



DEPARTMENT OF LABOR

Occupational Safety and Health Administration

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Prevention of Workplace Violence in Healthcare and Social Assistance

AGENCY: Occupational Safety and Health Administration (OSHA), DOL.

ACTION: Request for Information (RFI).

SUMMARY: Workplace violence against employees providing healthcare and social assistance services is a serious concern. Evidence indicates that the rate of workplace violence in the industry is substantially higher than private industry as a whole. OSHA is considering whether a standard is needed to protect healthcare and social assistance employees from workplace violence and is interested in obtaining information about the extent and nature of workplace violence in the industry and the nature and effectiveness of interventions and controls used to prevent such violence. This RFI provides an overview of the problem of workplace violence in the healthcare and social assistance sector and the measures that have been taken to address it. It also seeks information on issues that might be considered in developing a standard, including scope and the types of controls that might be required.

DATES: Submit comments on or before [**INSERT DATE 120** DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]. All submissions must bear a postmark or provide other evidence of the submission date.

ADDRESSES: Submit comments and additional materials by any of the following methods:

Electronically: Submit comments and attachments electronically at <http://www.regulations.gov>, which is the Federal eRulemaking Portal. Follow the instructions online for making electronic submissions.

Facsimile: OSHA allows facsimile transmission of comments and additional material that are 10 pages or fewer in length (including attachments). Send these documents to the OSHA Docket Office at (202) 693-1648. OSHA does not require hard copies of these documents. Instead of transmitting facsimile copies of attachments that supplement these documents (for example, studies, journal articles), commenters must submit these attachments to the OSHA Docket Office, Technical Data Center, Room N-3653, OSHA, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. These attachments must identify clearly the sender's name, the date, subject, and docket number OSHA-2016-0014 so that the Docket Office can attach them to the appropriate document.

Regular mail, express mail, hand delivery, or messenger (courier) service: Submit comments and any additional material (for example, studies, journal articles) to the OSHA Docket Office, Docket No. OSHA-2016-0014 or RIN 1218-AD 08, Technical Data Center, Room N-3653, OSHA, U.S. Department of Labor, 200 Constitution Ave., NW., Washington, DC 20210; telephone: (202) 693-2350. (OSHA's TTY number is (877) 889-5627.) Contact the OSHA Docket Office for information about security procedures concerning delivery of materials by express mail, hand delivery, and messenger service. The hours of operation for the OSHA Docket Office are 10 a.m. to 3:00 p.m., e.t.

Instructions: All submissions must include the Agency's name and the docket number for this Request for Information (OSHA-2016-0014). OSHA will place comments and other material, including any personal information, in the public docket without revision, and these

materials will be available online at <http://www.regulations.gov>. Therefore, OSHA cautions commenters about submitting statements they do not want made available to the public and submitting comments that contain personal information (either about themselves or others) such as Social Security numbers, birth dates, and medical data.

If you submit scientific or technical studies or other results of scientific research, OSHA requests (but is not requiring) that you also provide the following information where it is available: (1) identification of the funding source(s) and sponsoring organization(s) of the research; (2) the extent to which the research findings were reviewed by a potentially affected party prior to publication or submission to the docket, and identification of any such parties; and (3) the nature of any financial relationships (e.g., consulting agreements, expert witness support, or research funding) between investigators who conducted the research and any organization(s) or entities having an interest in the rulemaking and policy options discussed in this RFI. Disclosure of such information is intended to promote transparency and scientific integrity of data and technical information submitted to the record. This request is consistent with Executive Order 13563, issued on January 18, 2011, which instructs agencies to ensure the objectivity of any scientific and technological information used to support their regulatory actions. OSHA emphasizes that all material submitted to the record will be considered by the Agency if it engages in rulemaking.

Docket: To read or download submissions or other material in the docket, go to: <http://www.regulations.gov> or the OSHA Docket Office at the address above. The <http://www.regulations.gov> index lists all documents in the docket. However, some information (e.g., copyrighted material) is not available publicly to read or download through the Web site.

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FOR FURTHER INFORMATION CONTACT:

Press Inquiries: Frank Meilinger, Director, OSHA Office of Communications, Room N-3647, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210; telephone: 202-693-1999; email: Meilinger.Francis2@dol.gov.

General and technical information: Lyn Penniman, OSHA Directorate of Standards and Guidance, Room N-3609, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210; telephone: 202-693-2245; email: Penniman.lyn@dol.gov.

SUPPLEMENTARY INFORMATION:

Copies of this Federal Register notice: Electronic copies are available at: <http://www.regulations.gov>. This Federal Register notice, as well as news releases and other relevant information, also are available at OSHA's web page at <http://www.osha.gov>.

References and Exhibits (optional): Documents referenced by OSHA in this request for information, other than OSHA standards and Federal Register notices, are in Docket No. OSHA-2016-0014 (Prevention of Workplace Violence in Healthcare). The docket is available at: <http://www.regulations.gov>, the Federal eRulemaking Portal. For additional information on submitting items to, or accessing items in, the docket, please refer to the Addresses section of this RFI. Most exhibits are available at <http://www.regulations.gov>; some exhibits (e.g., copyrighted material) are not available to download from that webpage. However, all materials

in the dockets are available for inspection and copying at the OSHA Docket Office, Room N-3653, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC.

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I. Overview

OSHA is considering whether to commence rulemaking proceedings on a standard aimed at preventing workplace violence in healthcare and social assistance workplaces perpetrated by patients or clients. Workplace violence affects a myriad of healthcare and social assistance workplaces, including psychiatric facilities, hospital emergency departments, community mental health clinics, treatment clinics for substance abuse disorders, pharmacies, community-care facilities, residential facilities and long-term care facilities. Professions affected include physicians, registered nurses, pharmacists, nurse practitioners, physicians' assistants, nurses' aides, therapists, technicians, public health nurses, home healthcare workers, social and welfare workers, security personnel, maintenance personnel and emergency medical care personnel.

OSHA's analysis of available data suggest that workers in the Health Care and Social Assistance sector (NAICS 62) face a substantially increased risk of injury due to workplace violence. Table 1 compiles data from the Bureau of Labor Statistics' (BLS) Survey of Occupational Injuries and Illnesses (SOII). In 2014, workers in this sector experienced workplace-violence-related injuries at an estimated incidence rate of 8.2 per 10,000 full time workers, over 4 times higher than the rate of 1.7 per 10,000 workers in the private sector overall (BLS Table R8, 2015). Individual portions of the healthcare sector have much higher rates. Psychiatric hospitals have incidence rates over 64 times higher than private industry as a whole, and nursing and residential care facilities have rates 11 times higher than those for private industry as a whole. The overall rate for violence-related injuries in just the social assistance subsector was 9.8 per 10,000, and individual industries, such as vocational rehabilitation with

rates of 20.8 per 10,000 full-time workers are higher. In 2014, 79 percent of serious violent incidents reported by employers in healthcare and social assistance settings were caused by interactions with patients (BLS, 2015, Table R3, p. 40).

Table 1

Cases of Intentional Injury by Other Person(s) by Industry Sectors in 2014	Nonfatal injury cases¹	Rate per 10,000 full time workers²
All Private Sector Industries	15,980	1.7
Goods Producing	260	0.1
Service Producing	15,710	2.1
Trade-Transportation-and Utilities	1,950	0.9
Leisure and Hospitality	1,160	1.2
Professional and Business Services	470	0.3
Information	40	0.2
Financial Activities	90	0.1
Other Services, Except Public Administration	80	0.3
Educational and Health Services	11,920	7.7
Educational Services	810	4.4
Health Care and Social Assistance	11,100	8.2
Ambulatory Healthcare Services	960	1.9
Hospitals	3,410	8.9
Nursing and Residential Care Facilities	4,690	18.7
Social Assistance	2,050	9.8

1/BLS Table R4, 2015, <http://www.bls.gov/iif/oshwc/osh/case/ostb4370.pdf>

2/BLS Table R100, 2015, <http://www.bls.gov/iif/oshwc/osh/case/ostb4466.pdf>

BLS relies on employers to report injury and illness data and employers do not always record or accurately record workplace injuries and illnesses (Ruser, 2008; Robinson, 2014; BLS, 2014). In addition, healthcare and social assistance employees may be reluctant to report incidents of workplace violence (see Section V.A.3.b below).

Surveys of healthcare and social assistance workers provide another source of data useful for describing the extent of the problem. In one survey, 21 percent of registered nurses and nursing students reported being physically assaulted in a 12-month period (ANA, 2014). The U.S.

Department of Health and Human Services (HHS) National Electronic Injury Surveillance System-Work Supplement (NEISS-WORK) reported that, of the cases where healthcare workers sought treatment for workplace violence related injuries in 2011 in hospital emergency rooms, patients were perpetrators an estimated 63 percent of the time (US GAO, 2016). Other perpetrators include patients' families and visitors, and co-workers (Stokowski, 2010; BLS Data, 2013).

