National Nurses United

National Nurses United petitions the Secretary of Labor to promulgate a standard on workplace violence in healthcare

The Occupational Safety and Health Administration should act immediately to mandate prevention and protection from workplace violence for healthcare workers.

The following document provides evidence of the problem, reasoning why the Agency should act immediately, and a proposed rule.

July 11, 2016

The Honorable Thomas E. Perez
U.S. Secretary of Labor
Occupational Safety & Health Administration
200 Constitution Avenue, NW
Room Number N3626
Washington, D.C. 20210

The Honorable David Michaels, PhD, MD
Assistant Secretary of Labor for OSHA
U.S. Department of Labor
Occupational Safety and Health Administration
200 Constitution Avenue, NW
Washington, D.C. 20210

RE: Petition for a Federal Workplace Violence Prevention Standard to Protect Healthcare Workers

Dear Secretary Perez and Assistant Secretary Michaels:

National Nurses United (NNU), representing over 185,000 members, is the largest union and professional association of registered nurses (RNs) in the United States. As such, we are concerned that our members are afforded their right to a safe and healthful workplace and are fully protected by their employers from hazardous exposures that may occur in the course of doing their jobs. On behalf of our members, please accept this petition for the promulgation of a workplace violence prevention standard to protect healthcare workers by the federal Occupational Safety and Health Administration (OSHA). We believe such a standard is necessary to protect RNs and other healthcare workers from the increasing rates of violence in their workplaces.

The risk of workplace violence is a serious occupational hazard for RNs and other healthcare workers. Countless acts of assault, battery, and aggression that routinely take place in healthcare settings demonstrate a frightening trend of increasing violence faced by healthcare workers throughout the country. In addition to innumerable anecdotal and media accounts, several national surveys document the prevalence of violence committed against healthcare workers. As a persistent and endemic workplace hazard for our members, NNU has advocated for occupational health and safety standards to prevent violence in healthcare settings. Our efforts have resulted in the establishment of some of the best state-level standards on preventing and reducing violence in the workplace for our members. Where state-level standards have not

been established, we have won strong protections for our members through collective bargaining. But despite these strides, protections for RNs and other healthcare workers across the country will remain piecemeal in light of OSHA's exclusive jurisdiction in 24 states. OSHA must take leadership and fulfill its obligation to pass a comprehensive workplace health and safety standard to prevent and reduce workplace violence.

I. OSHA is Obligated to Engage in Responsible Rulemaking to Protect Worker Health and Safety and, Therefore, Must Issue a Standard on Workplace Violence Prevention and Reduction.

Through the Occupational Health and Safety Act (OSH Act), Congress mandated the prioritization of the safety of workers and the prevention of occupational injury and created an obligation by employers to provide a workplace free from recognized hazards, including workplace violence in healthcare settings.[1] To fulfill this legislative mandate, OSHA was tasked and is required by the OSH Act to promulgate mandatory health and safety standards to protect workers across the country from workplace hazards.[2]

Congress envisioned in the passage of the OSH Act that all workplace safety standards promulgated by OSHA be highly protective.[3] It recognized that OSHA's leadership would be necessary in creating uniform standards across the nation, requiring, where conflicts existed among occupational standards, that "the Secretary [of Labor] promulgate the standard which assures the greatest protection of the safety or health of the affected employees."[4] Thus, where serious occupational hazards persist despite voluntary measures, OSHA is required by law to act and to establish a mandatory workplace health and safety standard.

A formal OSHA standard on workplace violence in healthcare would fulfill the Agency's statutory obligations. Through the creation of specific requirements for employers' workplace violence prevention plans, a formal standard would fortify OSHA's ability to enforce this obligation to protect healthcare employees from workplace violence through improved measures in evaluating and citing violations. As documented by a Government Accountability Office (GAO) report from March 2016 recommending that OSHA provide additional information to assist inspectors in developing citations and recommending that OSHA develop a policy for following up on hazard alert letters concerning workplace violence hazards in healthcare facilities, OSHA inspectors would be able to utilize the specific requirements of a formal standard to assess the effectiveness of employers' plans, ensuring that these plans are comprehensive, focused on prevention, and created with the input and insight from affected

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[1] 29 U.S.C. § 651 (1970).
[2] 29 U.S.C. §§ 651(b)(3), (b)(9) (1970).
[3] Control of Hazardous Energy Sources (Lockout/Tagout), 58 Fed. Reg. 16612-02, 16614-15, at fn. 109 (Final Rule, supplementation statement of reasons, Mar. 30, 1993) (codified at 29 C.F.R. § 1910) ("In setting safety standards, OSHA must act consistently with the Act's overriding purposes, which is to provide a high degree of employee protection.").
[4] 29 U.S.C. § 655(a).

employees.[5] As obligated by legislative mandate, OSHA is required to engage in its regulatory authority and create a comprehensive standard to ensure the prevention and reduction of workplace violence for RNs and other healthcare workers.

