Healthcare Workplace Violence Prevention Regulations: An Overview with a Focus on Hospital Reporting

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California Hospital Association
Overview

Background

- **June 2014** — OSHA Standards Board grants petitions filed by labor and asks Cal/OSHA to convene advisory committee

- **September 2014** — Senate Bill 1299 was passed/signed requiring Cal/OSHA to adopt workplace violence prevention (WPVP) regulations for hospitals

- **October 2016** — OSHA Standards Board adopts proposed regulation
Overview (cont.)

Compliance Timeline

• April 1, 2017 — All covered employers must have violent incident logs, recordkeeping in place

• July 1, 2017 — Hospitals must begin reporting

• April 1, 2018 — All covered employers must be compliant with remaining requirements
Overview (cont.)

Scope

• Health facilities, including hospitals, long-term care, intermediate care, congregate care, correctional treatment center, psychiatric hospital
  • Including any service that falls under the hospital’s license

• Home health care and home-based hospice

• Emergency medical services and medical transport, including when provided by firefighters and other emergency responders
Overview (cont.)

Scope (cont.)

• Drug treatment programs

• Outpatient medical services to the incarcerated in correctional and detention settings

• NOTE: DDS facilities must comply as long as they are not designated to close by 2021. CDCR facilities are exempt.
Definition

Any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes:

• The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma or stress, regardless of whether the employee sustains an injury

• An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury
• Covers all general acute care hospitals, acute psychiatric hospitals and special hospitals
  • Covers all hospital operations and any off-site locations on the hospital license
  • Seeking clarification as to sites with only administrative offices

• Based on OSHPD hospital facilities list, NOT CDPH license number
Online Reporting Portal

- Contains link to reporting tool
- Contains reporting FAQs
- Contains training modules

www.dir.ca.gov/dosh/workplace-violence-reporting-for-hospitals.html
Hospital Reporting – Update (cont.)
Each hospital must have:

- One designated person at the hospital/system to authorize users
  - For health systems, this can be the same or a different person for each hospital
- A generic email address for receipt of information from Cal/OSHA on WPVP
  - This must be constantly monitored as it is the primary method of communication by Cal/OSHA
- Hospital/health facility may designate as many authorized users as desired
Online Reporting

- Must submit initial report within required time frame based on information available at that time — no obligation to update
  - Online reporting does not require narrative; all responses are prompted

- Cal/OSHA use of the data
  - Post the total number of incidents reported and names of hospitals that reported
  - Post summary statistics on an aggregated basis
Preparatory Activity — February

- Cal/OSHA sent hospitals pre-registration letters addressed to administrator/CEO
  - These were customized so if you have not received yours you need to contact Cal/OSHA immediately
- Cal/OSHA to launch the WPV web page
Preparatory Activity – March through June

- Hospital pre-registration info should be submitted by hospitals to Cal/OSHA IT
- Reporting tutorial modules should be available on the Cal/OSHA website
- Hospitals should register users who will be authorized to submit reports

July 1, 2017 – Hospitals begin reporting
Additional Updates

• Training
  • CHA and Cal/OSHA are still working through the training obligation with respect to individuals who are performing work at the hospital but are not employed by the hospital (either primary or joint employer); includes physicians
  • Plan is to develop FAQs to address these issues
  • Where concerns arise, please bring them to CHA’s attention
  • In January, Cal/OSHA held an advisory committee on general industry WPVP regulations; CHA is monitoring
Workplace Violence Prevention Requirements — Ways to Implement, Operationalize and Comply

Sandra Williams
EOC Manager/Safety Officer
Alameda Health System
Today’s Focus

- Shared Common Goal
- Workplace Violence Components
- Organizational Commitment
- Implementation & Compliance Considerations
- Incident Algorithm
- Questions & Answers
The inception of this process has been a collaborative effort between CHA, Cal/OSHA, labor unions and health care representatives.

CHA has advocated on behalf of hospitals:

- Represented hospitals’ interests on proposed law
- Met with Labor to reach an understanding and consensus
- Petitioned at hearings for hospitals’ perspectives
- Advocated for best practices to allow hospitals to implement operational language
Shared Common Goal
SAFETY RESPONSIBILITY

Staff  Patients  Visitors
All health care organizations share the same common goal for workplace safety. We want staff to be:

- Safe while performing their duties
- Protected in their work environment
- Free from the potential of harm and violence
- Secure in healthy workplaces
- Prepared to respond to safety events
Workplace Violence Components
Types of Workplace Violence

Four categories are referenced for workplace violence:

- Type 1 — Criminal Intent
- Type 2 — Customer/Client/Patient
- Type 3 — Worker-on-Worker
- Type 4 — Personal Relationship
Staff Protection