A survey of 175 licensed social workers and 98 agency directors in a western state found that 25 percent of social workers had been assaulted by a client, nearly 50 percent had witnessed violence in a workplace, and more than 75 percent were fearful of violent acts (Rey, 1996). A similar survey of a national sample of 633 workers randomly drawn from the National Association of Social Workers Membership Directory reported that 17.4 percent of the respondents reported being physically threatened, and 2.8 percent being assaulted. Verbal abuse was prevalent and was reported by 42.8 percent respondents (Jayaratne *et al.*, 1996).

Though non-fatal injuries predominate by a large extent, homicides accounted for 14 fatalities in healthcare and social service settings that occurred in 2014, and 10 that occurred in 2013 (BLS SOII and CFOI Data, 2011-2014).¹

This RFI is focused on workplace violence occurring in health care and social assistance for several reasons. While workplace violence occurs in other industries, health care services and social assistance services have a common set of risk factors related to the unique relationship between the care provider and the patient or client. The complex culture of healthcare and social assistance, in which the health care provider is typically cast as the patient's advocate, increases

¹ Many of the deaths in the healthcare setting involved a shooting, with many perpetrated by someone the worker knew, such as a domestic partner or coworker (US GAO, 2016). While such incidents often garner media attention, they are not the typical foreseeable workplace violence incidents that are associated with predictable risk factors that employers can reduce or eliminate. OSHA does not intend to address these types of incidents in any rulemaking activity.

resistance to the notion that healthcare workers are at risk for patient-related violence (McPhaul and Lipscomb, 2004). In addition, the number of healthcare and social assistance workers is likely to grow as the sector is a large and growing component of the U.S. economy.

OSHA has a history of providing guidance to employees and employers in this sector since 1996 (see Sections II and V). In addition, a body of knowledge has emerged in recent years from research about the factors that increase the risk of violence and the interventions that mitigate or reduce the risk in health care and social assistance. As a result, workplace violence is recognized as an occupational hazard for healthcare and social assistance, which, like other hazards, can be avoided or minimized when employers take appropriate precautions to reduce risk factors that have been shown to increase the risk of violence. See Section V.A.2., Worksite analysis and hazard identification, for a discussion of risk factors.

Though OSHA has no intention of including violence that is solely verbal in a potential regulation, the Agency does ask a series of questions about threats that could reasonably be expected to result in violent acts. These threats could be verbal or written, or could be marked by body language.

In order to chart the best course going forward and inform OSHA's approach to this hazard, OSHA has posed a number of detailed questions for comment throughout the RFI. To make the best decisions about OSHA's next steps in this area, the questions posed are designed to better elucidate these general subjects:

- The scope of the problem in healthcare and social assistance – frequency of incidents of workplace violence, where those incidents most commonly occur, and who is most often the victim in those incidents;
- The common risk factors that could be addressed;

- Interventions and controls that data show are working already in the field;
- The efficacy, feasibility and cost of different options.

The remainder of the RFI is organized as follows. Section II provides background on the growing awareness of the problem of workplace violence in health care and social assistance, and steps taken to date by OSHA, states, and the private sector. Section III discusses and seeks information on definitional issues. Section IV provides an overview of current data on the problem of workplace violence in the health care and social assistance sectors, and seeks input on a potential scope for a standard. Using OSHA’s workplace violence guidelines as a starting point, Section V discusses the elements of a workplace violence prevention program that might be included in a standard, and asks for public input on these elements. Finally, Section VI seeks input on costs and economic impacts, and Section VII contains the references relied on by OSHA in preparing this RFI.

II. Background

A. OSHA’s prior actions to protect healthcare and social assistance workers from workplace violence

1. Guidelines for Preventing Workplace Violence for Healthcare and Social Assistance

Protecting healthcare and social assistance workers from workplace violence is not a new focus for OSHA. In 1996, OSHA published the first version of its “Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers.” The same year, NIOSH published and broadly disseminated its document describing violence as an occupational hazard in the healthcare workplace, as well as risk factors and prevention strategies for mitigating the hazard (NIOSH, 1996). In 2002, NIOSH published a report entitled “Violence: Occupational

Hazards in Hospitals” (NIOSH, 2002). The current revision of OSHA’s violence prevention guidelines (2015) is at: <http://www.osha.gov/Publications/osh3148.pdf>.

OSHA’s Guidelines are based on industry best practices and feedback from stakeholders, and provides recommendations for policies and procedures to eliminate or reduce workplace violence in a range of healthcare and social services settings. Information on five settings was included in the updated guidelines: hospital settings, residential treatment settings, non-residential treatment/services settings, community care settings, and field work settings. In addition, the updated 2015 version covers a broader spectrum of workers in comparison with previously published guidelines because healthcare is increasingly being provided in other settings such as nursing homes, free-standing surgical and outpatient centers, emergency care clinics, patients’ homes, and pre-hospitalization emergency care settings.

The Guidelines recommend a comprehensive violence prevention program that consists of five core elements or “building blocks”: (1) management commitment and employee participation; (2) worksite analysis; (3) hazard prevention and control; (4) safety and health training; and (5) recordkeeping and program evaluation. These elements are discussed further in Section V below. While these guidelines provide much detailed, research-based information on specific controls and strategies for various healthcare and social assistance settings to help employers and employees prevent violence, they are recommendations and therefore non-mandatory.

Lipscomb and colleagues (2006) report the results of a participatory intervention study that implemented and then evaluated violence prevention programs that were based on the 1996 OSHA Guidelines in three New York state mental health facilities. The New York State Office of Mental Health (OMH), working through its labor-management health and safety committee

established a policy requiring all 26 in-patient OMH facilities to develop and implement a proactive violence-prevention program. Recognizing the opportunity for a “natural” experiment, the study investigators chose three “intervention” and “comparison” sites, with the intervention sites benefitting from consultation with the study team and with the project’s New York State-based violence-prevention coordinator. The intervention had three main components: 1) implementation of a facility-specific violence prevention program; 2) conducting a risk assessment; and 3) designing and implementing feasible recommendations evolving from the risk assessment. The OSHA elements of management commitment and employee involvement, worksite analysis, hazard control and prevention, and training were operationalized within the project. The authors stated that the guideline’s emphasis on management commitment and employee involvement was critical to the successful implementation of the program. Program impact was evaluated through focus groups and surveys. A comparison of pre- and post-intervention survey data indicate an improvement in staff perception of the quality of the facility’s violence-prevention program (*i.e.*, OSHA elements) in both intervention and comparison facilities.

In 2015, OSHA also published a complementary webpage, “Caring for Our Caregivers: Strategies and Tools for Workplace Violence Prevention in Healthcare” containing resources and tools to help healthcare facilities develop and implement a workplace violence prevention program, located at: https://www.osha.gov/dsg/hospitals/workplace_violence.html. The focus of this guidance is primarily hospitals and behavioral health facilities, and the content was developed from examples shared with OSHA by healthcare facilities with various components of successful violence prevention programs.

2. Enforcement Directive

Although OSHA has no standard specific to the prevention of workplace violence, the Agency currently enforces Section 5(a)(1) (General Duty Clause) of the OSH Act against employers that expose their workers to this recognized hazard. Section 5(a)(1) states that employers have a general duty to furnish to each of its employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to its employees (29 U.S.C. 654(a)(1)). Section 5(a)(1) does not specifically prescribe how employers are to eliminate or reduce their employees' exposure to workplace violence. A standard on workplace violence would help clarify employer obligations and the measures necessary to protect employees from such violence.

To prove a violation of the General Duty Clause, OSHA must provide evidence that: 1) the employer failed to keep the workplace free of a hazard to which its employees were exposed; 2) the hazard was recognized; 3) the hazard was causing or likely to cause death or serious injury; and 4) a feasible and useful method was available to correct the hazard.

Prior to 2011, federal OSHA rarely used the General Duty Clause to inspect and cite healthcare and social assistance facilities for the hazard of workplace violence, in part because no guidance existed on how to conduct such an inspection. In September 2011, OSHA took an important step toward beginning to address workplace violence in healthcare and other high-risk settings by publishing a compliance Directive CPL 02-01-052 (https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-01-052.pdf), detailing potential hazards in those settings and providing OSHA compliance officers with enforcement guidance to respond to complaints regarding the hazard of workplace violence. The Directive provides guidance on how a workplace violence enforcement case should be developed and what steps Area Offices

should take to assist employers in addressing this hazard. The Agency is currently in the process of updating and revising its Directive.

A relatively small percentage of the inspections related to workplace violence in health care facilities resulted in general duty clause citations. From 2011 through 2015, OSHA inspected 107 hospitals (NAICS code 622) and nursing and residential care facilities (NAICS code 623) and issued 17 general duty clause citations to healthcare employers for failing to address workplace violence (OSHA Enforcement Data).