II. Workplace Violence is a Long Recognized and Growing Hazard for Healthcare Workers.

A. Workplace violence incidents are high for healthcare workers and are increasing.

The most recent Bureau of Labor Statistics (BLS) injury and illness data available from 2014 shows that reported incidents are high in the healthcare settings.[6] The combined number from publicly and privately owned healthcare settings ranged from 2,070 in ambulatory care settings, to 10,750 in nursing homes, to 11,900 in hospitals. The total number reported across all private healthcare facilities was an alarming 16,910. The BLS Survey of Occupational Injuries and Illnesses (SOII) data for 2013 estimated rates of nonfatal workplace violence against healthcare workers in inpatient facilities are 5 to 12 times greater than for workers overall, depending on the type of healthcare facility.[7]

Data from the U.S. Department of Health and Human Services National Electronic Injury Surveillance System—Work Supplement (NEISS-Work) estimates that the rate in 2011 of nonfatal injuries from workplace violence for healthcare workers was statistically greater than all workers combined.[8] The most recent BLS injury and illness data available from 2014 shows that rates differ depending on healthcare settings.[9] Although they are high across all healthcare settings, public hospitals and nursing homes have the astonishing rates of 154 and 228 per 10,000 workers, respectively. The following BLS data in Table 1 includes injuries caused by "Violence and other injuries by persons or animal."

Table 1: Incident rates for Workplace Violence in Healthcare Facilities[10]

	Hospital			Ambulatory			Nursing Home		
Year	Private	State	Local	Private	State	Local	Private	State	Local
2014	16.8	154	19.3	4	--	--	30.8	228.1	53.7

[5] *See* U.S. Government Accountability Office. *Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence* (GAO-16-11) (hereinafter "GAO Report" (2016), *available at* http://www.gao.gov/products/GAO-16-11 (Accessed July 10, 2016).

[6] *See* Bureau of Labor Statistics. U.S. Department of Labor. "Occupational Injuries and Illnesses and Fatal Injuries Profiles," *available at* http://data.bls.gov/gqt/InitialPage (Accessed July 10, 2016).

[7] Government Accountability Office (2016). *Workplace Safety and Health: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence* (GAO-16-11) at p. 10. http://www.gao.gov/products/GAO-16-11 (Accessed June 13, 2016).

[8] *Id.*

[9] *See* Bureau of Labor Statistics. U.S. Department of Labor. "Occupational Injuries and Illnesses and Fatal Injuries Profiles," *available at* http://data.bls.gov/gqt/InitialPage (Accessed July 10, 2016).

[10] *Ibid.*

Between January 1, 2012 and September 30, 2014, a total of 112 U.S. healthcare facilities reported 10,680 OSHA-recordable injuries from workplace violence.[11] Registered nurses and nurse assistants had the highest injury rates of all occupations examined.[12] In the time period of the study, between 2012 and 2014, injury rates due to workplace violence increased for all job classifications and nearly doubled for both nurses and nurse assistants. Only 49% of all reports examined in this study specific the type of assault that led to the injury. Of these, 99% were physical assaults. The workplace violence injuries recorded were clustered in locations where direct patient care is provided in healthcare facilities.[13]

Similarly, a 2007 report commissioned by the National Institute of Occupational and Environmental Health (NIOEH), entitled "Evaluation of Safety and Security Programs to Reduce Violence in Healthcare Settings" explained that healthcare workers, especially nurses, have long been recognized as experiencing a high risk of work-related assault, with an average of almost 70,000 violent victimizations reported per year. [14]

A study published in 2002 surveyed nurses from three departments in a 770-bed acute care hospital regarding their experiences of verbal and physical violence at work in the previous year. An overwhelming majority of nurse respondents reported that they had experienced violence on the job: 88% reported experiencing verbal violence and 74% reported experiencing physical violence.[15]

While the most recently available data indicates that rates of workplace violence are high for healthcare workers, it is also important to recognize that the problem is increasing. The healthcare industry has grown rapidly over the past ten years and, according to the BLS projections, will continue to grow over the next ten years.[16] Not only are there more affected

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[11] OSHA-recordable injuries are defined as work-related injuries and illnesses that result in at least one of the following: death, loss of consciousness, days away from work, restricted work activity or job transfer, medical treatment beyond first aid, or a diagnosis by a physician or other licensed health care professional. *See* 29 C.F.R. §§ 1904, et seq.; *see also* Occupational Safety & Health Administration. U.S. Department of Labor. "OSHA Recordkeeping and Reporting Requirements," *available at* https://www.osha.gov/recordkeeping/ (Accessed July 10, 2016).

[12] U.S. Centers for Disease Control and Prevention. "Occupational Traumatic Injuries Among Workers in Health Care Facilities—United States, 2012-2014,"*available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6415a2.htm (Accessed July 10, 2016).

[13] *Ibid.*

[14] Peek-Asa, Corinne, Veerasathpurush Allareddy, Carri Casteel, Maryalice Noceira, Robert Harrison, Suzi Goldmacher, Julie Curry, David Valiante, James Blando, and Emily O'Hagan. "Evaluation of Safety and Security Programs to Reduce Violence in Health Care Settings." National Institute of Occupational and Environmental Health (Jan 2007), *available at* https://www.cdph.ca.gov/programs/ohsep/Documents/wvpfinalreport.pdf (Accessed July 9, 2016).

[15] May, Deborah D. and Laurie M. Grubbs. "The extent, nature, and precipitating factors of nurse assault among three groups of registered nurses in a regional medical center." *J. of Emergency Nursing*. (2002) 28 (1):11-17.