- Hospitals must protect staff from patients, or those accompanying patients, from using physical force, a weapon or serious threats.
- Hospitals must develop WPVP plans and prepare to train staff on how to assess patients for the potential of violence.
WPV — Direct Impact and Potential Harm

- Employee
- Other Staff Responding or Watching
- Person with Patient
- Patient
Organizational Commitment
Executive leadership must ensure a WPVP program exists and is enforced. Key considerations for success may entail:

- Supporting the hospital(s) WPVP committee’s recommendations
- Adopting measures to protect staff from exposure to potential harm/violence
- Allocating resources to enhance workforce safety

Benefit

- Increased staff retention and satisfaction
- Demonstrated commitment and investment in staff safety
Considerations For WPVP Program Leadership

Actions to consider when identifying a leader:

- Assign internal staff member or hire person from outside with appropriate background to manage plan/program
  - Person should have a broad understanding of workforce safety and hospital operations
  - Knowledge of applicable WPVP regulations
  - Provide resources for staff to successfully perform duties and responsibilities
Implementation & Compliance Considerations
WPVP Building Blocks

- Workplace Violence Prevention Plan
- Regulations & Registration
- Illness and Injury Plan
- Point Person
- Multi-disciplinary Committee
- Standardized Operating Procedures
- Electronic Reporting Systems
Establish a timeline to develop and meet the regulation requirements.

<table>
<thead>
<tr>
<th>Preliminary Activities</th>
<th>Phase I</th>
<th>Phase II</th>
<th>Phase III</th>
<th>Phase IV</th>
<th>Phase V</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete registration</td>
<td>1. Research plan and policies</td>
<td>1. Decide whether to revise IIP</td>
<td>1. Design training curriculum for initial and refresher</td>
<td>1. Launch training</td>
<td>1. Launch and implement comprehensive WPVP program</td>
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<tr>
<td>2. Determine reporting process</td>
<td>2. Examine policies</td>
<td>2. Draft language for WPVP Plan</td>
<td>A. Staff with direct contact</td>
<td>2. Curriculum</td>
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<tr>
<td>3. Develop internal log(s)</td>
<td>3. Identify risk assessment tools</td>
<td>3. Assemble workgroup and establish agenda</td>
<td>B. Respond to alarms</td>
<td>A. Staff with direct contact</td>
<td></td>
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<tr>
<td>5. Identify needs</td>
<td>A. Gen. Acute</td>
<td>5. Design/Test internal electronic reporting processes</td>
<td>D. Off-site vendors</td>
<td>C. Vendors</td>
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<td>6. Determine budget impact</td>
<td>B. Sub-Acute/ SNF</td>
<td></td>
<td>E. Special Training</td>
<td>D. Special training</td>
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</tbody>
</table>
WPVP Committee Preparation

Assemble members and convene a WPVP committee to begin addressing regulatory requirements:

• Review internal documents that support the plan
• Discuss how to integrate, streamline and convert language into a plan/policy that is applicable to the environment
• Analyze reports and risk data to identify departments or areas where past injuries occurred
WPVP Multidisciplinary Committee — Potential Key Stakeholders

- Staff from high-risk areas/departments
- Human Resources
- Workers’ Compensation
- Employee Relations
- Safety Officer
- Licensing and Accreditation
- Behavior Care/Social Worker
- Staff Developer
- Contracting
- Vendor Management
- Labor Unions
- Training and Education

- Security
- Risk Management
- Nursing Leaders
- Behavior Care
- Home Health
- Pharmacy
- Business Office/Registration
- Social Services
- Pharmacy
- Imaging
- Laboratory
- Patient Affairs/Client Services
Review Plans/Policies

Identify existing plans and policies that will support the WPVP:

- Plans/Policies must be identified
- Use existing or create new tools
- Identify any communications or reporting gaps
- Compare regulatory language to existing plans or policies
- Send policies through committee approval process
Examples

Below are examples of familiar plans and policies that may exist. Compare and use documents to foster further development of the Workplace Violence Plan:

- Illness and Injury Plan
- Workplace Violence Prevention
- Zero Tolerance for Violence
- Assaultive Behavior
- Disruptive Behavior
- Security Management
- Employee Assistance
Assessment Tools

Use pre-existing tools designed to assist staff in assessing potentially aggressive or violent patient behavior that may lead to an assault. Consider these tools:

- Emergency Department Assessment
- Maternal Child Health Assessment
- Pediatric Assessment
- Behavior Care Assessment
- Sub-Acute/Skilled-Nursing Facility Assessment
- Home Health Assessment
- Emergency Medical Services Assessment
The BVC assesses the presence of six observable patient behaviors that help staff determine whether the patient is:

- Confused
- Irritable
- Boisterous
- Verbally threatening
- Physically threatening
- Attacking objects
Interpretation and Operationalisation

Interpretation of scoring:
- Score = 0  The risk of violence is small
- Score = 1-2  The risk of violence is moderate. Preventive measures should be taken.
- Score > 2  The risk of violence is very high. Preventive measures should be taken. In addition, a plan should be developed to manage the potential violence.

