New Cal/OSHA Workplace Violence Prevention Regulation Webinar

January 10, 2017
CHA Webinar

Welcome
Liz Mekjavich
California Hospital Association
Continuing Education

Continuing education will be offered for this program for compliance, healthcare executives, legal, nursing and risk managers.

Full attendance, completion of online survey, and attestation of attendance is required to receive CEs for this webinar. CEs are complimentary and available for registrant. Post-event survey will be sent this afternoon. Please fill out the survey — we value your input on our programs.

Faculty

Juliann Sum, JD, ScM was appointed chief of the California Division of Occupational Safety and Health (Cal/OSHA) in 2014. Ms. Sum has more than 30 years' experience working to improve occupational safety and health throughout the state, most recently serving as acting chief of Cal/OSHA from 2013 – 2014. In addition to serving as special advisor to the director of the California Department of Industrial Relations, she was project director with the Institute for Research on Labor and Employment at UC Berkeley, and attorney and industrial hygienist with the Labor Occupational Health Program.
Patrick Corcoran MPH, CIH is a senior safety engineer with Cal/OSHA's Consultation Service. Mr. Corcoran has 16 years' experience with Cal/OSHA, including 5 years as Cal/OSHA's Training Coordinator. As Training Coordinator he was responsible for the training and professional development of Cal/OSHA's compliance officers and consultants. In that capacity he taught in Cal/OSHA's internal courses on the Bloodborne Pathogens, Aerosol Transmissible Disease, and Laboratory Safety standards. In addition, Mr. Corcoran spent more than a decade in Cal/OSHA Enforcement conducting investigations of accidents, complaints, and programmed visits.

Caryn Thornburg, LVN, BAIS, MS is the safety, emergency management and security officer for Stanford Health Care — ValleyCare. She a member of California Hospital Association's advisory board which worked with Cal/OSHA to develop standards on workplace violence prevention in health care and also an instructor for CHA's Active Shooter, IAP and HICS trainings.
Gail Blanchard-Saiger, JD, is vice president of labor and employment for the California Hospital Association. Ms. Blanchard-Saiger provides leadership for state legislative and regulatory issues related to hospital human resources and labor relations.
Background

- 2011 – AB 30 (failed)
- 2013 – SB 718 (failed)
- 2014
  - SB 1299 – Healthcare Workplace Violence Prevention Bill is signed requiring Cal/OSHA to develop regulations for acute care hospitals by July 1, 2015
  - Two labor unions filed petitions with Cal/OSHA to convene an advisory committee on this subject

Background

- CHA convened a multi-disciplinary workgroup to provide input
- Cal/OSHA began Advisory Committee Process in 2014
  - Five meetings with stakeholders to identify issues and begin to vet language
  - Cal/OSHA distributed three discussion drafts of potential regulations
Background

- Formal regulatory process was initiated on October 30, 2015
  - Initial 45-day comment period
  - Three revisions subject to 15-day comment period were released
- Final regulations were adopted by the Cal/OSHA Standards Board on October 20, 2016
- Three stakeholder meetings on the hospital reporting obligation have been held

Background

- CHA and the WPVP Workgroup evaluated all proposed regulations, providing written and verbal comment
  - In addition, multiple conversations were held with Cal/OSHA staff
- www.calhospital.org/workplace-violence-prevention
Workplace Violence Prevention in Health Care: A New Regulation

Juliann Sum, JD, ScM, Chief of Cal/OSHA
Patrick Corcoran, MPH, CIH, Cal/OSHA Senior Safety Engineer

California Hospital Association Webinar
Sacramento, California
January 10, 2017

How Did We Get Here?

• Hospital security requirements, AB 508 (1994)
• Cal/OSHA enforcement under:
  • Injury and Illness Prevention Program, 8 CCR § 3203
  • Employee Alarm Systems, 8 CCR § 6184
• Cal/OSHA special orders requiring particular corrective actions (8 CCR § 6305)
• Petitions in 2014 for a standard to prevent WPV in health care
• SB 1299 requiring a standard to prevent WPV in hospitals
Case Study: WPV Incident, pre-8 CCR § 3342