[16] Bureau of Labor Statistics (2015). *Industry employment and output projections to 2024, available at* http://www.bls.gov/opub/mlr/2015/article/industry-employment-and-output-projections-to-2024-2.htm (Accessed June 13, 2016).

workers, rates of workplace violence injuries have also increased in recent years. Between 2011 and 2013, rates increased about 12%.[17] With these rapidly increasing rates and employment, more and more workers will be harmed and killed unless protections are created.

B. Statistics regarding workplace violence in healthcare settings underreport the problem.

The recent GAO report, which reported these statistics and more, discussed the inadequacy of these surveys in capturing all incidents of workplace violence. Both the NEISS-Work survey and the BLS SOII surveys included only workplace violence incidents that result in injuries. These surveys do not capture the many workplace violence incidents that do not result in a physical injury but still have devastating consequences for a worker's mental health and well-being. Thus, the actual number of healthcare workers affected by workplace violence is held to be much higher.

Numerous studies have shown that workplace violence rates are underreported. One survey of healthcare workers collected information about rates of workplace violence experienced and how many incidents were reported to the employer. This study found that 88% of respondents had not reported a workplace violence incident in the previous year.[18] Another study compared BLS injury and illness data to other databases, including workers' compensation and OSHA injury survey data, for Michigan companies. This study found that the actual number of reportable injuries is as much as three times higher than the BLS data.[19] It is significant to note that rates of workplace violence are significantly higher in reality than the BLS and other data sources.

C. OSHA has long recognized workplace violence as a hazard with significant impact on healthcare workers.

In interpreting its own statutory mandate under the OSH Act, OSHA has long recognized, and cautioned, that failure of employers to adopt adequate workplace violence prevention practices can place healthcare workers at risk for serious injury and death and that such failure would constitute a violation of the General Duty Clause.[20] Over the past two decades, OSHA

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[17] GAO Report, *supra* note 5, at pp. 18-19.

[18] Arnetz, Judith E., PhD, MPH, PT, Lydia Hamblin, MA, Joel Ager, PhD, Mark Luborsky, PhD, Mark J. Upfal, MD, MPH, Jim Russell, BSN, and Lynnette Essenmacher, MPH. "Underreporting of Workplace Violence: Comparison of Self-report and Actual Documentation of Hospital Incidents." Workplace Health and Safety Oct. 8, 2015, *available at* http://whs.sagepub.com/content/63/5/200 (Accessed July 10, 2016).

[19] Rosenman, Kenneth D., Alice Kalush, Mary Jo Reilly, Joseph C. Gardiner, Matthew Reeves, and Zhewui Luo. "How Much Work-Related Injury and Illness is Missed by the Current National Surveillance System?" *J. of Occ. and Environ. Med.* 48 (2006), *available at* https://msu.edu/~kalush/projects/JOEMWorkplaceInjuries.pdf (Accessed July 9, 2016).

[20] *See* Occupational Safety & Health Administration. U.S. Department of Labor. OSHA Standard Interpretations Letter (Dec. 10, 1992), *available at* www.osha.gov/SLTC/workplaceviolence/standards.html (Accessed July 10, 2016) ("Whether or not an employer can be cited for a violation of [the General Duty Clause] is entirely

released a series of guidelines and fact sheets regarding workplace violence and prevention. The first such guideline, *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, was published in 1996 and has been updated twice, in 2004 and in 2015.[21] In a 2002 fact sheet, OSHA warned employers that failure to abate workplace violence hazards is considered a violation of the General Duty Clause, stating that "[e]mployers who do not take reasonable steps to prevent or abate a recognized violence hazard in the workplace can be cited" for violating the General Duty Clause.[22]

An agency's guidelines are given due deference where the guidelines fall within an agency's particular expertise.[23] Noting that the "rulings, interpretations and opinions" of an agency "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance."[24] Longstanding guidance developed independent of litigation is accorded particular deference.[25]

OSHA developed guidance recognizing that failure to adopt adequate workplace violence prevention practices in the face of recognized and abatable risk of workplace violence can violate the General Duty Clause. That guidance is longstanding. It was developed independent of any litigation. Accordingly, that guidance is due respectful deference. This is especially true because the guidance is reasonable and consistent with the purpose of the Act.[26]

Congress tasked OSHA with assuring "so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources…" including by passing mandatory standards.[27] From the available data and from our members' experiences, it is clear that OSHA is not upholding its duty, assigned by Congress, to protect healthcare workers from workplace violence. OSHA needs to pass a formal workplace violence prevention standard and implement a strong enforcement campaign to effectively protect healthcare workers from workplace violence.

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dependent on the specific facts . . . . The recognizability and foreseeability of the hazard, and the feasibility of the means of abatement, are some of the critical factors to be considered.")

[21] Occupational Safety & Health Administration. U.S. Department of Labor. *Guidelines for Preventing Workplace Violence for Health and Safety Workers* (2015), *available at* https://www.osha.gov/Publications/osha3148.pdf (Accessed July 10, 2016).