Operationalisation of behaviours/items:

<table>
<thead>
<tr>
<th>Confused</th>
<th>Appears obviously confused and disorientated. May be unaware of time, place or person.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irritable</td>
<td>Easily annoyed or angered. Unable to tolerate the presence of others.</td>
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<tr>
<td>Boisterous</td>
<td>Behaviour is overtly &quot;loud&quot; or noisy. For example slams doors, shouts out when talking etc.</td>
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<tr>
<td>Physically threatening</td>
<td>Where there is a definite intent to physically threaten another person. For example the taking of an aggressive stance; the grabbing of another person's clothing; the raising of an arm, leg, making of a fist or modelling of a head-but directed at another.</td>
</tr>
<tr>
<td>Verbally threatening</td>
<td>A verbal outburst which is more than just a raised voice; and where there is a definite intent to intimidate or threaten another person. For example verbal attacks, abuse, name-calling, verbally neutral comments uttered in a snarling aggressive manner.</td>
</tr>
<tr>
<td>Attacking objects</td>
<td>An attack directed at an object and not an individual. For example the indiscriminate throwing of an object; banging or smashing windows; kicking, banging or head-butting an object; or the smashing of furniture.</td>
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</table>

NB: For the behaviours/items physically threatening, verbally threatening and attacking objects the operationalisation was adapted from the Behavioural Status Index (Reed, Woods & Robinson, 2000) by one of the authors (Woods).
Screening Considerations

Examine the screening indicators staff will use to determine risk factors for violence:

- Risk for violence
- Substance abuse history
- Trauma history
- Treatment history
Persons Accompanying Patient

Assess polices and practices that restrict those who refuse to adhere to the hospital’s “Zero Tolerance for Violence” policy. The persons may be:

- Abusive
- Aggressive
- Violent
- Under the influence of drugs and alcohol

Consider developing a clear understanding with patients and those accompanying the patient about acceptable behavior.
Useful Data

Analyze existing data reported at the hospital to establish a baseline for the number, frequency and location of potential and real incidents:

- Code Gray or Silver activity reports
- Security reports/daily summaries
- CrimeCast/CAP report
- Employee injury logs
- Occurrence reports
Annual Assessments

Annual Plan Assessment
- Review plan and make changes where necessary

Analyze effectiveness by:
- Addressing corrective actions
- Reporting WPV incidents
- Contacting law enforcement
- Identifying harm risks
- Providing counseling
- Post-incident debriefing
- Staff training

Environmental Assessment:
- Parking lot
- High-risk areas
- Remote locations
- Escape routes
- Exterior lighting
- Employee entryways
- Harmful objects
- Valuables
Plan Assessments and Hazards

Everyone has a role in providing information for the assessment

<table>
<thead>
<tr>
<th>Assessment Criteria</th>
<th>Staff</th>
<th>Managers</th>
<th>Risk Mgt</th>
<th>Security</th>
<th>Grounds/Gardener</th>
<th>Engineering/BMD</th>
<th>Medical Staff</th>
<th>Executives</th>
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<tr>
<td>Annual Review</td>
<td>X</td>
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<td>Parking Lot</td>
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<td>High-Risk Areas</td>
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<td>Remote Locations</td>
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<td>Escape Routes</td>
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<td>Exterior Lighting</td>
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<td>Employee Entryways</td>
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Parking lot safety considerations:

- Sufficient lighting
- Security devices
- Designated staff parking
- Trimmed shrubbery
- Active security patrols
- Intact gates/arms/fences
- Access control
- Signage on all floors
- Stairwell identification
Consider shuttle bus safety:

• Safe pick-up locations
• Scheduled pick-ups
• Drivers have communication devices for emergencies

Instructions for staff parking at patients’ homes:

• Park on street near patient’s home
• Avoid underground garages
High-Risk Areas

Assess high-risk areas to address staff safety concerns:

- Emergency departments
- Behavior Care Services
- Large waiting room areas
- Screening areas
- Patient bathrooms
- Examination/Patient rooms
- Consultation/Interview rooms
- Patient homes
- Business office/cashier
- Cafeteria
- Solitary rooms
- External environment
Remote Locations

