet-proof vest and fully equipped alone into that residence. When the nurse brought it to the attention of her supervisor, she was given a hard time, and the case was given to another worker.

Ingela Dahlgren, SEIU Nurse Alliance of California, represents 90 public health nurses that go into drug infested, high crime areas. She gave an example of a nurse that narrowly escaped from a home with pit bulls, after a man followed her with the dogs to her car and she was able to lock her door in time. The only device was a cell phone that was recently given to her.

Richard Negri, spoke about homecare workers concerned about working alone being one of the largest issues. He suggested the use of a buddy system, GPS tracking device, marked vehicles, security check out/check in as possible solutions.

Samantha Contreras, stated that when neighborhoods are described as infested, crimes and violence can happen in every neighborhood no matter what class and economic status of people lives there. She represents in-home supportive services workers, spoke of home care workers that live in homes with people they care for – dementia, Alzheimers, Downs Syndrome. They work alone and have no one to call upon for help besides law enforcement. Because they're in the home, it's not recognized as a workplace. There is no way for them to put in a complaint or no one to call upon to report an incident. She urges Cal/OSHA to take note because it's out of Cal/OSHA's jurisdiction in many ways and falls upon the Dept of Social Services. The likelihood of these workers to report a family member for WPV to law enforcement is highly unlikely.

Kim Rosenberger, California State Council, SEIU, mentioned that having a database that would be helpful in homecare where people are self-employed so that there's a system to flag people for aggression so that people will know what they're going into and how to be prepared.

Jennifer Gabales, California Association for Health Services at Home (CAHSAH), stated they have limits on marking cars for privacy (e.g. hospice patient). They do have the ability to discharge patient if there's a safety issue in the home (illegal activity by a family member, combative patient, or general noncompliance with the treatment plan they agreed to), in order to protect their workers. What she is hearing is the inability of staff to report any risks that they sense in their environment, and to ensure that they know how to report safety issues and that the agency itself has a policy or means to disenroll and do their members need to be reminded that they have that right to keep their workforce safe by disenrolling patients and how that process would work, how they would document on the OASIS form, what code, etc. There are some other training issues that could help in ensuring that existing regulations regarding workplace safety are adhered to.

Richard Negri asked if the agency is also bound by occupational safety laws and has to provide a safe work environment for its workers. **Jennifer Gabales** said yes, but there are other laws besides workplace safety that impact a health agency. There are other regulations that prevent discharging patients until they find another provider willing to take their case. But if they've documented that it's a safety risk for their workers they can disenroll that patient and they have no obligation to find another agency to provide the care. Home health and hospice agencies are licensed by the State and 96% of them are certified for Medicare reimbursement and have to apply federal regulations to all of their patients regardless of the payer source. If

looking at existing regulations, the question is whether they're being followed or are providers actually aware of what existing tools they have in order to keep their workers safe.