[22] Occupational Safety & Health Administration. U.S. Department of Labor. OSHA Workplace Violence Fact Sheet (2002), *available at* http://www.osha.gov/OshDoc/data_General_Facts/factsheet-workplace-violence.pdf (Accessed July 10, 2016).

[23] *See Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944) (noting that the "rulings, interpretations and opinions" of an agency "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance"); *Red Lion Broadcasting v. FCC*, 395 U.S. 367, 381 (1969) ("the construction of a statute by those charged with its execution should be followed unless there are compelling indications that it is wrong").

[24] *See Skidmore v. Swift & Co.*, 323 U.S. at 140.

[25] *See Alaska Dept. of Envtl. Conservation v. EPA*, 540 U.S. 461, 487-88 (2004).

[26] *Elec. Smith, Inc. v. Sec'y of Labor*, 666 F.2d 1267, 1270 (9th Cir. 1982) ("The Commission's interpretations of OSHA must be treated with deference, and may not be overturned if reasonable and consistent with the purposes of the Act.").

[27] 29 U.S.C. § 651.

III. In Absence of a Standard, OSHA's Current Efforts to Prevent Workplace Violence are Inadequate.

A. OSHA enforcement limited and inconsistent under the general duty clause and guidelines.

Strong enforcement programs are necessary to encourage employer compliance with OSHA standards. OSHA already has established that workplace violence qualifies under the General Duty Clause[28] and has taken some action to see that it is enforced. Accordingly, the agency has performed inspections and issued citations under the General Duty Clause. In April 2015, it also released an enforcement directive and a three-year National Emphasis Program-Nursing Home and Residential Care Facilities, after a previous National Emphasis Program was set to expire, to increase enforcement efforts around workplace violence in healthcare settings.[29]

However, the recent GAO report on workplace violence in healthcare examined OSHA's enforcement record on workplace violence under the General Duty Clause and found it wanting. The GAO analysis found that approximately 65% of the inspections of healthcare facilities for workplace violence that OSHA conducted between 1991 and April 2015 took place between 2012 and 2014. The analysis also found that OSHA citations are region-dependent and inconsistent across the United States. Three of the ten OSHA regions conducted 60% of all the inspections performed. Moreover, only 5% of the inspections conducted in healthcare facilities between 1991 and early 2015 resulted in a General Duty Clause citation.[30]

It is clear that enforcement efforts have not been coordinated or effective. OSHA inspectors interviewed during the GAO analysis agree:

> Some inspectors and other regional officials from 5 OSHA regional offices said it is difficult to collect sufficient evidence to meet all four criteria [for a General Duty Clause citation] during an inspection.... Another inspector noted that an employer may have a minimal workplace violence prevention program and that it is sometimes difficult to prove that the employer has not done enough to address the hazard.[31]

On June 25, 2015, following the release of the GAO report, OSHA issued a memorandum to establish guidance for inspections conducted in inpatient healthcare settings, North American Industry Classification System (NAICS) Major Groups 622 (hospitals) and 623 (nursing and

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[28] *See* OSHA Workplace Violence Fact Sheet (2002), *supra* note **Error! Bookmark not defined.**.

[29] Occupational Safety & Health Administration. U.S. Department of Labor. Enforcement Directive on National Emphasis Program – Nursing and Residential Care Facilities (NAICS 623110, 623210 and 623311) (Enforcement Directive CPL 03-00-016 (April 2015), *available at* https://www.osha.gov/OshDoc/Directive_pdf/CPL_03-00-016.pdf (Accessed July 10, 2016).

[30] GAO Report, *supra* note 5, pp. 21, 22.

[31] *Id.* at pp. 28.

residential care facilities).[32] The memorandum requires that all inspections, both programmed and unprogrammed, cover the focus hazards from the expired National Emphasis Program - Nursing and Residential Care Facilities which includes workplace violence among a list of four other focus hazards. While admirable, the memorandum does not establish a clear and enforceable standard to protect healthcare workers from violence in the workplace.

B. Voluntary measures by industry are persistently insufficient.

In the area of workplace violence in healthcare settings, OSHA first issued voluntary guidelines in 1996, which were updated in 2004 and again last year. These guidelines provide recommendations for employers on how to assess and evaluate workplace violence hazards and on control measures that may be implemented to reduce or eliminate these hazards, but fall short of creating any mandatory requirements or enforceable provisions to protect workers. Our experience tells us that coordinated worker enforcement campaigns are necessary to ensure that healthcare employers comply even with mandated standards and laws.

Employers have not followed non-mandatory suggestions or guidelines where there are no associated penalties or consequences. One study found that more than 80% of U.S. employers report no change in their workplace violence prevention programming after a significant violent event, even though 35% cite negative effects such as increased absenteeism and reduced productivity.[33] OSHA should recognize that voluntary guidelines have not and will not ensure that healthcare workers are protected from workplace violence.

The failure of voluntary guidelines and the recognition of the necessity for developing standards are evident in the American National Standard, which was approved by the American National Standards Institute, Inc. (ANSI). ANSI, a recognized source of national consensus standards in federal regulation,[34] developed its worplace violence standard based on "a majority consensus among professionals from disparate disciplines (including security, human resources, mental health, law enforcement and legal arenas) regarding practices viewed as effective, recommended, and—in some cases—essential through work in this field."[35] Glaringly missing from ANSI's process of creating national standards are any workers directly affected by workplace violence in the healthcare industry and their unions. The lack of worker representation and participation in ANSI is juxtaposed to the unabashed presence of representatives of healthcare employers, universities, insurance providers as well as a variety of corporate interests.