Incident description

Accident: 201504603 - Physician Killed By Patient

Cal/OSHA Findings

https://www.osha.gov/pls/imis/establishment.inspection_detail?id=120343009

Rulemaking Timeline

- **June 19, 2014**: OSHSB grants petitions and asks Cal/OSHA to convene advisory committee
- **Fall 2014**: Senate Bill (SB) 1299, Workplace violence prevention plans for hospitals, is passed and signed – requiring a regulation be developed
- **October 20, 2016**: OSHSB adopts the proposed regulation
- **April 1, 2017**: Effective date of 8 CCR § 3342
  - NOTE: Violent incident logs, recordkeeping and hospital reporting must be in place by **April 1, 2017**; remainder in place by **April 1, 2018**
Subsections of the Regulation

8 CCR § 3342:
• (a) Scope and application
• (b) Definitions
• (c) Workplace violence prevention plan
• (d) Violent injury log
• (e) Review of the workplace violence prevention plan
• (f) Training
• (g) Reporting requirements for hospitals
• (h) Recordkeeping

Scope and Application

• Health facilities including hospitals, intermediate care, congregate care, correctional treatment centers, psychiatric hospitals
  - Including any service that falls under the hospital’s license
• Home health care and home-based hospice
• Emergency medical services and medical transport, including those services when provided by firefighters and other emergency responders
• Drug treatment programs
• Outpatient medical services to the incarcerated in correctional and detention settings
• EXCEPTIONS: DDS facilities scheduled to close by 2021 are exempt. CDCR facilities are exempt
Definition of Workplace Violence

• “Workplace violence” means 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 following:
  - 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;

Definition of Workplace Violence

Four workplace violence types:

• “Type 1 violence” means workplace violence committed by a person who has no legitimate business in the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
• “Type 2 violence” means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.
• “Type 3 violence” means workplace violence against an employee by a present or former employee, supervisor, or manager.
• “Type 4 violence” means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.
Workplace Violence Prevention Plan

Employer must establish procedures:

• To obtain the active involvement of employees and their representatives:
  - In developing, implementing, and reviewing the Plan
  - In identifying, evaluating, and correcting WPV hazards
  - In designing and implementing training
  - In reporting and investigating WPV incidents
• To coordinate with other employers whose employees work in the same facility, service, or operation

Employer must establish procedures:

• To obtain assistance from law enforcement
  - Employer may not discipline employee for seeking help from local law enforcement
• To accept and respond to reports of WPV
• To communicate with employees regarding WPV matters
• To identify and evaluate risk factors
  - Environmental risk factors, including in outdoor areas
  - Patient-specific risk factors
  - Visitors and others who demonstrate a risk of committing WPV
Workplace Violence Prevention Plan

**Employer must establish procedures:**

- To correct WPV hazards using applicable, feasible methods. Examples:
  - Ensuring sufficient numbers of staff to prevent and immediately respond to WPV incidents
  - Eliminating line-of-sight barriers
  - Removing, fastening, or controlling objects that may be used as weapons
  - Preventing transport of unauthorized firearms and other weapons

Workplace Violence Prevention Plan

**Employer must establish procedures:**

- Post-incident response and investigation
  - Provide immediate medical care and first aid
  - Make individual trauma counseling available
  - Conduct debriefing
  - Seek input on what could have prevented the incident
Violent Incident Log

**Employer must record WPV incidents:**

- Solicit information from the employees
- Omit personal identifying information
- Include particular data regarding:
  - Perpetrator
  - Circumstances
  - Location
  - Type of incident
  - Consequences of the incident
- Review the log during the annual review of the workplace violence prevention plan (Plan)

Review of the WPV Prevention Plan

**Employer must establish and implement a system to review the Plan’s effectiveness:**

- At least annually – for the overall facility or operation
- Additional reviews – for the entire facility or a particular unit or operation:
  - To reflect new or modified tasks
  - To include newly recognized WPV hazards
  - To review and evaluate WPV incidents involving serious injury or death
  - To respond to information indicating a deficiency
Training

Basic requirements:

• Provide effective training
• Cover the required content, addressing the WPV risks that the employees are reasonably anticipated to encounter in their jobs
• Give the training at the required times
• Ensure that the employees actually receive the training

Training

Of interest to hospital employers:

• A hospital employer must ensure that all employees working at the hospital receive the required training
  - In dual-employer situations, the hospital is the host or site employer of the employee
  - In multi-employer situations, the hospital has contracted with another employer to perform work at the hospital
• Training may be provided by the hospital, the employee’s primary or direct employer, or a contracted third party
• Training may be provided online or in written format, as long as the training is effective
Training