B.State Laws

As of August 2015, nine states had enacted laws that require employers who employ healthcare and/or social assistance workers to establish a plan or program to protect those workers from workplace violence: California, Connecticut, Illinois, Maine, Maryland, New Jersey, New York, Oregon, and Washington (US GAO, 2016). State laws differ widely in definitions of workplace violence, requirements and scopes of facilities covered. For example, Washington and New Jersey cover the healthcare sector broadly, while Maine covers only hospitals and Illinois covers only developmental disabilities and mental health centers. Eight state laws require worksite risk assessment to identify hazards that may lead to violent incidents; however, not all state regulations specify how to conduct a risk assessment. Only Maine does not have a requirement for a risk assessment. All the states but Maine also require violence prevention training, although requirements differ in frequency and format of training, as well as the occupations of the employees required to be trained. All nine states require healthcare employers to record incidents of violence against workers. Some laws apply specifically to healthcare settings (e.g., Washington Labor and Industries' RCW 49.19), while others apply more broadly to cover additional industries or sectors. New York is the only state that operates its own OSHA program that has a standard that specifically requires a violence prevention

program; however, coverage is limited to public employees. California law requires hospitals to conduct security and safety assessments, and to use the assessment to develop and update a security plan (California Health and Safety Code Section 1257.7). Also, as of 1991, Cal/OSHA's Workplace Injury and Illness Prevention standard requires a program to address and prevent known occupational hazards, including violence.

Tragic events are often the impetus for legislation. Such was the case when a psychiatric technician was strangled on the Napa State Hospital grounds by a patient in November 2010. (<http://articles.latimes.com/2010/nov/03/local/la-me-hospital-violence-20101103>). In February 2014, two healthcare worker unions, the Service Employees International Union (SEIU) and SEIU Nurse Alliance of California, filed petitions requesting the California Occupational Safety and Health Standards Board to adopt a new standard that would provide more protections to healthcare workers, specifically against workplace violence.

In June 2014, California's Board requested the Division of Occupational Safety and Health to convene an advisory committee and develop a proposal for workplace violence protection standards. In September 2014, the governor signed Senate Bill (SB) 1299, requiring the Board to adopt standards developed by the Division that would require facilities to adopt a workplace violence prevention plan as part of their injury and illness prevention plan. On October 20, 2016, California announced the adoption of those standards, and became the first state to promulgate an occupational health and safety standard requiring healthcare facilities to take certain specific steps to establish, implement and maintain an effective workplace violence prevention plan. Implementation will begin in 2017.

Some studies in the published literature evaluated whether healthcare facilities located in states with state laws have higher quality violence prevention programs than in states with no

requirements, as a measure of the value or efficacy of state laws (Peek-Asa et al., 2007; Peek-Asa et al., 2009, Casteel et al., 2009). Peek-Asa et al. (2007) compared workplace violence programs in high-risk emergency departments among a representative sample of hospitals in California (a state with a violence prevention law) and New Jersey (which at the time of the study did not have such a law). California had significantly higher scores for training, policies and procedures, but there was no difference in the scoring for security and environmental approaches. Program component scores were not highly correlated. For example, hospitals with a strong training program were not more likely to have strong policies and procedures. The authors concluded that a comprehensive approach that coordinates the components of training, policies, procedures, environmental approaches, and security is likely to be achieved only through multidisciplinary and representative input from the staff and management (Peek-Asa et al., 2007).

Two years later, the same authors (Peek-Asa et al., 2009) conducted studies that compared workplace violence programs in a representative sample of psychiatric units and facilities in California and New Jersey. The researchers found that a similar proportion of hospitals in both states had workplace violence prevention training programs. A higher proportion of hospitals in California had written workplace violence policies and a higher proportion of New Jersey hospitals had implemented environmental and security modifications to reduce violence.

One study examined the effects of a state law on workers' compensation costs, and supports the conclusion that Washington State's efforts to reduce workplace violence in the healthcare industry have led to lower injury rates and workers' compensation costs. From 1997 to 2007, the state's average annual rate of workers' compensation claims associated with workplace violence in the healthcare and social assistance industry was 75.5 per 10,000 full-time

equivalent workers (FTEs). From 2007 to 2013, the rate had fallen to 54.5 claims per 10,000 FTEs, a decrease of 28 percent. This improvement coincides with Washington’s 2009 rule that required hazard assessments, training, and incident tracking for workplace violence (Foley, and Rauser, 2012).

C. Recommendations from Governmental, Professional and Public Interest Organizations

In response to a request from members of Congress, the GAO conducted an investigation of OSHA’s efforts to protect healthcare workers from workplace violence in healthcare. The investigation focused on healthcare, and included residential care facilities and home health care services.

During its investigation, GAO identified nine states with workplace violence prevention requirements for healthcare employers, examined workplace violence incidents, conducted a literature review, and interviewed OSHA and state officials. The final report, published in April 2016, included a summary of interviews of healthcare workers, who described a range of violent encounters with patients. See the table below for details.

Table 2

Examples of Workplace Violence Incidents Reported by the Health Care Workers GAO Interviewed	
Health care facilities	Examples of reported workplace violence incidents
Hospitals with emergency rooms	<ul style="list-style-type: none"> • Worker hit in the head by a patient when drawing the patient’s blood and suffered a concussion and a permanent injury to the neck • Worker knocked unconscious by a patient when starting intravenous therapy on the patient
Psychiatric hospitals	Worker punched and thrown against a wall by a patient and had to have several surgeries. As a result of the injuries, the

	<p>worker was unable to return to work.</p> <ul style="list-style-type: none"> •Patient put worker in a head-lock, and worker suffered neck pain and headaches and was unable to carry out regular workload •Patient broke healthcare worker’s hand when the healthcare worker intervened in a conflict between two patients
Residential care facilities	<ul style="list-style-type: none"> •Patient became upset after being deemed unfit to return home and attacked the worker •Worker hit in the head by a patient and suffered both physical and emotional problems as a result of the incident
Home health care services	<ul style="list-style-type: none"> •Worker attacked by patient with dementia and had to defend self •Worker was sexually harassed by a patient when the patient grabbed the worker while rendering care

Source: GAO, Workplace Safety and Health: Additional Efforts Needed to Help Protect Healthcare Workers from Workplace Violence, 2016.

In its final report, the GAO recommended that OSHA provide additional information to assist inspectors in developing citations, develop a policy for following up on hazard alert letters concerning workplace violence hazards in healthcare facilities, and assess the results of its efforts to determine whether additional action, such as development of a standard, may be needed.

OSHA agreed with the GAO’s recommendations and stated that it would take action to address them. Since then, OSHA’s Training Institute in the Directorate of Training and Education developed a course on Workplace Violence Investigations for its Compliance Safety and Health Officers (CSHOs) and other staff with responsibilities in this area. In June 2016, approximately 30 CSHOs, Area Directors, Acting Area Directors, and other OSHA staff, participated in the first offering of the 3-day course on workplace violence, which included exercises using actual scenarios encountered by investigators. The Agency’s publication of this RFI is in part a response to the GAO’s recommendation to consider issuance of a standard addressing workplace violence. OSHA will review the record developed as a result of the information received and decide on the appropriate course of action regarding a standard.

In July 2016, a coalition of unions representing healthcare workers, including SEIU, AFL-CIO, and the American Federation of Governmental Employees, petitioned the Agency for a Workplace Violence Prevention Standard. National Nurses United (NNU) filed a similar petition. While NNU petitioned the Agency for a standard covering its membership only (healthcare workers), the broader coalition of labor unions requested a standard covering all workers in healthcare and social assistance. By this time, the Agency had already made the public aware about the publication of an RFI by November 2016, via the Unified Regulatory Agenda.

In recent years, several nursing professional associations have published statements on workplace violence (ANA, 2015; APNA, 2008; ENA, 2010). In addition, the ANA has published a model state law, “The Violence Prevention in Health Care Facilities Act,” recommending that healthcare facilities establish violence prevention programs to protect healthcare workers from acts of violence (ANA, 2011).

Some organizations have recommended specific programmatic elements, policies, procedures and processes to reduce and prevent workplace violence. In 2008, APNA published recommendations for addressing workplace violence. In 2011, it published a report that included recommendations for adequate staffing, increased security, video monitoring, and safe areas for nurses (Cafaro, 2012; <http://www.apna.org/i4a/pages/index.cfm?pageID=4912#sthash.2JKbjy3w.dpuf>). The American Association of Occupational Health Nurses, Inc. has published strategies for preventing workplace violence. It also noted the problem of underreporting of workplace violence events, which it recommended should be addressed so that “the scope of non-fatal violence in the

workplace” is adequately measured and in turn “informed targeted prevention strategies” are developed (AAOHN, 2015).

In 2013, Public Citizen published “Health Care Workers Unprotected; Insufficient Inspections and Standards Leave Safety Risks Unaddressed,” which recommended that OSHA promulgate a standard to address the hazardous situations of workplace violence. Based on their analysis of data from the Bureau of Labor Statistics, the U.S. Census Bureau, OSHA, the AFL-CIO, and The Kaiser Family Foundation, they recommended that such a standard should require employers to create a policy of zero tolerance for workplace violence, including verbal and nonverbal threats; require workplace policies that encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks; provide protections to employees to deter employers from retaliating against those who report workplace-violence incidents; and require employers to develop a comprehensive plan for maintaining security in the workplace (Public Citizen, 2013).