Deborah Gold asked if employees run into unanticipated situation (e.g. providing care for a disoriented, combative resident) how are agencies helping that worker right at that moment, not changing their care plan over time. What kind of procedures do agencies have for the health care provider that is attacked in the home? How are you tracking them? What are the safety measures that you take to protect the worker at that moment? **Jennifer Gabales** replied that if she walked into a home that was unsafe, she would leave and call her administrator. **Deborah** stated that she's heard from home health workers that they walk into the home and then something occurs, maybe because a patient is disoriented or may occur because something else is going on in the home, and understands that down the road you may attempt to discharge that patient or move them into some other care plan. But in that moment, how are you tracking that nurse or other health care provider and making sure they are safe? How do they know that someone is under attack and needs help? **Jennifer** replied that outside of calling 911 immediately she doesn't know what every single member would have in place for their workers. There is a schedule and they're dealing with medical records on a regular basis. A lot of them have electronic records where they enter patient's information before they leave (larger agencies, not rural). Nurses have schedules and families expect them to be there and she hasn't heard of a case where a nurse goes into a home and is never heard from again. Of course, nurses are at risk when they go into someone's home but they are trained to look for signs and indications that it's an unsafe environment. But before they go in to provide treatment, an assessment has already occurred. They don't just get a patient by a phone call, they get it from another healthcare provider that's ordered the treatment so they do have some background information on the patient and family before they go in. If there was something in the health record that said "while grandma was in the hospital, grandson came in and this was the problem we had" then they'd have some information, but they do go in blind initially. **Deborah** stated it would be helpful for Jennifer Gabales to ask her members if they have best practices around this and how they are tracking their nurses or employees when they're going into homes, how they're responding to incidents. Deborah understands their legal ability to discharge the patient but the Division is interested in what's going on in home health environments that would protect the workers at the moment of where these incidents occur. We are aware of incidents that occur because we have incidents of workers' comp that have occurred as well as those not in workers' comp. **Jennifer** replied that she surveyed members to get a sense of what's happened to them and got nothing back. She doesn't have every home health agency in her membership. There are about 2,000 home health agencies and she has about a quarter of them in her membership. There are thousands of agencies that provide care for tens of thousands of patients and there are 188 home health incidents on the chart, so she feels that the actual incidence is very small but it doesn't mean that it's not a problem. It's hard for her to come up with experience from her members because it's such a minute portion of the home health population. **Deborah** clarified that these are not the home health population, these are employees in home health who have suffered an injury that was significant enough to get into the workers' comp system and as people have said, this is the tip of the iceberg in terms of violent incidents. You have to have a significant injury to be in worker's comp. The Division would like to see the programs that are preventing those injuries if anyone has anything to offer.

Cindy Conner, LA County Sherriff's Dept., stated there are crime apps available to everyone. She polled home health nurses and asked what training they had received from their agency regarding any red flags that would alert you if there's potentially a hazard in this home. One agency told her there was a group of gang members just across the street, so walk on the other side of the street. Another told her there's a chain link fence and there's a possibility of dogs so

she was instructed to rattle the fence to see if dogs will run up to her. And another was told to call if there is a problem. She hasn't heard of any concrete training that's been provided to equip a nurse with telltale signs to be aware of, which concerns her. **Katherine Hughes** asked Cindy whether radio mics that officers wear to talk to dispatch would work for home health. **Cindy** replied that a lot of nurses don't want to be tracked because they're encouraged to stay in the house a lot longer than they're comfortable and held accountable. She's heard of a Vortex system which is a tracking mechanism used in AZ. In law enforcement, they used to not like being tracked, but they educated their officers that this is a safety issue. She doesn't like the idea of advertising that someone is from home health care with a sticker on the car door because someone may think that it is ripe for picking. She thinks that tracking is great, however it's like the panic buttons in that they're after the fact. She believes that situational awareness so they're developing training to create awareness and avoidance of particular situations so that nobody comes up from behind you and jumps you on the back or you're getting into a room and you're cornered and you have no way of getting out.

Kate Durand, Laguna Honda Hospital, talked about training from the perspective of home health and long term care facility. Training is great and there needs to be a component in the standard about training, but there are pros and cons to emphasizing training as the major control. It's great to have training so people can anticipate violence and to assess the situation. The problem is when you respond to an incident by providing an employee with more training, that indicates it was the staff member's fault, that they didn't know what to do or they did something wrong. That feeds into an underreporting in their facility. On the good side of training, there needs to be a training component but also provide them with the ability to walk away without fear of retaliation. They encourage staff, when they're in a situation where somebody is beginning to become violent, to make sure the patient is in a safe position or safe location and then walk out of the room and tell them you'll come back later.

Christian Bobadilla, College Hospital Cerritos, used to work in home health for 24-hour home care. He was sent to care for a girl with cerebral palsy where there were spousal confrontations and they would get physical aggressive with the child. He wasn't trained on how to react to those types of situations and told the parents his job was to protect the girl no matter what and they calmed down. He wasn't sent back to the house because of that issue but was never given training or told what to do.