**Initial training**

- For all employees when the Plan is first established or when the employee is newly hired or newly assigned:
  - Overview of the Plan
  - How to recognize the potential for violence
  - Strategies to avoid harm
  - Hospital alarm systems and how to use escape routes
  - Role of private security personnel, if any
  - How to report violent incidents
  - Resources

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Training

**Refresher training**

- For employees performing patient contact activities and their supervisors
- At least annually
- To review topics included in the initial training and the results of reviews of the Plan
- Additional focus on information applicable to those employees
Training

Opportunity for interactive Q&A
• Required for initial training and refresher training
• The person answering employees’ questions must be knowledgeable about the employer’s Plan
• Computer-based learning is permitted so long as questions can be answered within one business day

Training

Specified training
• For employees assigned to respond to violent incidents or confront or control persons showing violent behavior:
  - General and personal safety measures
  - Aggression and violence predicting factors
  - The assault cycle
  - Characteristics of aggressive and violent patients and victims
  - Verbal intervention and de-escalation techniques and physical maneuvers to defuse and prevent violent behavior
  - Strategies to prevent physical harm
  - Appropriate use of restraining techniques
  - Appropriate use of medications as restraints
• Opportunity to practice maneuvers and techniques with other team members; debrief of the practice session to correct issues
Reporting Requirements for Hospitals

• Required by SB 1299
• Covers general acute care hospitals and acute psychiatric hospitals
• Must report to Cal/OSHA any violent incident that involves
  − The use of physical force against an employee by a patient, or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury; or
  − An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains and injury

Reporting Requirements for Hospitals

• **Report within 24 hours:**
  − A fatality or an injury that requires inpatient hospitalization for a period in excess of 24 hours for other than medical observation or in which an employee suffers a loss of any member of the body or suffers any serious degree of permanent disfigurement
  − An incident involving the use of a firearm or other dangerous weapon
  − An urgent or emergent threat to the welfare, health, or safety of hospital personnel such that they are exposed to a realistic possibility of death or serious physical harm
Reporting Requirements for Hospitals

- **Report within 72 hours:**
  - All other incidents involving the use of physical force against an employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress
  - Regardless of whether the employee sustains an injury
  - For this requirement, injury is defined as meeting the criterion in the Log 300 recordkeeping requirements, generally as requiring medical treatment beyond first aid

- Online reporting tool is being developed, along with FAQs and online tutorials
- SB 1299 requires Cal/OSHA to post a report online regarding violent incidents at hospitals
  - Including recommendations on the prevention of violent incidents at hospitals
- Cal/OSHA will not display data by individual hospital name
Recordkeeping

- Records of WPV hazard identification, evaluation, and correction – one year
- Training records – one year
- Records of violent incidents – five years
  - Do not include “medical information”
- Make available to Cal/OSHA, employees, and employee representatives on request

Resources

- 8 CCR § 3342: Workplace Violence Prevention in Health Care
- OSHA Publication 3148: Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, 2004
- OSHSB Workplace Violence Prevention in Health Care page
  - Final statement of reasons
  - Documents relied upon
Hospital Reporting Update

Gail Blanchard-Saiger
California Hospital Association

Hospital Reporting - Update

- Covers all hospital operations and any off-site locations on the hospital license
- Based on OSHPD hospital facilities list
- Online portal on Cal/OSHA website
- System will be accepting reports as of April 1, 2017
- Each hospital must have:
  - One designated person at the hospital/system to authorize users
  - A generic email address for receipt of information from Cal/OSHA on WPVP
Online report:
- Must submit initial report within required timeframe based on information available at that time - no obligation to update
- Online reporting does not require narrative; all responses are prompted
- FAQs and other resources will be available on the portal
- Cal/OSHA use of the data
  - Post the total number of incidents reported and the names of hospitals that reported
  - Post summary statistics on an aggregated basis

Preparatory Activity – Tentative Schedule:
- February
  - Send hospitals pre-registration letters addressed to administrator/CEO
  - WPV webpage go live
  - Tutorial modules 1 – 3 available
- March
  - Hospital pre-registration info submitted to Cal/OSHA IT
  - Tutorial modules 4 – 6 available
  - Hospitals may start registering users – March 8
Where we are today, is due to the efforts of a multi-disciplinary team and support from senior leadership who are committed to ensuring our environment is safe for our staff, patients, and visitors!
WPV – Snapshot in Time, One Year Ago