The Society for Human Resource Management’s (SHRM) Workplace Violence Policy provides guidance on prohibited conduct, reporting procedures, risk reduction measures, employees at risk, dangerous/emergency situations, and enforcement for human resource professionals.

D. Questions for Section II

The following questions are intended to solicit information on the topics covered in this section. In general, OSHA is interested in hearing about healthcare facilities’ experiences with provisions of state laws that have been shown to be effective in some way. Wherever possible, please indicate the title of the person completing the question and the type and the number of employees at your facility. OSHA is also interested in hearing from employers and managers in

public sector facilities in New York State about their experiences with the Public Employees Safety and Health workplace violence prevention regulations.

Question II.1: What state are you employed in or where is your facility located? If your state has a workplace violence law, what has been your experience complying with these requirements? Are there any specific provisions included in your workplace violence law that you think should or should not be included in an OSHA standard? If so, what provisions and why?

Question II.2: For employers and managers: If your state has a workplace violence prevention law, have you or are you conducting an evaluation of the effectiveness of its programs or policies? If you are conducting such an analysis, how are you doing it? Have you been able to demonstrate improved tracking of workplace violence incidents and/or a change in the frequency or severity of violent incidents? If you think it is effective, please explain why. If you think it is ineffective, please explain why.

Question II.3: If your state has workplace violence prevention laws, how many hours do you spend each year (month) complying with these laws?

Question II.4: Please specify the number or percentage of staff participating in workplace violence prevention activities required under your state laws.

Question II.5: Do you have experience implementing any of the workplace violence prevention practices recommended by the American Psychiatric Nurses Association (APNA), American Association of Occupational Health Nurses (AAOHN), or similar organizations? If so, please discuss the resources it took to implement the practice, and whether you think the practice was effective. Please provide any data you have to support your conclusions.

III. Defining workplace violence

A. Definition and types of events under consideration

As discussed in the overview above, the data show that injuries and fatalities in the health care and social assistance sector due to workplace violence are substantially elevated compared to the private sector overall. This section addresses the question of how to define the universe of workplace violence that OSHA might cover in a standard. This involves at least two issues: (1) what events constitute “violence” (i.e., should physical assaults be covered only, or should threats be considered as well?); and (2) should there be consideration of the type of injury (physical, psychological) and a threshold for harm that could be sustained as a result of the activity.

The National Institute of Occupational Safety and Health (NIOSH) defines workplace violence as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty” (<https://www.cdc.gov/niosh/docs/2002-101/>). Examples of violence include threats (expressions of intent to cause harm, including verbal threats, threatening body language, and written threats), physical assaults (attacks ranging from slapping and beating to rape, homicide, and the use of weapons such as firearms, bombs, or knives), and muggings (aggravated assaults, usually conducted by surprise and with intent to rob) (NIOSH at: <http://www.cdc.gov/niosh/docs/2002-101/default.html>). OSHA’s web page refers to “workplace violence” as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. Both the NIOSH definition and the general one on OSHA’s website include harassment and intimidation; however, OSHA’s focus has been solely on physical injuries resulting in serious harm. The effects of violence on individuals represent a range in intensity and include minor physical injuries; serious physical injuries; temporary and permanent physical disability; psychological trauma; and death. Healthcare and social assistance workers involved in workplace violence incidents can suffer physical injury, disability, and chronic pain; employees who experience violence also suffer psychological problems such as loss of sleep, nightmares, and flashbacks (Gerberich *et al.*, 2004).

Further, workplace violence can be classified into the following four categories, based on the relationship between the perpetrator and the victim/worker: Type I (criminal intent; the perpetrator has no legitimate relationship to the business), Type II (customer/client/patient), Type III (worker-on-worker), and Type IV (personal relationship) (UIIPRC, 2001). Type II events occur most commonly in healthcare and social assistance and these events are the type

addressed by this RFI. Type III (sometimes referred to as “lateral violence”) is also commonly reported in the literature, especially when taking verbal abuse into account.

OSHA intends to address only Type II, or customer/client/patient violence in this RFI. Type I, or criminal intent, perpetrated by criminals with no connection to the workplace other than to commit a crime, typically does not apply the healthcare environment. OSHA does not intend to seek information specific to Type I or Type III incidents, “lateral” or “worker-on-worker” violence. In addition, OSHA does not intend to cover Type IV incidents or violence that happen to be carried out in a healthcare workplace but are based on personal relationships. Although such incidents often garner media attention, they are not the typical foreseeable workplace violence incidents that are associated with predictable risk factors in the workplace that employers can reduce or eliminate. OSHA has determined that Type I, III and IV incidents are generally outside the scope of any potential rulemaking activity stemming from this RFI.

B. Questions for Section III

The following questions are intended to solicit information on the topics covered in this section. Wherever possible, please indicate the title of the person providing the information and the type and number of employees of your healthcare and/or social assistance facility or facilities.

Question III.1: CDC/NIOSH defines workplace violence as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty” (CDC/NIOSH, 2002). Is this the most appropriate definition for OSHA to use if the Agency proceeds with a regulation?

Question III. 2: Do employers encourage reporting and evaluation of verbal threats? If so, are verbal threats reported and evaluated? If evaluated, how do employers currently evaluate verbal threats (i.e., who conducts the evaluation, how long does such an evaluation take, what criteria are used to evaluate verbal threats, are such investigations/evaluations effective)?

Question III.3: Though OSHA has no intention of including violence that is solely verbal in a potential regulation, what approach might the Agency take regarding those threats, which may include verbal, threatening body language, and written, that could reasonably be expected to result in violent acts?

Question III.4: Employers covered by OSHA's recordkeeping regulation must record each fatality, injury or illness that is work-related, that is a new case and not a continuation of an old case, and meets one or more of the general recording criteria in section 1904.7 or the additional criteria for specific cases found in section 1904.8 through 1904.11. A case meets the general recording criteria in section 1904.7 if it results in death, loss of consciousness, days away from work or restricted work or job transfer, or medical treatment beyond first aid. What types of injuries have occurred from workplace violence incidents? Do these types of injuries typically meet the OSHA criteria for recording the injury on the 300 Log?

Question III.5: Currently, a mental illness sustained as a result of an assault in the workplace, e.g., Posttraumatic Stress Disorder (PTSD), is not required to be recorded on the OSHA 300 Log "unless the employee voluntarily provides the employer with an opinion from a physician or other licensed healthcare professional with appropriate training and experience (psychiatrist, psychologist, psychiatric nurse practitioner, etc.) stating that the employee has a mental illness that is work-related (1904.5(b)(2)(ix))." Although protecting the confidentiality of the victim is important, an unintended consequence of omitting these incidents from the 300 Log is that the extent of the problem is likely underestimated. In a workplace violence prevention standard, should this exclusion be maintained or be removed? Is there a way to capture the information about cases, while still protecting confidentiality?

Question III.6: Are you aware of cases of PTSD or psychological trauma related to workplace violence in your facility? If so, was it captured in the recordkeeping system and how? Please provide examples, omitting personal data and information.

Question III.7: Are there other indicators of the extent and severity of workplace violence in healthcare or social assistance that OSHA has not captured here? Please provide any additional data that you are aware of, or any indicators you have used in your workplace to address workplace violence.

IV. Scope

A. Health Care and Social Assistance

The Health Care and Social Assistance sector is composed of a wide range of establishments providing varying levels of healthcare and social assistance services, from general medical-surgical hospitals to at-home patient care to treatment facilities for substance abuse disorders, and different types of establishments providing social assistance, such as child day care services, vocational rehabilitation and food to the needy. In 2015 the healthcare industry had a total of 1,432,801 establishments and employed 18,738,870 workers in both healthcare and non-healthcare occupations (BLS, Census of Employment and Wages, 2016 and Occupational Employment Statistics, 2015). The Health Care and Social Assistance sector provides a range of services employing a diverse group of occupations at places such as; nursing homes, free-standing surgical and outpatient centers, emergency care clinics, patients' homes, and pre-hospitalization emergency care settings. The largest occupational group employed in the Health Care and Social Assistance industry are healthcare practitioners (defined as healthcare professionals, technicians, and healthcare support workers), which included 6,288,040 workers in 2015, an increase of 1.2 million workers over the past 10 years (BLS, Occupational

Employment Statistics, 2016). Healthcare practitioners are employed across various industries, but the industry with the largest concentration of healthcare practitioners is General Medical and Surgical Hospitals, which employed 2,926,350 workers in 2015.