Christina Lockyer, CNA for a long-term facility has seen verbal violence, resident to resident violence, family members verbally attacking staff, and a resident following staff around. Management responded that he had that right and staff would go to a break room and the resident would be there harassing a nurse or CNA. They have training but sometimes they don't have the proper staff to go with that training. They're so short staffed in long-term care that these things happen.

Elsa Monroe, stated that she worked as a home health nurse in New Orleans in a high risk, dangerous neighborhood where houses had been abandoned. She had a hospice patient and would have a private security company following her with an identifiable car with a badge and a gun. He waited outside for her and family members knew in advance she was coming. There was a nurse that was killed and that prompted the home health agencies to take care of the nurses. In the projects, the families had to reassure the home health agencies that the nurses would be taken care of and the families did pull through.

Samantha Contreras, ULTCW, stated that chronic understaffing at skilled nursing facilities creates an environment for workplace violence for three reasons:

1. Healthcare staff does not have opportunities to build rapport with the residents due to understaffing and high staff turnover.
2. Low quality of care may lead to nursing home residents to lash out in an attempt to protect themselves in a non-criminal violent manner.
3. For safety purposes, healthcare staff should never have to work alone and unprotected.

The fines for understaffing at facilities are minimal and they'll keep doing it over again because the fines are not a sufficient way to prevent them from not hiring enough staff. They feel that it's necessary to require facilities to provide adequate staffing in order to prevent workplace violence.

Shemiaka Meitzenheimer, home health aide, got a report on a patient that she was supposed to go take care of and the report said that it was in a good neighborhood. The company she worked for didn't let employees wear nursing uniforms and instead instructed them to wear beige pants and a collared shirt in order to be discreet. However the report didn't indicate that another family member was trying to go at it with the family member that lived with the patient because they wanted the patient to live in their home so they could get paid. She was in a situation where she had to lock herself in the bathroom with the patient while they fought. You can get the report but a lot of times it doesn't say about other family members trying to fight for the patient and if you report it to the company, they reply that it's family business and the worker is there for the patient and not to be involved with the family member's business.

Lisa Hall, CAHF, added that long-term care facilities are audited for staffing once a year and are fined for understaffing. There are so many regulations already and long-term care is the most-regulated industry next to nuclear power. She feels that the regulation seems to be heading to only address training but the proper tools for staff are needed as well.

Deborah Gold stated that generally when Cal/OSHA does regulations, we want to look at effective control measures and we've been talking about them. Cindy Conner talked about management commitment and leadership. A lot of people talked about the need for appropriate training and the limits of training, about the solutions that allow the worker to get away from or get help in a violent incident. Whereas in hospitals and some fixed facilities there are things that can be done with facility design, some people have talked about how they don't work out that well because people get separated from sources of help. We want to hear from you about either what you think are effective control measures specific to individual circumstances or what you think has or hasn't worked in terms of what might be included in the standard.

Richard Negri, SEIU 121RN, has found that in every situation he has dealt with in SEIU and in regards to workplace violence and even other hazards. What works best is when their employees have a say in the control with the employer so that employee participation at the site specific environment always brings out the most preventive environment.

Yvonne Choong, California Medical Association, is concerned that some people have mentioned a tracking database on patients. Legally, it's very thorny and you get into what's considered part of the medical record. Who's doing the assessment to determine whether the patient is dangerous? This is the kind of information that follows the patient around so you want to be careful and it shouldn't be so that anyone can go in and flag someone. Their physicians have suggested something like that where there could be an APB on dangerous patients. There are a lot of obstacles to doing that and in addition patients have the right to view their own records as well so if they see these people flagged them as a danger. If you decide to explore this area, you need to talk to some privacy and medical information experts to see what the limits are.