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[32] Assistant Secretary for Occupational Safety and Health, U.S. Department of Labor. Memorandum. "Inspection Guidance for Inpatient Healthcare Settings," June 25, 2015, *available at*https://www.osha.gov/dep/enforcement/inpatient_insp_06252015.html (Accessed July 9, 2016).

[33] Bureau of Labor Statistics, U.S. Department of Labor. "Survey of Workplace Violence Prevention," 2006, *available at* http://www.bls.gov/iif/oshwc/osnr0026.pdf (Accessed July 9, 2016).

[34] *See* 29 C.F.R. § 1910.2(g).

[35] Engineering 360, "Standards Detail" for ASIS/SHRM, Workplace Violence Prevention and Intervention American National Standard, 2011available at http://standards.globalspec.com/std/1401097/asis-wvpi-1 (Accessed July 10, 2016).

ANSI's orientation towards industry representation highlights the scope of the problem in establishing occupational safety and health standards that can effectively address hazards that employees face in the workplace. Not surprisingly, the "voluntary standards" set by the guardians of healthcare management and corporate interests have failed to stem the tide of workplace violence. This is an overwhelming testament to the futility of "voluntary" guidelines in reducing death and disability in the workplace and especially in the healthcare setting. Forty-five years of ineffective voluntary measures requires the immediate attention of the Secretary of Labor to direct OSHA forthwith to proceed with rulemaking on this problem recognized by virtually all involved in healthcare to be of critical importance and, in the vernacular of healthcare workers, needs to be addressed "stat."

OSHA itself has recognized that "[t]he courts have interpreted OSHA's general duty clause to mean that an employer has a legal obligation to provide a workplace free of conditions or activities that either the employer or industry recognizes as hazardous and that cause, or are likely to cause, death or serious physical harm to employees when there is a feasible method to abate the hazard."[36] A lack of evidence regarding feasible control measures can be a major barrier to issuing a General Duty Clause citation and to passing a standard. The body of available evidence, however, supports the effectiveness of control measures in preventing workplace violence incidents and reducing injuries in hospitals and other healthcare settings. For your reference we have attached our literature review documenting and weighing the evidence to find that there are studies that show significant decreases in workplace violence incidents and injuries when control measures are implemented. While most studies found only implement one or a few control measures instead of a comprehensive prevention plan, it is still valuable evidence to show that particular control measures do have a significant impact. These effective control measures can then be selected as part of the prevention plan.

We have also attached testimony from our member, given at the press conference marking the release of the GAO report, which illustrates the ways that control measures could have prevented the workplace violence incident and injury from which she continues to suffer.

IV. Individual States Have Moved Ahead of OSHA in Protecting Healthcare Employees From Workplace Violence.

Through the stewardship of NNU and our affiliate, the California Nurses Association (CNA), healthcare workers in California will soon be covered under a comprehensive workplace violence prevention standard promulgated by the California Division of Occupational Safety and Health (Cal/OSHA) that we believe will be the best in the nation. California recently enacted CNA-sponsored legislation requiring the creation of a statewide standard on workplace violence prevention plans based on the long-standing recognition that violence in healthcare settings is a serious occupational hazard for healthcare workers in California and throughout the nation.[37] Completion of the rulemaking process is expected this summer. The final standard will reflect

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[36] Occupational Safety &Health Administration. U.S. Department of Labor. *Workplace Violence: Enforcement, available at* https://www.osha.gov/SLTC/workplaceviolence/standards.html (Accessed July 9, 2016).

[37] *See* Cal. Lab. Code § 6401.8.

the collaborative process of the Cal/OSHA with CNA members, employer representatives, and members of other unions.

CNA's experience in California serves as an apt model on the national scale. On February 20, 2014, CNA submitted a petition to California's Occupational Safety and Health Standards Board (OSHSB) calling for a workplace violence prevention standard to protect California RNs and other healthcare workers from violence in their workplaces. The petition was granted by OSHSB, which noted that "violence directed against healthcare workers is a serious and on-going problem' and that "no federal OSHA standard or national consensus standard directly addresses workplace violence protection."[38] The OSHSB authorized an advisory committee, the Workplace Violence Prevention in Healthcare Committee, composed of unions, healthcare employers, and other stakeholders, to begin developing the standards. The committee held its first meeting on September 10, 2014.

During that same year and in recognition of the serious threat of workplace violence against RNs and other healthcare workers, Senator Alex Padilla, now California's Secretary of State, authored legislation, S.B. 1299, directing Cal/OSHA to issue a standard with specific, prescribed elements requiring healthcare employers to establish, implement, and maintain workplace violence prevention plans. We are proud to have sponsored this important legislation on behalf of our California members. This legislation is now law.