• Code Grays on the floors had been increasing, sometimes occur more on the floor(s) than in the ED in a given month
  – Incidents on floors are a result of having to hold patients awaiting placement for mental/bx. health
• Formal identification/evaluation process for patients needed to be developed
• Hand-off communication (SBAR) – ED-to-floors relied on verbal report
  – Different electronic charting systems ED/in-patient
• Ancillary staff going into patient rooms and not knowing the history of the patient and potential for violence
  – AM lab draws – 5 AM, flip on lights, awaken patient, and do the necessary draw
  – Transporters being in areas by themselves with patients who had the potential to be violent – elevators/Xray
  – Dietary delivering trays (consider paper plates and plastic silverware, if appropriate)
  – EVS cleaning rooms
  – Volunteers delivering papers, books, puzzles, etc.
    • Volunteers no-longer provide items to “Orange Dot” patients

WPV – Snapshot in Time, One Year Ago (cont.)

• Situational awareness of staff – work at a hospital, not a psych facility or the jail
• Paradigm shift and cultural mindset change with staff – it’s not part of the job!
• Maternal child visitors/family and CPS involvement – need a different screening tool
• Large forensic population we serve – escape/flight risk, armed law enforcement (LE) in patient care areas
  – Alameda County Jail is the 3rd largest in CA and 5th largest in the country
  – Federal Bureau of Prisons – low security and a minimum security prison for approximately 1200 women
• Restraints – how to “take down” a patient safely and as a team
Three Focus Areas

• **Communication**
  – During our gap analysis we identified areas where staff were unaware that patient may have a potential for violence and we needed a way for anyone entering the room to be aware of the potential for violence

• **Risk Assessment Tool**
  – Through literature review and collaboration with the various departments, we developed risk assessment tools to identify behaviors of concern or individuals who had the potential to be violent

• **Training**

Risk Assessment For ED/Clinics

• ED has a risk assessment with five distinctive elements of observable behavior indicating the potential for violence in patients, their families and friends

• Nursing violence assessment framework and described through the acronym S.T.A.M.P.

• Other behavioral risk factor models out there, such as D.A.N.G.E.R.O.U.S.
  – Mary Muscari, PhD, CRNP (2009)
  – The Brøset Violence Checklist (Psychiatric Settings)
S.T.A.M.P.

- Staring and eye contact (Evil Eye/Stink Eye)
- Tone and volume of voice
- Anxiety,
- Mumbling, and
- Pacing


Risk Screening for In-Patients

- Neurological or cognitive disorder
  - Acute/Chronic cognitive impairment
    - Lack of impulse control – stroke, tumor, seizure, dementia, Alzheimer’s, autism spectrum disorder, traumatic brain injury
- Mental health disorder or psychiatric hold (5150)
  - Paranoia, schizophrenia, bi-polar, borderline personality disorders, narcissism
Risk Screening for In-Patients

• **Current drug or alcohol abuse**
  – Overdoses, detoxing or withdrawal, drug dependency, chronic pain patients, history of drug seeking behavior (frequent fliers)
  • Opioids, benzodiazepines, amphetamines

• **Current incarceration**
  – County and federal forensic patients regardless of a guard being with the patient or not

Risk Screening for In-Patients

• **Disruptive Behavior – Current or Previous**
  – Credible verbal threat of violence against staff
  – Name calling
  – Racial/Sexual harassment
  – Physical aggression, assault, battery
  – Body fluids
  – Spitting
  – Hitting/Kicking
  – Biting
Risk Screening for In-Patients

• If a individual screening positive in one of the five areas, then we implement our “Risk for Violent Behavior Interventions”

• Order request/set is activated which triggers notifications to PBX, security and myself via fax

Orange Magnetic Dots – Visual Aids

Orange magnetic dot is placed on the door jamb going into patient room at eye level.