Katherine Hughes stated that her understanding is that if she's a nurse assigned to a patient or resident and is reviewing their medical history or medical records, that's not a HIPAA violation. So if they're tracking it somehow and it's a healthcare worker assigned to care for that patient that's not a privacy violation if what is being said is relevant. When she's charting and she has a combative patient, she puts it in the chart that her patient is combative and she hopes that when she's reporting off to the next shift that, if she fails to verbally tell that person that the patient is combative and this is what they did, they go back and they read that stuff and it helps them be aware of it. She understands what Ms. Choong is saying about databases that Cal/OSHA might have access to. **Deborah Gold** intervened the discussion and stated that Cal/OSHA is not going to establish an inter-facility database on patients and that goes far beyond its authority. What Cal/OSHA has done in the state hospitals or within an institution is to require them to have a method to communicate between shifts and an effective method of charting. Other than that, you don't have to worry that Cal/OSHA is going to establish a state-wide database of patients that may be violent

Yvonne Choong, California Medical Association, agrees that that's not what she was talking about – individual practitioners making notes in charts. You don't want a home health worker saying the patient was combative and they think they may have Alzheimer's. She gave an example of what they want to avoid, such as courts keep a database of people that are chronically filing frivolous lawsuits, or a problem patient list.

Rob Newells, Children's Oakland, stated that administration buy-in is needed. What works for them is the threat management team is made up of social services, nursing, security, human resources, patient advocacy, safety, etc. They get together every month and review all workplace violence incidents and all other threats such as inappropriate behavior between a parent and a child. They review them and make sure that someone is handling them, whether they pass it to human resources or security or to the Sheriff. You have a policy but folks have to know that something is going to happen when they report workplace violence so that piece has to be public.

Richard Negri, SEIU 121RN, stated it would be helpful to have something similar to the Bloodborne Pathogens sharps log, after an incident. It has to very specific for people like him so that he could look at trends and identify where it's taking place, and think about mechanisms of prevention so that the same injury doesn't occur again. If we have something similar in regards to workplace violence, which would be helpful for him to do his job on a day to day basis and we can log what's going on, look at trends and identify things we can do differently.

Rita Lewis, stated that one of the things they are constantly dealing with is that the majority of healthcare is a frenzied response to lawsuits or new legislation and things get rushed. She said at San Quentin their conversion of the majority of what used to be their medical hospital is now a mental facility specifically for the condemned. So many things end up being ignored and everything seems to be reactive instead of proactive.

Kate Durand, Laguna Honda Hospital, stated that an effective control measure that could be required would be some kind of alarm system or duress buttons. That's not necessarily going to work in home healthcare but it would in fixed facilities. They give all of their nursing staff duress badges and there are also duress buttons throughout the nursing units. Their experience at Laguna Honda is that they do use them occasionally and they are effective.

Ruby Sloan, John George Psychiatric Hospital, stated having deputies in their facilities for 3 years was effective and that was probably the only time they had less assaults. The people that are going to be assaultive have no respect for staff but they did have a lot of respect for the deputies.

Cindy Conner, asked Kate Durand what is the plan in place for when the duress buttons are pushed and secondly, she mentioned that they follow up after an event to review what they did well and what they could have done better. When they debrief an incident, they engage in a dialogue so that it has a positive feel to it as opposed to the implication that it was the employee's fault because there are preventable incidents but also unprompted incidents that occur. You have to create environment for the employees to feel comfortable enough to talk about what they could have done better but also to applaud them for the successes. **Kate Durand** replied there are two different things, the badges that each staff member wears that have a button on them. Those buttons send a signal to the nurses' station, where they can see where the badge is being pushed from. That use would be for a CNA who is alone in a resident's room and is feeling uncomfortable or unsafe or is being assaulted and they can hit their button and other staff on that floor will come to their assistance. Then they have buttons that are at the nurses' station and other areas in the unit that send a signal directly to the Sheriff's Dept. Laguna Honda Hospital is unique in that they have the San Francisco Sheriff's Dept. as their onsite security. It takes them a little bit longer to get there than the nursing staff. They also have staff that will just call the Sheriff and also observe that their residents have respect for the deputies. If they have a particular resident who is being problematic, they have a policy that the nursing staff will call the Sheriff's Dept. and ask for a deputy to accompany them into the room to do the patient care, but it is not a long term solution.