The state's Senate Committee on Labor and Industrial Relations noted in the legislative record that healthcare workers had a high risk of work-related assault with RNs in particular having the highest risk.[39] Relying on the 2007 National Institute of Occupational and Environmental Health report, the Senate committee recognized that industry prevention efforts were inadequate, stating that the report "found some consistent areas which suggested potential for improved protection and/or improved efficiency."[40] In its analysis, the state Senate committee highlighted the following problem areas as in clear need of improvement:

1. Surveillance of workplace violence events is uncoordinated and inefficient;
2. Nursing staff within emergency departments were often unsatisfied with their interactions with security personnel;
3. Although all hospitals trained the majority of personnel in emergency and psychiatric units, no hospitals trained all employees regularly stationed in the unit;
4. Employee training programs rarely included review of violence trends within their specific hospital;
5. OSHA logs and employers' reports did not provide detailed information about the

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[38] California Occupational Safety and Health Standards Board. "Revised Proposed Petition Decision of the California Occupational Safety and Health Standards Board (Petitions 538 and 539)," pp. 1-2 (Jun. 19, 2014), *available at* http://www.dir.ca.gov/oshsb/documents/petition_539_propdecision_revised.pdf (last visited Jul. 10, 2016).

[39] Hearing on S.B. 1299 Before the California Senate Committee on Labor and Industrial Relations, , 2013-2014 Regular Session, pp. 3-4 (April 24, 2014) (Committee analysis and report).

[40] *Id.* at p. 4.

circumstances of a violent event, which could limit prevention efforts; and

6. Few hospitals had effective systems to communicate about the presence of violent patients, hospital security equipment systems were uncoordinated and insufficient to protect the unit, and security programs and training were often less complete in psychiatric units than in emergency departments.[41]

And California is in good company. Connecticut, Illinois, Maine, Maryland, New Jersey, New York, Oregon, and Washington all recognize and regulate workplace violence in healthcare, social services, or both. All nine states' requirements are similar to OSHA's guidelines on effective comprehensive workplace violence prevention plans.[42] In addition to these states recognized in the GAO report, NNU-affiliate Minnesota Nurses Association recently worked with state legislators to pass a law that requires hospitals to develop and implement comprehensive workplace violence prevention plans. This law took effect January 1, 2016. Several additional states seek to educate employers about the hazard of workplace violence through published guidance. North Carolina, for example, published guidelines explaining that healthcare, long-term care, and social service workers all face an increased risk of work-related assaults.[43]

A state-by-state effort, however, is insufficient to protect all healthcare workers. Twenty-four states are under federal OSHA jurisdiction in addition to the private industry in five additional states.[44] Federal OSHA should act now to promulgate a workplace violence prevention standard so that all US healthcare workers are protected from workplace violence.

V. Proposed Elements for a Federal Workplace Violence Regulation.

There are fundamental elements that any workplace violence prevention standard must include in order for the standard to achieve optimal protection for workers. We expect OSHA to evaluate whether and how to expand the scope, if the Agency elects to enter rulemaking. Should the Agency grant this petition for a workplace violence prevention standard, we submit the following proposed provisions as a framework from which the standard may be developed:

(a) Scope and application.

(1) Scope: The rule should apply to healthcare facilities, service categories, and operations as listed below:

(A) Ambulatory Health Care Services (NAICS 621)

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[41] *Ibid.*

[42] GAO Report, *supra* note 5, at pp. 39-41.

[43] N.C. Dept. of Lab., *Workplace Violence Prevention Guidelines and Program for Healthcare, Long Term Care and Social Services Workers* (Dec. 2013), *available at* http://www.nclabor.com/osha/etta/indguide/ig51.pdf (Accessed July 2016).

[44] Occupational Safety & Health Administration. U.S. Department of Labor. *Table of OSHA-Approved State Plans: Basic Facts and Information, available at* https://www.osha.gov/dcsp/osp/approved_state_plans.html#ftn (Accessed June 13, 2016).

(B) Hospitals (NAICS 622)

(C) Nursing and Residential Care Facilities (NAICS 623)

(2) The employer shall provide all safeguards required by this section, including provision of personal protective equipment, training, and medical services, at no cost to the employee, at a reasonable time and place for the employee, and during the employee's working hours.

(b) Workplace Violence Prevention Plan. Every employer covered by this section shall establish, implement and maintain an effective workplace violence prevention plan (Plan) that is in effect at all times in every unit, service, and operation. The Plan shall be in writing, shall be specific to the hazards and corrective measures for the unit, service, or operation, and shall be available to employees at all times. The written Plan shall include all of the following elements:

(1) Names and/or job titles of the persons responsible for implementing the Plan.

(2) Effective procedures to obtain the active involvement of employees and their representatives in developing, implementing, and reviewing the Plan, including their participation in identifying, evaluating, and correcting workplace violence hazards, designing and implementing training, and reporting and investigating workplace violence incidents. This process shall also include the involvement of security personnel who are employees of the facility, or representatives of employees who provide security services to the employer.

(3) Methods the employer will use to coordinate implementation of the Plan with other employers whose employees work in the healthcare facility, service, or operation, to ensure that those employers and employees have a role in implementing the Plan. These methods shall ensure that employees of other employers and temporary employees are provided the training required by the standard and shall ensure that workplace violence incidents involving those employees are reported, investigated, and recorded.