Table 3

Top 5 Occupations in Healthcare and Social Assistance Industry between 2005 and 2015		
	2005	2015
Healthcare and social assistance industry	15.2 million	18.7 million
Healthcare practitioners and technical occupations	5.1 million	6.3 million
Healthcare support occupations	2.9 million	3.5 million
Office and administrative support occupations	2.5 million	2.7 million
Personal care and service occupations	1.0 million	1.9 million
Community and social services occupations	0.8 million	1.0 million

BLS, Occupational Employment Statistics, April 2016

Across all industries there were 8.0 million Health Care Practitioners and Technical workers employed in 2015 and can be found in various parts of the private sector outside of the Health Care and Social Assistance sector, for example in Air Transportation, Accommodations, Recreation, and Retail Trade. Of the almost 8.0 million Healthcare Practitioners and Technical workers, 515,970 are employed at retail trade facilities, the majority are at specifically at Health and Personal Care Stores.

For purposes of assessing workplace violence risk, OSHA has used the BLS category of Intentional Injury by Other Person. OSHA has not included here the BLS category of Injury by Person – Unintentional or Intent Unknown. That category may include some incidents classifiable as workplace violence, but also includes large numbers of injuries resulting from such causes like attempting to lift patients. Unintentional injuries resembling workplace violence may also be common in mental health services. Of the almost 16,000 cases of

Intentional Injury by Other Persons in the private sector in 2014, 11,100 were in the Healthcare and Social Assistance sector (BLS Table R4, November 2015).

The rate of intentional injury in the Healthcare and Social Assistance sector as a whole was 8.2 per 10,000 full time workers, over four times the rate across all private industry, 1.7 per 10,000 full-time workers in 2014 (BLS Table R8, November 2015). Within the Healthcare and Social Assistance sector, the incident rates for Intentional Injury by Other Person(s) ranges from a low of 0.4 per 10,000 full-time workers in Offices of Physicians (lower than private industry as a whole) to a high of 109.5 per 10,000 full-time workers in Psychiatric and Substance Abuse Hospitals² (BLS Table R8, November 2015). Of the four major subsectors within Health Care and Social Assistance in 2014, the highest incident rate of Intentional Injury by Other Person(s) was 18.7 per 10,000 in Nursing and Residential Care Facilities. The incident rates for the next two highest subsectors, Hospitals, and Social Assistance were half that of Nursing and Residential Care Facilities, 8.9 and 9.8 respectively. The subsector of Nursing and Residential Care Facilities includes establishments providing services to a diverse population of patients, many of whom need a higher level of care at these facilities. In contrast, the services provided in the other areas of the Health Care and Social Assistance sector may typically involve more routine health care services requiring less physically demanding care from staff. This wide range reflects the diversity of workplace conditions and patient interactions faced by workers in the Health Care and Social Assistance economic sector.

² The term “Substance Abuse Hospital” is used because it is the official designation in the NAICS code manual for such facilities.

Table 4

Incident rate for Violence and Other Injuries by Private Industry in the United States per 10,000 full time workers in 2014	
	Intentional injury by other person
All Private Industry	1.7
Health care and social assistance	8.2
Ambulatory health care services	1.9
Offices of physicians	0.4
Offices of physicians except mental health	0.3
Offices of mental health physicians	8.5
Offices of other health practitioners	-
Outpatient care centers	4.1
Medical and diagnostic laboratories	5.6
Home health care services	5.0
Other ambulatory health care services	3.1
Ambulance services	5.3
All other ambulatory health care services	-
Hospitals	8.9
General medical and surgical hospitals	6.7
Psychiatric and substance abuse hospitals	109.5
Other hospitals	7.3
Nursing and residential care facilities	18.7
Nursing care facilities	15.8
Residential mental health facilities	34.9
Community care facilities for the elderly	7.2
Other residential care facilities	39.9
Social assistance	9.8
Individual and family services	10.2
Child and youth services	4.0
Services for the elderly and disabled	11.0
Emergency and other relief services	-
Community housing services	-
Vocational rehabilitation services	20.8
Child day care services	6.5

(BLS Table R8, November 2015)

Note: Dash indicates data do not meet BLS publication guidelines for their Survey of Occupational Injuries and Illnesses

The industries in the Social Assistance subsector provide a wide variety of services directly to clients, and include industries with incident rates of intentional injury that are higher

than those in the Ambulatory Health Care sector. The highest incident rate within this sector for intentional injury by other person was in Vocational Rehabilitation Services with 20.8 per 10,000 full time workers in 2014. The next highest industry in this sector was Services for the Elderly and Disabled with an incident rate of 11 per 10,000 full time workers. This sector includes, among other industries, services for children and youth, the elderly, and persons with disabilities; community food and housing services; vocational rehabilitation; and day care centers. Consequently, the risk of workplace violence to healthcare workers differs depending on the nature of the setting and the level of interaction with patients.

The severity of workplace violence in the Health Care and Social Assistance sector is even greater in state government entities where the incident rate for intentional injury by other person(s) in 2014 was 79.3 per 10,000 full time workers. Across state government sectors the incident rate for intentional injury by other persons in the Health Care and Social Assistance sector is the highest even compared to the sector for Public Administration at 10.5 per 10,000 full time workers, which includes Police Protection and Correctional Institutions. State-run healthcare facilities often serve individuals with fewer available health care options and populations with fewer preventive healthcare services. State-run healthcare and social assistance facilities may face unique challenges compared to the private sector.

Table 5

Incident rate for Violence and Other Injuries by Select State Industries in the United States per 10,000 full time workers in 2014	
	Intentional Injury by Other Person
ALL STATE GOVERNMENT	15.8
SERVICE PROVIDING	16.2
Healthcare and Social Assistance	79.3
Hospitals	97.4
Nursing and Residential Care Facilities	116.8
Public Administration	10.5

Justice, Public Order, and Safety Activities	23.1
Police Protection	8.7
Correctional Institutions	37.2

BLS Table S8, April 2016

Locally-run health care and social assistance facilities, on the other hand, appear to present risks that are comparable to private facilities, the incident rate of intentional injury by other persons in sector of Healthcare and Social Assistance was 13.1 per 10,000 full time workers. The overall incident rate for the Public Administration sector in local governments is not much lower at 11.1 per 10,000 full time workers.

Table 6

Incident rate for Violence and Other Injuries by Select Local Government Industries in the United States per 10,000 full time workers in 2014	
	Intentional Injury by Other Person
ALL LOCAL GOVERNMENT	8.7
SERVICE PROVIDING	8.8
Healthcare and Social Assistance	13.1
Hospitals	13.0
Nursing and Residential Care Facilities	39.9
Public Administration	11.1
Justice, Public Order, and Safety Activities	22.5
Police Protection	36.8
Fire Protection	7.1

BLS Table L8, April 2016

Another way to consider the data is by occupation. Nursing-Psychiatric and Home Health Aides (which includes Psychiatric Aids and Nursing Assistants) had the highest rates of violence in 2014 across three of the four sectors. Out of the 4,690 injury cases in Nursing and Residential Care Facilities (based on data from BLS provided upon request), 2,640 of the cases

of workplace violence were perpetrated against Nursing-Psychiatric and Home Health Aides in 2014 (BLS SOII 2014 Data, requested June 2016). Across all private industries, the highest rates of incidents for Intentional Injury by Other Person(s) were for Psychiatric Aides at 426.4 per 10,000 full time workers, followed by Psychiatric Technicians at 206.8 per 10,000 full time workers in 2014 (BLS Table R100, November 2015). These two occupations reflect the highest rates of intentional injury by other person(s) that occurs in the major sector of healthcare practitioners and technical occupations.

Table 7

Cases of Intentional Injury by Other Person(s) by Industry and Occupation in 2014		2014
All Private Sector Industries		15,980
Goods Producing		260
Service Producing		15,710
Healthcare and Social Assistance		11,100
Ambulatory Healthcare Services		960
	Counselors- Social Workers- and Other Community and Social Service Specialists	100
	Health Diagnosing and Treating Practitioners	150
	Health Technologists and Technicians	230
	Nursing- Psychiatric- and Home Health Aides	290
	Occupational Therapy and Physical Therapist Assistants and Aides	-
	Other Personal Care and Service Workers	100
Hospitals		3,410
	Counselors- Social Workers- and Other Community and Social Service Specialists	180
	Health Diagnosing and Treating Practitioners	1,110
	Health Technologists and Technicians	610
	Other Healthcare Practitioners and Technical Occupations	20
	Nursing- Psychiatric- and Home Health Aides	1,030
	Occupational Therapy and Physical Therapist Assistants and Aides	-
	Other Personal Care and Service Workers	100
Nursing and Residential Care Facilities		4,690
	Counselors- Social Workers- and Other Community and Social Service Specialists	370
	Health Diagnosing and Treating Practitioners	170

	Health Technologists and Technicians	310
	Nursing- Psychiatric- and Home Health Aides	2,640
	Occupational Therapy and Physical Therapist Assistants and Aides	
	Other Personal Care and Service Workers	770
	Social Assistance	2,050
	Counselors- Social Workers- and Other Community and Social Service Specialists	190
	Health Diagnosing and Treating Practitioners	30
	Health Technologists and Technicians	-
	Nursing- Psychiatric- and Home Health Aides	150
	Other Personal Care and Service Workers	1,060