Kathy Hughes, SEIU 121RN, mentioned that training is needed when the Plan is implemented, annual renewal training with a designated person who's responsible for the Plan that does the education that's live and interactive so if someone has questions the person responsible for the training is there to answer the questions. Every time there's a new recognized hazard or a new policy in place or when an employee asks for training, so if it's been a long time and an employee hasn't had any SMART training for a while, they can ask their employer to be re-educated. These are the types of things SEIU would like to see for training and they realize it's not the only mechanism for control. Employee involvement is very vital and she dislikes it when they put policies in place and don't ask the frontline workers. Half of the time those policies don't work because they're not realistic and the people that decide them aren't the ones that work there. So the employees have to be part of developing the plan, developing what the controls are, identifying the hazards, identifying some of the things that would work, and annually re-evaluating those plans and control mechanisms, such as marking a car. When there are things that can be fixed, they need to have the power and the ability to make those changes so the employer is responsible for implementing those because it would be an equal team. Obviously if there are costs involved, the employer would have more to say about that than the employee because we have to be realistic and don't want to put the employer out of business. They want employee involvement from the beginning to the end and have the ability to fix the problem. They want to prevent and show employers savings on workers' comp and spending on prevention is the better way to do it. There has to be some post-incident mechanism in place for psychological and physical workplace violence, as well as debriefing.

Rob Newells, UCSF Benioff Children's Hospital, stated that OSHA should require employers to have a person responsible for the workplace violence program. Everyone assumes that security is responsible, but security only has a piece of the picture and there needs to be

somebody to pull all those pieces together from security, human resources, employee health and every place else.

Kimberly Rosenberger, California State Council, SEIU, read a statement from **Richard Pan, MD, MPH, Assemblymember, 9th District and Chair, Assembly Committee on Health**.

> "Ensuring worker safety should be a top priority for this agency. Healthcare workers must be given the support they need to ensure they and their colleagues are safe in the workplace. As we move forward, we need to look at appropriate protections necessary to prevent workplace violence and assure worker safety.
>
> There is recent evidence of an epidemic of violence against healthcare workers. Most incidents are not reported because many workers believe reporting is time consuming with little supervisory support and reporting doesn't make a difference. Unfortunately, there are significant consequences that result from workplace violence in healthcare settings including job dissatisfaction, increased occupational strain, and poor patient outcomes. Violence can come from patients, visitors, co-workers, and supervisors.
>
> It is essential that facilities ensure that both their full-time and temporary staff members have the training and education necessary to provide appropriate levels of patient care as defined under this new regulation.
>
> But education is not enough. This agency must require facilities to create a safe patient care and work environment that is not conducive to and prevents violence. Workplace stressors such as low supervisor support, work overload, poor workgroup relationships, or impending workplace changes, such as downsizing or restructuring, may increase the risk of aggression in the workplace. Non-traditional healthcare settings are particularly vulnerable. Appropriate staffing that assures workers are not placed at high risk such as working alone without immediate assistance from co-workers is important. In addition, accurate data collection of workplace violence incidents is essential to reducing and eliminating workplace violence. This agency should demand a culture of safety against violence in healthcare workplaces.
>
> Your support for effective, meaningful protections for healthcare workers against workplace violence is appreciated."

Ms. Rosenberger relayed Dr. Pan's apologies for not being able to make the meeting and that he will continue to check in on this issue with Cal/OSHA.

Deborah Gold then asked for input on the last topic on the agenda, barriers to implementing an effective program. People have identified some of them, and that Cal/OSHA is not the only regulator, things are going on particularly for licensed facilities, things are going on in terms of communication and HIPAA. California has stronger medical privacy laws than HIPAA. The question is what are the other barriers to implementation of effective workplace violence prevention programs that people can identify. People have raised the issue of working alone as being a big issue.

Kathy Hughes, stated that something Dr. Pan touched on and they didn't was making sure that the standard applies to contracted employees as well as employees of the specific facility. That's addressed in the safe patient handling regulation, that everybody that works there whether they're a full-time employee of that particular employer or whether they're a contracted employee, needs to be covered.