Assess remote locations to increase safety:

- Low-traffic hallways
- Courtyards
- Stairwells
- Isolated treatment areas
- Recreation areas
- Elevator lobbies
- Offices
- Workspace trailers
- Kitchens
- Basements
Escape Routes

Assess work areas to ensure escape routes exist:

- Ease of egress from offices/exam rooms
- Positioning furniture to prevent obstructed exits
- Confirm line of sight
- Exit paths when working in rooms/multi-bed bays
Exterior Lighting

Assess exterior lighting to ensure areas are well lit:

- Light poles
- Wallpacks
- Soffit lights
- Photo cell lights
- Ground lights
- Flood lights
- Overhead lights
- Walkway lights
- Signage lights
Employee Entryways

Assess employee entryways for:

- Access control
- Presence of mirrors
- Hallway lighting
- Security check points
- Security cameras
- Clear line of sight
Alarms

- Assess whether additional alarms are needed
  - Fixed alarms
  - Personal alarms
- Confirm staff’s knowledge about location of alarms
- Create maps and location of panic buttons
- Periodically test alarms
Harmful Objects

Assess treatment rooms and workspaces to eliminate harmful objects:

- Lamps
- Syringes
- Bed tables
- Chairs
- Clipboards
- Linen hampers
- Receptacles
- Wearable items (e.g., stethoscopes/lanyards)
Assessment of where and how valuable items are stored and managed:

- Electronics
- Medical equipment
- Cash
- Pharmaceuticals
- Wheelchairs
- Medical supplies
- Gift shop
- Shipping and receiving
- Mail room
• All employees must be trained. Assign the appropriate level of training according to the employees’ roles and responsibilities based on:
  • Patient contact
  • Response to alarms
  • Working in emergency department

• Training can be conducted through electronic means only if it is effective. Facilities must assign someone who knows the program and can answer questions within one business day after the training
  • Training must include contract security and law enforcement
  • Other service contractors should receive information
Training Curricula

Initial training requirements:

- Identified workplace violence hazards in facility
- Workplace Violence Prevention Plan
- Recognition of potential violence
- Avoiding potential harm and factors of escalation
- Strategies to avoid physical harm
- Recognizing alerts, alarms or other warnings

- Role of private security
- Reporting of private security
- Reporting violent incidents to law enforcement
- Resources available for coping with incidents of violence
- Opportunity for interactive questions
Staff who will require special training include assignments that cover:

- Responding to alarms
- Notifications of violent incidents
- Controlling persons with aggressive or violent behavior

Training will include:

- Aggression
- Violence-predicting factors
- Assault cycle
- Maneuvers to defuse and prevent violence
- Restraining techniques

Special Training Example

- Risk assessment/factors
- Situational awareness
- Ensure environmental safety
- Managing aggression
- Alert security/safety teams
- Use appropriate de-escalation measures

Take Down — Example of coordinate maneuvers
https://www.youtube.com/watch?v=ZtV2o-ALk7U&feature=youtu.be

“The vast majority of people with mental illness are not violent, not criminal and not dangerous.”
Incident Algorithm
If a WPV incident occurs at your facility, three priority tasks should be immediately executed:

- Investigate the incident and obtain as many details as possible
- Record what happened and the types of injuries
- Report injuries at your facility
- Must include vendor-related injuries
Response Policy

• Staff members should use alerting systems to summons response teams when de-escalation measures are ineffective

• Specially trained staff members respond to the incident using strategies to defuse or maneuvers to restrain when appropriate

• Staff has the right to contact law enforcement when an assault occurs

• Refer to protocol for care and treatment of staff
Response Policy (cont.)

• Notify leader/ WPVP team members
  • Investigation is conducted, reports are generated and recording of the incident is documented

• Provide information and access to Employee Assistance Program (EAP) counseling services

• Incident debriefing is scheduled

• Conduct plan assessment for effectiveness
Questions & Answers
California Code of Regulations, Title 8, Section 3342, Violence Prevention in Healthcare. (December 8, 2016)

California Hospital Association, Healthcare Workplace Violence Prevention: How to comply with the Cal/OSHA Regulations. (2017)


Occupational Safety & Health Administration (December 2015) “Caring for our Caregivers.” Retrieved, February 26, 2017  

https://www.cdc.gov/ViolencePrevention/overview/publichealthapproach.html


https://www.youtube.com/watch?v=ZtV2o-ALk7U&feature=youtu.be


https://www.slideshare.net/tutimd/managing-aggression-part-1

http://www.health.harvard.edu/newsletter_article/mental-illness-and-violence

Thank You

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