BLS SOII 2014 Data, requested June 2016

Note: Dash indicates data do not meet BLS publication guidelines for their Survey of Occupational Injuries and Illnesses

Violence in the workplace is a topic that has been studied heavily using different data sources such as workers' compensation data, and occupation specific surveys. The results from these studies highlight similar findings to that of BLS's SOII data by industry, both showing that workplace injury rates of workers in the healthcare industry rank among the highest across private sector industries. In one study, Washington State workers compensation data was evaluated for the period between 1997 and 2007 (Foley, and Rauser, 2012). The results showed that the industry sectors with the highest rates of workplace violence were Health Care and Social Assistance (75.5 claims per 10, 000 FTEs), Public Administration (29.9 per 10,000 FTEs), and Educational Services (15.0 claims per 10,000 FTEs). Within the Health Care and Social Assistance sector, the industry groups with the highest estimated claim rates were Psychiatric and Substance Abuse Hospitals³ at 875 per 10,000 FTEs, and Residential Mental Retardation, Mental Health and Substance Abuse Facilities at 749 per 10,000 FTEs. The rates of these two Health Care and Social Assistance groups are 65 times and 56 times the overall

³ The term "Substance Abuse Hospital" is used because it is the official designation in the NAICS code manual for such facilities.

claim rate of 13.4 per 10,000 FTEs for workplace violence in all industries. A study that surveyed staff in a psychiatric hospital (Phillips, 2016) found that 70 percent of staff reported being physically assaulted within the last year. Another study that surveyed over 300 staff in a psychiatric hospital found that ward staff, which had the highest levels of patient contact, were more likely than clinical care and supervisory workers to report being physically assaulted by patients (Kelly and Subica, 2015; as reported in US GAO, 2016). Data from HHS' NEISS-Work data set showed that in 2011 the estimated rate of nonfatal workplace violence injuries for workers in healthcare facilities was statistically greater than the estimated rate for all workers. The Department of Justice's National Crime Victimization Survey (NCVS) data set showed that from 2009 through 2013 healthcare workers experienced workplace violence at more than twice the estimated rate for all workers (after accounting for the sampling error). These results consistently point to the healthcare industry and occupations within the healthcare field as having the highest risks to workplace violence compared to other private sector industries.

The four subsectors that make up the Health Care and Social Assistance sector include a wide range of establishments providing varying types of services to the general public, and placing workers at elevated levels of exposure to workplace violence relative to other economic sectors. The Health Care and Social Assistance sector includes industries with the highest rates for Intentional Injury by Other Persons exceeding all other private sector industries.

B. Questions for Section IV

The following questions are intended to solicit information on the topics covered in this section. Wherever possible, please indicate the title of the person completing the question and the type and employee size of your healthcare and/or social assistance facility.

Question IV.1: Rates of workplace violence vary widely within the healthcare and social assistance sector, ranging from extremely high to below private industry averages. How would you suggest OSHA approach the issue of whom should be included in a possible standard? For example, should the criteria for consideration under the standard be certain occupations (e.g., nurses), regardless of where they work? Or is it more appropriate to include all healthcare and social assistance workers who work in certain types of facilities (e.g., in-patient hospitals and long-term care facilities)? Another approach could be to extend coverage to include all employees who provide direct patient care, without regard to occupation or type of facility. If OSHA were to take this approach, should home healthcare be covered?

Question IV.2: If OSHA issues a standard on workplace violence in healthcare, should it include all or portions of the Social Assistance subsector? Are the appropriate preventive measures in this subsector sufficiently similar to those appropriate to healthcare for a single standard addressing both to make sense?

Question IV.3: The only comparative quantitative data provided by BLS is for lost workday injuries. OSHA is particularly interested in data that could help to quantitatively estimate the extent of all kinds of workplace violence problems and not just those caused by lost workday injuries. For that reason, OSHA requests information and data on both workplace violence incidents that resulted in days away from work needed to recover from the injury as well as those that did not require days away from work, but may have required only first aid treatment.

Question IV.4: OSHA requests information on which occupations are at a higher risk of workplace violence at your facility and what about these occupations cause them to be at higher risk. Please provide the job titles and duties of these occupations. Please provide estimates on

how many of your workers are providing direct patient care and the proportion of your workforce this represents.

Question IV.5: The GAO Report relied on BLS SOII data, HHS NEISS data and DOJ NCVS data. Are there any other data sets or data sources OSHA should obtain for better estimating the extent of workplace violence?

Question IV.6: The data provided by BLS are for relatively aggregated industries. Instance of high risk of workplace violence can be found aggregated with industries with low average risk, and low risk of workplace violence within industries with high risk. Please describe if your establishment's experience with workplace violence is consistent with the relative risks reported by BLS in the tables found in this section? If you are in an industry with high rates, are there places within your industry where establishments or kinds of establishments have lower rates than the industry as a whole? If you are in an industry with relatively low rates, are there work stations within establishments or within the industry that have higher rates?

Question IV.7: Are there special circumstances in your industry or establishment that OSHA should take into account when considering a need for a workplace violence prevention standard?

Question IV.8: Please comment if the workplace violence prevention efforts put in place at your establishments are specific to certain settings or activities within the facility, and how they are triggered.

Question IV.9: OSHA has focused on the Health Care and Social Assistance sectors in this RFI. However, workers who provide healthcare and social assistance are frequently found in other industries. Should a potential OSHA standard cover workers who provide healthcare or social assistance in whatever industries they work?

V. Workplace violence prevention programs; risk factors and controls/interventions

A.Elements of Violence Prevention Programs

OSHA has recognized the unique challenges of workplace violence in healthcare and social assistance for decades. OSHA’s “Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers,” which was last updated in 2015 is based on industry best practices and feedback from stakeholders, provides recommendations for policies and procedures to eliminate or reduce workplace violence in a range of healthcare and social assistance settings. The guidelines recommend a comprehensive violence prevention program that covers the following five core elements: (1) management commitment and worker participation; (2) worksite analysis and hazard identification; (3) hazard prevention and control; (4) safety and health training; and (5) recordkeeping and program evaluation. Below, OSHA uses this framework in discussing and seeking information on the elements that might be included in a workplace violence standard. In addition, because there are particular concerns with underreporting of workplace violence in the healthcare and social assistance sector, below OSHA also discusses and seeks information on effectiveness of its whistleblower protection requirements in these sectors.

1.Management commitment and employee participation.

OSHA’s Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers highlight the benefits of commitment by management and establishment of a joint management-employee committee, whether the committee is focused on workplace violence prevention or worker safety more broadly. The structure of the management-employee teams will differ based on the facility’s size and the availability of personnel to staff it.

OSHA is interested in hearing from employers and individuals working in healthcare and social assistance about their experiences with management commitment and employee participation. Specific questions regarding these topics are at the end of Section V.

2. Worksite analysis and hazard identification.

OSHA's guidelines emphasize worksite analysis and hazard identification. A worksite analysis involves a mutual step-by-step assessment of the workplace to find existing or potential hazards that may lead to incidents of workplace violence.

Healthcare and social assistance workers face a number of risk factors that are known to contribute to violence in the workplace. Common risk factors (or factors that have been shown to increase the risk of harm if one is exposed to a hazard) for workplace violence generally fall into two groups: (1) patient, client and setting-related and (2) organizational-related (OSHA, 2015a, p. 4-5). The patient/client and setting-related group includes: a) working directly with people who have a history of violence, especially if they are under the influence of drugs or alcohol or a diagnosis of dementia; b) lifting, moving and transporting patients and clients; c) working alone in a facility or in patients' homes; d) poor environmental design of the workplace that may block employee vision or interfere with escape from a violent incident; poor lighting in hallways, corridors, rooms, parking lots and other exterior areas; e) lack of means of emergency communication; f) long waiting periods for service; or g) working in neighborhoods with high crime rates.

Organizational risks (the second group) arise from workplace policies, or the lack thereof. Examples include a lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff; working when understaffed, especially during mealtimes and visiting hours; inadequate security and mental

health personnel on site; not permitting smoking; allowing unrestricted movement of the public in clinics and hospitals; allowing a perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges; and an overemphasis on customer satisfaction over staff safety (OSHA, 2015a).

Studies show that staff working in some hospital units or areas are at greater risks than others. High-risk areas include emergency departments (EDs), admission areas, long-term care and geriatrics settings, behavioral health, waiting rooms, and obstetrics and pediatrics, among others (DeSanto et al., 2013).

Assault rates for nurses, physicians and other staff working in EDs have been shown to be among the highest (Crilly et al., 2004; Gerberich et al., 2005; Gates et al., 2006; Gacki-Smith et al., 2009). In high volume urban emergency departments and residential day facilities, staff are in frequent contact with patients or family members who may have a history of violence, and/or a history of substance abuse disorders. Also, an increasing number of patients are in possession of handguns and weapons (Stokowski, 2010).