Rob Newells, UCSF Benioff Children's Hospital Oakland, stated their two biggest barriers are training and the training issues are the time that it takes and getting people scheduled. He doesn't schedule employees to do their shifts, but getting them away from patient care to do an 8-hour initial training then 4 hours for the annual updates has been a challenge. Then there's the underreporting piece, one of the biggest reasons is that their staff cares too much about their patients so they take stuff they normally wouldn't take. A staff member was doing a procedure on a patient and the mentally ill mother had her in a headlock and the staff member continued to do the procedure and didn't report it. There was a social worker that didn't report the fact that a patient brought a gun to the visit because they didn't want the patient to get in trouble. The underreporting doesn't happen just because the employee doesn't want to get in trouble; it's also because employees care too much.

Michael Musser, California Teachers Association, one of the barriers he sees in education is beyond the scope of Cal/OSHA. They're a public entity and it's funding for public education. Looking at their nurses, nurses' aides, paraprofessionals working one on one in the classroom with highly dependent students and are being affected on the job daily, it's all about the funding from state government that doesn't allow them to have the proper resources in public education to support these individuals. It's not necessarily the regulations that are out there but there are other issues that are affecting employees in California that are beyond regulations.

Elsa Monroe, San Quentin State Prison, stated some of the solutions have been with public health – the epidemiology report on a monthly basis, adequate staffing, and having reviews after a sentinel event like a debriefing. The idea of a multi-disciplinary meeting would definitely help. With public health, epidemiology goes along way because it identifies the circumstances like how many events, how many stabbings, how many issues have occurred and that would keep everybody in unison with what was going on, on a recurring basis.

Richard Negri, SEIU121RN, stated some of the barriers to implementation are what we've heard, that we don't need it because there are too many regulations and it costs a lot of money. Another is that there are facilities that say they don't need to do anything anyway until you have something so you're caught between a rock and a hard place. The concern about funds is that it doesn't always take into consideration the millions and millions of dollars that are spent on workers' comp, the amount of money that is invested in post-incident versus preventive measures and mechanisms. Another barrier is too much focus on administrative controls and not so much on very simple and inexpensive engineering controls, such as the use of mirrors. He would have felt safer walking from the restrooms down the corridor at LAC-USC. Doors can be set up so they open inside versus outside. There can be site-specific engineering controls that are inexpensive that can be considered for prevention that are less expensive than investing money in workers' comp.

Leslie Morrison, Disability Rights California, used to be a psych nurse and appreciates how hard everyone's jobs are and sees what the risks are. She feels that one of the barriers is stigma and bias against people with mental illness and she gets concerned when she hears talk about labeling people as being violent and how that label follows them. She also was concerned about programs at College Hospital, particularly mental health, that facilities keep those programs engaging and keeping patients busy and active and involved. When designing workplace violence programs involving the very patients who are being served there because while there's violence against the staff, there's violence that's patient on patient. At Napa, for every one violent incident against a staff member, there are four between patients. We have to be careful about labeling people and the stigma that follows them forever.

Deborah Gold thanked Ms. Morrison for coming because the advisory committee wants to be working with patient advocacy groups and creating a safer environment for workers and for patients is the same.

Richard Negri, SEIU121RN, agrees and stated that every healthcare worker he's known were patient advocates and activists first and foremost. He echoed Mr. Newells' comment that healthcare workers care so much about their patients that they're not reporting about their own health and safety. They wouldn't be in this business if they weren't patient advocates and activists first and foremost. It's come to the point that it's so pandemic and there have to be mechanisms of prevention between the violence and healthcare workers doing their jobs so they can keep these patients and the quality of care going and ongoing.

Kathy Hughes stated it's not a patient problem, it's a systems problem. If the system was safer, if the facilities were safer, the patients would be safer and there wouldn't be the opportunities for them to do the things that are beyond their control.