(4) A policy prohibiting the employer from disallowing an employee from, or taking punitive or retaliatory action against an employee for, seeking assistance and intervention from local emergency services or law enforcement when a violent incident occurs. The Plan shall also include effective procedures to accept and respond to reports of workplace violence, including Type 3 violence, and to prohibit retaliation against an employee who makes such a report.

(5) Communication procedures regarding the Plan, including how employees will document and communicate to other employees and between shifts and units, information regarding conditions that may increase the potential for workplace violence incidents.

(6) Procedures to identify and evaluate environmental risk factors that may contribute to or increase the risk of workplace violence. Such assessments must occur upon initial implementation of the Plan, and at least once annually thereafter. The

assessment must be specific to each unit and area of the facility, including areas surrounding the facility, such as parking areas and outdoor spaces. Environmental risk factors include, but are not limited to, the following:

(A) Employees working in locations isolated from other employees (including employees engaging in patient contact activities);

(B) Poor illumination or blocked visibility;

(C) Lack of effective escape routes;

(D) Lack of physical barriers between employees and persons at risk of committing workplace violence;

(E) Presence and availability of alarm systems, including obstacles and impediments to accessing alarm systems;

(F) Entryways where unauthorized entrance may occur;

(G) Presence of furnishings or any objects that can be used as weapons;

(H) Storage of high-value items, currency, or pharmaceuticals;

(7) Procedures to identify and evaluate patient-specific risk factors and assess visitors that may contribute to or increase the risk of workplace violence. Assessment tools, decision trees, algorithms, or other effective means shall be used to identify situations in which Type 2 violence is more likely to occur and to assess visitor or other persons who display disruptive behavior or otherwise pose a risk of committing Type 1 workplace violence. Patient-specific risk factors shall include, but not necessarily be limited to, the following:

(A) A patient's mental status and conditions that may cause the patient to be non-responsive to instruction or to behave unpredictably, disruptively, uncooperatively, or aggressively;

(B) A patient's treatment and medication status, type, and dosage, as is known to the health facility and employees;

(C) A patient's history of violence, as is know to the health facility and employees;

(D) Any disruptive or threatening behavior displayed by a patient.

(8) Procedures to correct workplace violence hazards in a timely manner. Engineering and work practice controls shall be used to eliminate or minimize employee exposure to the identified hazards to the extent feasible. Corrective measures shall include, as applicable, but not be limited to, the following:

(A) Ensuring that sufficient numbers of staff are trained and available to prevent and immediately respond to workplace violence incidents during each shift. A staff person is not considered to be available if other

assignments prevent the person from immediately responding to an alarm or other notification of a violent incident.

(B) Providing line of sight or other immediate communication in all areas where patients or members of the public may be present. This may include removal of sight barriers, provision of surveillance systems or other sight aids such as mirrors, use of a buddy system, improving illumination, or other effective means. Where patient privacy or physical layout prevents line of sight, alarm systems or other effective means shall be provided for an employee who needs to enter the area.

(C) Configuring facility spaces, including, but not limited to, treatment areas, patient rooms, interview rooms, and common rooms, so that employee access to doors and alarm systems cannot be impeded by a patient, other persons, or obstacles.

(D) Removing, fastening, or controlling furnishings and other objects that may be used as improvised.

(E) Creating a security plan to prevent the transport of unauthorized firearms and other weapons into the facility.

(F) Maintaining sufficient staffing, including security personnel, who can maintain order in the facility and respond to workplace violence incidents in a timely manner.

(G) Installing an alarm system or other effective means by which employees can summon security and other aid to defuse or respond to an actual or potential workplace violence emergency.

(H) Creating an effective means by which employees can be alerted to the presence, location, and nature of a security threat.

(I) Establishing an effective response plan for actual or potential workplace violence emergencies that includes obtaining help from facility security or law enforcement agencies as appropriate. Employees designated to respond to emergencies must not have other assignments that would prevent them from responding immediately to an alarm.

(J) Assigning or placing minimum numbers of staff to reduce patient-specific Type 2 workplace violence hazards.

(9) Procedures for post-incidence response and investigation, including, but not limited to, the following:

(A) Providing immediate medical care or first aid to employees who have been injured in the incident;

(B) Providing individual trauma counseling to all employees affected by the incident;

(C) Reviewing any patient-specific risk factors and any risk reduction measures that were specified for that patient;

(D) Reviewing whether appropriate corrective measures developed under the Plan were effectively implemented;

(E) Soliciting from the injured employee and other personnel involved in the incident their opinions regarding the cause of the incident, and whether any measure would have prevented the injury.

(c) Violent Incident Log—The employer shall establish and implement a system for recording information about every incident, post-incident response, and workplace violence injury investigation. As part of this system, injured employees must be given an opportunity to fill out a section of the log pertaining to their own experience of the incident. The Log shall be reviewed during the mandatory annual review of the Plan.

(d) Annual Review of the Workplace Violence Prevention Plan. The employer shall establish and implement a system to review the effectiveness of the Plan at least annually, in conjunction with employees regarding their respective work areas, services, and operations. The review shall include an evaluation of the hazard assessment and evaluation procedures and a review of the all the violent incident logs from the previous year.