Workers in the healthcare occupations of psychiatric aides, psychiatric technicians, and nursing assistants experienced higher rates of workplace violence compared to other healthcare occupations and workers overall (BLS Table R100, 2015; Pompeii et al., 2015). Some studies have found that nursing assistants in long-term care have the highest incidence of assaults among all workers in the U.S. (Gates et al., 2005).

Surveys of nurses have identified risk factors including patient mental health or behavioral issues, medication withdrawal, pain, history of a substance abuse disorder, and being unhappy with care (Pompeii et al., 2015).

OSHA is interested in hearing from employers and individuals working in healthcare and social assistance about their experiences with worksite analysis and hazard identification, including how they use risk factors. Specific questions regarding these topics are at the end of Section V.

3. Hazard prevention and control

Once workplace violence hazards are identified, controls can be designed and implemented to prevent and control them. OSHA's hierarchy of controls includes: elimination, substitution, engineering controls, administrative controls, and work practices, and personal protective equipment (PPE) in that order. Engineering controls for workplace violence prevention are permanent changes to the work environment. Administrative controls are policies and procedures that reduce or prevent exposure to risk factors. Administrative strategies include modification of job rules and procedures, training and education, scheduling, or modifying assigned duties.

a. Engineering controls

Engineering controls attempt to remove the hazard from the workplace or create a barrier between the worker and the hazard. Examples of engineering controls include the installation of alarm systems, panic buttons, hand-held alarms, or noise devices, installation of door locks and increased lighting or use of closed-circuit video monitoring on a 24-hour basis (Haynes, 2013). Other examples include improvements to the layout of the admission area, nurses' stations and rooms. Where appropriate, some hospitals may have metal detectors installed to detect for guns, knives, box cutters, razors, and other weapons.

Effective interventions that have been described in the literature include K-9 security dog teams, metal detectors, and the installation of a security system, that includes metal detectors,

cameras, and security personnel (Stirling et al., 2001) and increased lighting (Gerberich et al. 2005).

b. Administrative controls

Administrative controls, sometimes referred to as management policies, include organizational factors and can have a major impact on day-to-day operations in healthcare and social assistance, for both staff and patients/residents. For example, staffing issues, such as mandatory overtime and inadequate staffing levels can lead to increased and unscheduled absences, high turnover, low morale and increased risk of violence for both healthcare and social assistance workers and their patients. Adequate numbers of well-trained staff can help ensure that situations with the potential for violence can be diffused before they escalate into full-blown violent incidents, resulting in fewer injuries. Adequate numbers of staff to address the needs of the patients can result in a higher level of safety and comfort for both patients and staff. Effective training can increase staff confidence and control in preventing, managing and de-escalating these incidents, resulting in a greater sense of safety for both staff and patients.

Employer policies often include security measures to prevent workplace violence, including policies for monitoring and maintaining premises security (e.g., access control systems, video monitoring security systems) and data security (e.g., measures to prevent unauthorized use of employer computer systems and other forms of electronic communication by a patient with a history of violence to obtain personal information about a staff member). Many organizations also have policies that limit or monitor access of nonemployees to the premises. Emergency departments (EDs), because they are typically open 24 hours a day, expose hospitals to the community at large and can pose unique safety and security concerns. If the hospital is located in a community or area with a high crime rate, the crime can spill into the ED.

Zero Tolerance policies are policy statements from employers/management that state that any violence to employees and patients/customers will not be tolerated. In general, zero tolerance policies require and encourage staff to report all assaults or threats to a supervisor or manager. Supervisors and managers keep a log of incidents, and all reports of workplace violence are investigated to help determine what actions to take to prevent future incidents. Some studies in the literature describe and discuss the effectiveness of zero-tolerance policies (Nachreiner et al., 2005; Lipscomb and London, 2015).

Policies that encourage employees to report incidents help ensure that hazards are addressed; however, the current evidence shows that many assaults go unreported (Snyder et al., 2007; Bensley et al., 1997; Gillespie et al., 2014; Kowalenko et al., 2013; Arnetz et al., 2015; Speroni et al., 2014; Pompeii et al., 2015).

Research has shown that injured healthcare and social assistance workers and their employers are reluctant to report violent incidents and resulting injuries out of fear of stigmatizing the patients or residents who are the perpetrators of the violence, particularly when they are mentally ill, developmentally disabled, or cognitively impaired elderly. There is also an attitude among many that violence toward those working with the public, especially with individuals with cognitive impairment, mental illness, or brain injury, is part of the job (Lipscomb and London, 2015; Speroni et al., 2014). Confusion on the part of nurses and other staff about what to report, and what legally constitutes “assault” and “abuse” as well as the lack of institutional support for reporting incidents can contribute to under-reporting (May and Grubbs, 2002).

c. Personal Protective Equipment

In OSHA’s hierarchy of controls, personal protective equipment is the least-preferred

type of control because these methods rely on the compliance of all individuals, and often places a burden on the individual worker rather than on the organization as a whole. However, there may be circumstances where the use of personal protective equipment (PPE) is appropriate for preventing workplace violence. For example, the ANA identified the use of gloves, sleeves, and blocking mats as a barrier method to protect staff from bites and scratches when caring for individuals with certain developmental disabilities and where other types of controls are infeasible (Lipscomb and London, 2015).

d. Innovative strategies

In addition to controls that fall into the traditional OSHA hierarchical approach previously described here, OSHA is also very interested in hearing about strategies and innovations that have been developed from the clinical experience of health professionals, particularly if they have been shown to be effective. The Agency is interested in how existing operations tools, such as electronic infrastructure and work practices, can be modified to support violence prevention in specific healthcare and social assistance settings. In addition, the Agency seeks information on cross-disciplinary tools and strategies that merge techniques from different disciplines (such as threat assessment, education, and clinical practice) to improve workplace safety and health. Examples of innovative approaches include soliciting information from patients and their families about risk factors and effective solutions through informal surveys or focus groups. One behavioral health facility that hires and employs “milieu officers,” typically corrections officers with mental health training whose job is to be visible and accessible on the unit and maintain control over the unit environment as a whole, has reduced violent incidents on some patient units.

New Hampshire Hospital, a state-run behavioral health facility, serves as a teaching hospital through its affiliation with the Geisel School of Medicine at Dartmouth College. This connection allows New Hampshire Hospital to serve as a living laboratory for ongoing research to identify precursors to violence and test new practices. Physicians engage patients as partners in their research, which is part of the hospital's drive for continual improvement. This connection to academic studies also helps to raise awareness of other new research and encourage staff members to adopt the best available evidence-based approaches.

OSHA is interested in hearing from employers and individuals working in healthcare and social assistance about their experiences with hazard prevention and control. Specific questions regarding these topics are at the end of Section V.

4. Safety and health training

OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers highlight education and training as an essential element of a workplace violence prevention program. Safety and health training helps ensure that all staff members are aware of potential safety hazards and how to protect themselves, their coworkers and patients through established policies and procedures. The content and frequency of training can vary, as well as the staff eligible for training. In general, training covers policies and procedures specific to the facility and perhaps the unit, as well as de-escalation and self-defense techniques. De-escalation of aggressive behavior and managing aggressive behavior when it occurs are very important components of the training (Nonviolent Crisis Intervention Training, 2014).

Training provides opportunities to learn and practice strategies to improve both patient safety and worker safety. The nationwide movement toward reducing the use of restraints (physical and medication) and seclusion in behavioral health—which is mandated in some states—along with the movement toward “trauma-informed care,” means that workers are

relying more on approaches that minimize physical contact with patients, intervening with verbal de-escalation strategies before an incident turns into a physical assault thereby reducing injuries. Trauma-informed care is a strengths-based approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (SAMHSA). The results can be a “win-win” for patient and worker safety (OSHA, 2015b). Training ensures consistent dissemination of information about policies and procedures, as well as an opportunity to practice and develop confidence with newly-learned skills and techniques, such as de-escalation. In particular, when implementing a zero tolerance policy, training staff on what and when to report is essential to changing the expectation that violence will not be tolerated.

Staff training on policies and procedures is usually conducted at orientation and periodically (e.g., annually or semi-annually) afterward. A number of studies show that training can be effective in reducing workplace violence (Swain, 2014; Martin, 1995; Allen, 2013).

Because duties, work locations, and patient interactions vary by job, violence prevention training can be customized to address the needs of different groups of healthcare personnel, particularly: nurses and other direct caregivers; emergency department (ED) staff; support staff (e.g., dietary, housekeeping, maintenance); security personnel; and supervisors and managers (Greene, 2008). The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)) emphasizes that security personnel need specific training on the unique needs of providing security in the healthcare environment, including the psychological components of handling aggressive and abusive behavior, and ways to handle aggression and defuse hostile situations (The Joint Commission, 2009).

OSHA is interested in hearing from employers and individuals working in healthcare and social assistance about their experiences with the various types of training and their effectiveness. Specific questions regarding training are at the end of Section V.