Ruby Sloan, John George Psychiatric Hospital, stated that a barrier is the culture of fear and intimidation. People that speak out are targeted and not supported a lot of times by other members so they stay silent

Pam Dannenberg, California Association of Occupational Health Nurses, agrees that people are intimidated and that folks that are in home care facilities, senior housing, etc. are from a culture that doesn't want to speak out. She encourages debriefing and agrees with Cindy Conner about being positive during the debriefing, and not only talk about the serious incidents but also about things that almost happened where no one was hurt. She's found that when talking to workers about the incidents and putting into place their suggestions , they start to trust you more and start to share more. Then you can come up with even more solutions than you thought possible. Usually at every institution there is some mechanism or concerned department that has a near miss incident form or non-reportable form, so tracking those and getting to the bottom of those things will prevent more from happening.

Elsa Monroe, San Quentin State Prison, reiterated that we haven't touched much on bullying in the workplace but that is one issue that we really need to put out there. Bullying also creates a sense of vertical violence, causes a lot of unnecessary anxiety, rapid turnover of medical staff. It also provides a culture of intimidation and fear. Also, they have a mental health track system and it's only for health providers, that they are allowed to see the pattern of behavior that the inmate has been logging throughout his history of being incarcerated – how many times he's assaulted staff, he's had seizures, how many pharmaceuticals he's been prescribed. This helps healthcare workers determine how he can be transferred safely from one institution to another. She believes that's what's missing in the other sector.

Richard Negri, SEIU121RN, stated when people talk about fear of retaliation and intimidation, he wants to point out that this is so real and that there's an individual that was just in the room had to leave because he was fired last week for being involved with this campaign. The gentleman who works at College Hospital was fired because after 4 years, they tallied up that he was late too many times. This is real and they are regrouping tomorrow to talk about how to get his job back, to prove the retaliation. These are not just words, these are people's lives and their livelihood. It goes hand in hand to say if they don't get this gentleman's job back, the healthcare industry is losing a lot of experienced workers so the quality of care is decreasing year over year. Workers are calling him that don't want to go back to work and are afraid to

work. People don't want to continue in this line of work and want to go back to school to get another career altogether.

Ingela Dahlgren, SEIU Nurse Alliance of California, stated this has been an amazing meeting and has brought attention to all the work in front of us. She mentioned another barrier is the pizza and ice cream parties that you get if there are no incidents of violence reported from your unit, such as the ER which wouldn't exist because the ER has incidents every day. It's a tool by management to intimidate or bribe workers with an ice cream. Those programs have to be declared illegal because that is ridiculous.

Deborah Gold stated that Federal OSHA has taken on some of those disincentive programs and anything that discourages people from reporting injuries, illnesses or hazards is not permitted under our regulations. She reminded that there's a meeting on the 19th focusing on the role of facility security and law enforcement, and how that plays into or not plays into preventing workplace violence. We're taking input from these meetings as well as what is sent to us with other ideas or things you want to talk about, and we plan on having a meeting in January where we'll have some draft language to discuss as well as a follow-up meeting in February or March. SB 1299 set a deadline for the Standards Board to adopt a regulation which is July 1, 2016 which puts us on a fast track on meetings because, as Ruby and others have said, this is a problem that's gone on for too long and we need to address it effectively. Hopefully, it will be noticed sometime in July 2015 so we have a chance of actually meeting the timeframe established by the legislature. Deborah thanked the attendees for their valuable input, asked them to keep the Division informed and adjourned the meeting.

ATTEN. NCE ROSTER

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MEETING NAME: Workplace Violence Prevention in Non-Hospital Health Care DATE: November 13, 2014

CHAIRPERSONS: Deborah Gold, Bob Nakamura LOCATION: Elihu Harris State Bldg 1515 Clay Street Oakland, Room 1

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

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ATTEN[illegible]NCE ROSTER

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ATTEN ANCE ROSTER

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ATTE ANCE ROSTER Pg 7

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CHAIRPERSONS: Deborah Gold, Bob Nakamura LOCATION: Elihu Harris State Bldg 1515 Clay Street Oakland, Room 1

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ATTENDANCE ROSTER

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ATTEN NCE ROSTER

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ATTEN. NCE ROSTER (Pg 11)

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ATTENDANCE ROSTER

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