(e) Training. The employer shall provide effective training to all employees, including temporary employees, working in the facility, unit, service, or operation. The training shall address the workplace violence hazards identified in the facility, unit, service, or operation, the corrective measures the employer has implemented, and the activities that each employee is reasonably anticipated to perform under the Plan. The employer shall have an effective procedure for obtaining the active involvement of employees and their representatives in developing training curricula and training materials, conducting training sessions, and reviewing and revising the training program. Training material appropriate in content and vocabulary to the educational level, literacy, and language of employees shall be used.

(A) All employees working in the facility, unit, service, or operation shall be provided initial training when the Plan is first established and when an employee is newly hired or newly assigned to perform duties for which the required training was not previously provided. Additional training shall be provided when new equipment or work practices are introduced or when a new or previously unrecognized workplace violence hazard has been identified. Refresher training shall be provided at least annually.

(B) Initial training shall include:

1. An explanation of the employer's Plan, including the employer's hazard identification and evaluation procedures, general and personal safety measures the employer has implemented, how the employee may communicate concerns about workplace violence without fear of reprisal, how the employer will address workplace

violence incidents, and how the employee can participate in reviewing and revising the Plan;

2. How to recognize the potential for violence, factors contributing to the escalation of violence and how to counteract them, and when and how to seek assistance to prevent or respond to violence;
3. Strategies to avoid physical harm;
4. How to report violent incidents to law enforcement;
5. Any resources available to employees for coping with incidents of violence, including, but not limited to, critical incident stress debriefing or employee assistance programs;
6. An opportunity for interactive questions and answers with a person knowledgeable about the employer's Plan.

(C) Employees assigned to respond to alarms or other notifications of violent incidents or whose assignments involve confronting or controlling persons exhibiting aggressive or violent behavior shall be provided training on the following topics prior to initial assignment and at least annually thereafter. This is in addition to the initial training. This additional training shall include:

1. General and personal safety measures;
2. Aggression and violence predicting factors;
3. The assault cycle;
4. Characteristics of aggressive and violent patients and victims;
5. Verbal and physical maneuvers to defuse and prevent violent behavior;
6. Strategies to prevent physical harm;
7. Restraining techniques;
8. Appropriate use of medications as chemical restraints;
9. An opportunity to practice the maneuvers and techniques included in the training with other employees they will work with, including a meeting to debrief the practice session. Problems found shall be corrected.

(f) Definitions:

(1) ALARM- The term "Alarm" means a mechanical, electrical or electronic device that does not rely upon an employee's vocalization in order to alert others.

(2) DANGEROUS WEAPON- The term "Dangerous weapon" means an instrument capable of inflicting death or serious bodily injury.

(3) ENGINEERING CONTROLS- The term "Engineering controls" means an aspect of the built space or a device that removes a hazard from the workplace or creates a barrier between the worker and the hazard. For purposes of reducing workplace violence hazards, engineering controls include, but are not limited to: electronic access controls to employee occupied areas; weapon detectors (installed or handheld); enclosed workstations with shatter-resistant glass; deep service counters; separate rooms or areas for high risk patients; locks on doors; furniture affixed to the floor; opaque glass in patient rooms (protects privacy, but allows the healthcare provider to see where the patient is before entering the room); closed-circuit television monitoring and video recording; sight-aids; and personal alarm devices.

(4) ENVIRONMENTAL RISK FACTORS- The term "Environmental risk factors" means factors in the facility or area in which healthcare services or operations are conducted that may contribute to the likelihood or severity of a workplace violence incident. Environmental risk factors include risk factors associated with the specific task being performed, such as the collection of money.

(5) PATIENT-SPECIFIC RISK FACTORS- The term "Patient-specific risk factors" means factors specific to a patient that may increase the likelihood or severity of a workplace violence incident, such as use of drugs or alcohol, psychiatric condition or diagnosis, history of violence, any condition or disease process that would cause confusion and/or disorientation.

(6) THREAT OF VIOLENCE- The term "Threat of violence" means a statement or conduct that causes a person, according to the reasonable person standard, to fear for his or her safety, and that serves no legitimate purpose.

(7) WORKPLACE VIOLENCE- The term "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:

(A) 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;

(B) 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;

(C) Four workplace violence types:

1. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.

2. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.
3. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.
4. "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.

(8) WORK PRACTICE CONTROLS- The term "Work practice controls" means procedures, rules and staffing which are used to effectively reduce workplace violence hazards. Work practice controls include, but are not limited to: appropriate staffing levels; provision of dedicated safety personnel (i.e. security guards); employee training on workplace violence prevention methods; and employee training on procedures to follow in the event of a workplace violence incident.

VI. In Conclusion, OSHA must promulgate a final workplace violence standard immediately.

Workplace violence has become a serious hazard for healthcare workers. While workplace violence is preventable, employers have not followed OSHA's voluntary guidance to implement comprehensive workplace violence prevention plans. OSHA's citations under the General Duty Clause have not served as sufficient enforcement to protect workers. To better protect workers, OSHA must promulgate a comprehensive workplace violence standard immediately. Therefore, OSHA must grant this petition and fulfill its statutory responsibility to protect healthcare workers from workplace violence.

Sincerely,

Bonnie Castillo

Bonnie Castillo, RN
Director of Health and Safety
National Nurses United