Ideal Room Assignments:
• Prefer closest to the nurses’ station
• Single room vs. double room
Patient Charts (Non-EHR)

This form is used house-wide to transport patients. If a patient has screened positive for potential violence then the transporters’ form is filled out regarding risk for violence and a orange sticker “dot” is place on the form.
Security/Engineering Shop — VisWalls

Annual Module

• Prior to SB 1299, we had been doing an annual module on Workplace Violence
• All employees must complete the module and it’s reflected in their annual evaluations
• We even have covered items in the modules as it relates to Active Shooter in a health care setting. Hospital events are not the same as what we are seeing at schools, malls, movie theaters, etc.
Training – In-House Program

- GAP analysis to include LE data, code data, employee injuries, patient population we serve, and identified some areas for improvement
- Conducted interviews with staff in various departments who had been involved in documented incidents and asked for their input
- Evaluated commercial programs and found they didn’t meet our needs and were not going to meet the requirements under the pending Cal/OSHA standards
- Third-party vendor did a security assessment of all campuses
- Developed in-house program for staff
- Includes didactic and hands-on
  - Enhanced our training program we were already doing under AB 508, H&SC 1257.7 and 1257.8
  - Used principles from various commercially-available programs
  - Developed our program specific to our environment and patient population
  - Opportunities for staff to discuss real-world events in their departments and make suggestions on how to improve our security posture
  - Items identified in class for improvement are shared with leadership

Workplace Violence Prevention Training (All Staff)

- Provide training to all employees in the facility, unit, service or operation, including temporary employees

- Communication
  - Communication about Class
  - Communication about Resources
  - HR communicating regarding evaluation
  - Annual requirements
  - Communicate Workplace Violence Plan and related policies

- Man
  - Getting new hires trained
  - Large amount of staff need to be trained, who gets trained
  - Annual training plan (staff time, prior to end)
  - Prioritized departments need training first e.g. ED, Legends, HVAC

- Method
  - Hospital Roll-out
  - CI Case: Service Recovery vs. DBB
  - Class Plan (hybrid, length, content etc)
  - Training Records

- Do
  - Space for Large Class with interactive
  - Standardize training materials
  - Train the trainer sessions
  - Class materials handouts
  - Drive to store files and video

- Machine
  - AV equipment: projector, laptop, drill, screen
  - Orientation to program e.g. staff time, training materials, access

- Material
  - Class Materials handouts
  - Cost center for program e.g. staff time, training materials, access
Training – Four Hours
All Individuals Who Come in Contact with Patients

SB 1299 training requirements included:
- Hands-on: non-violent defensive intervention
- Role play
- Situational awareness
- Verbal de-escalation
- Environmental risks due to facility and room designs
- Self-control plan
- Triggers/Behaviors of concern
- Rule of 5
- Trust your gut!
- Have a plan: A, B and C
- OK to leave the room – not expected to save hospital equipment or listen to the patient verbally abuse you
  “I’ll be right back, I have to go to the BR.”
- Staff are empowered to call 9-1-1

Training Program - Four Hours

- **Code Gray P&P Review**
  - Alert process
  - Activation
  - Staff can initiate
  - Staff could call 911 if they felt endangered or their life was threatened, followed by a call to 111
  - We would rather have staff activate to get additional resources before it becomes physical

- **Restraint Application**
  - More than how to tie to the bed frame and do the proper documentation
  - “I can’t breathe”
  - 90-minute rule

I challenge you to ask your nurses when they were trained on how to safely take down patients, not end up in a wrestling match or “dog pile” situation, and put them in four-point restraints.
Thank You

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Questions

Online questions:
Type your question in the Q & A box, hit enter

Phone questions:
To ask a question, hit *1
New WPVP guidebook to be mailed next week

Healthcare Workplace Violence Prevention

CHA’s latest guidebook explains Cal/OSHA’s new regulation and offers practical implementation tips to ease compliance with this far-reaching rule. *Healthcare Workplace Violence Prevention* includes important forms and resources, and:

- Describes the elements of a compliant workplace violence prevention plan
- Explains hospitals’ legal obligations
- Provides a comprehensive task-by-task planning and implementation checklist
- Details training and reporting requirements
- Addresses what to expect regarding enforcement

Upcoming Programs

Hospital Employee Safety & Workers’ Compensation Seminar
March 22, Sacramento
March 30, Costa Mesa

This seminar will update employers on numerous employee issues including workers’ compensation, reasonable accommodation, worker fatigue, workplace violence and safe patient handling. Regulatory investigation and enforcement activity will also be included.
Thank You and Evaluation

Thank you for participating in today’s seminar. An online evaluation will be sent to you shortly.

For education questions, contact Liz Mekjavich at (916) 552-7500 or lmekjavich@calhospital.org.