5. Recordkeeping and Program Evaluation

a. Recordkeeping

OSHA's recordkeeping regulations require employers to record certain workplace injuries and illnesses. The OSHA 300 Log can be a valuable source of evaluation metrics data for establishing baseline injury and illness rates and benchmarks for success. Information from the [OSHA 300 Log, 300A Annual Summary, and the 301 Incident Report](#) can be used to identify tasks and jobs with higher risks of injury or illness, and to monitor trends. Under OSHA's recordkeeping regulation, an employer must record each fatality, injury, and illness that is work-related, a new case, and meets one or more of the general recording criteria in section 1904.7 or the application to specific cases of section 1904.8 through 1904.11. The general recording criteria in section 1904.7 is triggered by an injury or illness that results in death, days away from work, restricted work or transfer to another job, loss of consciousness, or medical treatment beyond first aid. For each such injury, the employer is required to record the worker's name; the date; a brief description of the injury or illness; and, when relevant, the number of days the worker was away from work, assigned to restricted duties, or transferred to another job as a result of the injury or illness. Employers with 10 or fewer employees at all times during the previous calendar year and employers in certain low-hazard industries are partially exempt from routinely keeping OSHA injury and illness records (29 CFR 1904.1, 1904.2). Accurate records of injuries, illnesses, incidents, assaults, hazards, corrective actions, patient histories, and training

can help employers evaluate methods of hazard control, identify training needs, and develop solutions for an effective program.

All employers, including those who are partially exempt from keeping records, must report any work-related fatality to OSHA within 8 hours of learning of the incident, and must report all work-related inpatient hospitalizations, amputations, and losses of an eye to OSHA within 24 hours of learning of the incident (29 CFR 1904.39). These events can be reported to OSHA in person, by phone, or by using the reporting application on OSHA's public website at www.osha.gov/recordkeeping. See <https://www.osha.gov/recordkeeping2014/>.

Employers do not always record or accurately record workplace injuries and illnesses in general. Specifically, in a 2012 report OSHA found that for calendar years 2007 and 2008, approximately 20 percent of injury and illness cases reconstructed by inspectors during a review of employee records were either not recorded or incorrectly recorded by the employer (OSHA, 2012). BLS is working on improving reporting by conducting additional research on the extent to which cases are undercounted in the SOII and exploring whether computer-assisted coding can improve reporting (BLS, 2014). Further, as discussed above in Section V.A.3.b, there are a number of published studies that show that employees substantially underreport workplace violence cases.

OSHA is interested in hearing from employers and individuals in healthcare and social assistance facilities about their experiences with both recordkeeping to comply with OSHA requirements as well as reporting of incidents at the facility or unit level. Specific questions regarding recordkeeping are at the end of Section V.

b. Program Evaluation

Programs are evaluated to identify deficiencies and opportunities for improvement. Accurate records of injuries and illnesses can help employers gauge the effectiveness of intervention efforts. The evaluation of a comprehensive workplace violence prevention program typically includes, but is not limited to, measuring improvement based on lowering the frequency and severity of workplace violence incidents; keeping up-to-date records of administrative and work practice changes implemented to prevent workplace violence (to evaluate how well they work); surveying workers before and after making job or worksite changes or installing security measures or new systems to evaluate their effectiveness; tracking recommendations through to completion; keeping abreast of new strategies available to prevent and respond to violence as they develop; and establishing an ongoing relationship with local law enforcement and educating them about the nature and challenges of working with potentially violent patients. The quality and effectiveness of training is particularly important to assess.

OSHA is interested in hearing from employers and individuals in healthcare and social assistance facilities about their experiences with program evaluation. Specific questions regarding program evaluation are located in section V.3. below.

B. Questions for Section V

OSHA is interested in hearing from employers and individuals in facilities that provide healthcare and social assistance about their experiences with the various components of workplace violence prevention programs that are currently being implemented by their facilities. Wherever possible, please indicate the title of the person completing the question and the type and employee size of your facility. In particular, the Agency appreciates respondents addressing the following:

1. Questions on the overall program, management commitment and employee participation

Question V.1: Does your facility have a workplace violence prevention program or policy? If so, what are the details of the program or policy? Please describe the requirements of your program, or submit a copy, if feasible. When and how did you implement the program or policy? How many hours did it take to develop the requirements? Did you consult your workers through union representatives?

Question V.2: How is your program or policy communicated to workers? (e.g., web site, employee meetings, signage, etc.) How are employees involved in the design or implementation of the program or policy?

Question V.3: In your experience, what are the important factors to consider when implementing a workplace violence prevention program or policy?

Question V.4: At what level in your organization was the workplace violence prevention program or policy implemented? Who has responsibility for implementation? What are the qualifications of the person responsible for its implementation?

Question V.5: How well is your program or policy followed? Have you received sufficient support from management? Employees? The union, if there is one?

Question V.6: How did you select the approach to workplace violence prevention outlined in your facility program or policy (e.g., triggered by an incident, following existing guidelines, listening to staff needs, complying with state laws)?

Question V.7: Do you have a safety and health program in place in your facility? If so, what is the relationship between the workplace violence prevention program and the safety and health management system?

Question V.8: Does your facility subscribe to a management philosophy that encompasses quality measures, e.g., lean sigma, high reliability? If so, are metrics for worker safety included?

Question V.9: Does your facility have a safety and health committee? Does your facility also have a workplace violence committee? If so, what is the function of these committees? How are they held accountable? How is progress measured?

Question V. 10: Does your facility have a workplace violence prevention committee that is separate from the general safety committee or part of it? If separate, how do the two committees communicate and share information? How many hours do they spend meeting or doing committee work? How many hours of employee time does this require per year?

Question V.11: If the facility does not have a committee, are there reasons for that?

Question V.12: What is the make-up of the committee? How are the committee members selected? What is the highest level of management that participates? Are worker / union representatives included in a committee? Is there a rotation for the committee members?

Question V.13: What does the decision making process look like? Do the committee members play an equal role in the decision making? Is there a meeting agenda? Does the committee keep minutes and records of decisions made?

Question V.14: How are the workplace violence prevention committee's decisions disseminated to the staff and management? Does the committee address employees' safety concerns in a timely manner?

Question V.15: If OSHA were to require management commitment, how should the Agency determine compliance?

Question V.16: If OSHA were to issue a standard that included a requirement for employee participation, how might compliance be determined?

2. Questions on worksite analysis and hazard identification

Question V.17: Are workplace analysis and hazard identification performed regularly? If so, what is the frequency or triggers for these activities? Are there any assessment tools or overall approaches that you have found to be successful and would recommend? Please describe the types of successes or problems your facility encountered with reviewing records, administering employee surveys to identify violence-related risk factors, and conducting regular walkthrough assessments.

Question V.18: Who is involved in workplace analysis? How are the individuals selected and trained to conduct the workplace analysis and hazard identification? How long does it take to perform the workplace analysis?

Question V.19: What areas of the facility are covered during the routine workplace assessment? Please specify why these areas are included in the assessment and how many of these areas are part of the assessment.

Question V.20: What records do you find most useful for identifying trends and risk factors with regards to workplace violence? How many of these records are collected per year?

Question V.21: What screening tools do you use for the worksite analysis? Are these screening tools designed specifically to meet your facility's needs? Are questionnaires and surveys an effective way to collect information about the potential and existing workplace violence hazards? Why or why not?

Question V.22: Who provides post-assessment feedback? Is it shared with other employees and if so, how is it shared with the other employees?

Question V.23: Does your facility use patient threat assessment? If so, do you use an existing tool or did you develop your own? If you develop your own, what criteria do you use?

Question V.24: Does your facility conduct accident/incident investigations? If so, who conducts them? How are follow-ups conducted and changes implemented?

Question V.25: How much time is required to conduct your patient assessments? What is the occupational background of persons who do these assessments?

Question V.26: If OSHA were to implement a standard with a requirement for hazard identification and worksite analysis, how might compliance be determined?

Question V.27: What do you know or perceive to be risk factors for violence in the facilities you are familiar with?

3. Questions on hazard prevention and controls

Question V.28: Are you aware of any specific controls or interventions that have been found to be effective in reducing workplace violence in an ED environment? How was effectiveness determined? If so, can you provide cost information?

Question V.29: Are you aware of any specific controls or interventions that have been found to be effective in reducing workplace violence in a behavioral health, psychiatric or forensic mental health setting? How was effectiveness determined? If so, can you provide cost information?

Question V.30: Are you aware of any specific controls or interventions that have been found to be effective in reducing workplace violence in a nursing home or long-term care environment? How was effectiveness determined? If so, can you provide cost information?

Question V.31: Are you aware of any specific controls or interventions that have been found to be effective in reducing workplace violence in a hospital environment? How was effectiveness determined? If so, can you provide cost information?

Question V.32: Are you aware of any specific controls or interventions that have been found to be effective in reducing workplace violence in a home health environment? How was effectiveness determined? If so, can you provide cost information?

Question V.33: Are you aware of any specific controls or interventions that have been found to be effective in reducing workplace violence of any other environments where healthcare and/or social assistance workers are employed? How was effectiveness determined? If so, can you provide cost information?

Question V. 34: Are you aware of any existing or modified infrastructure and work practices, or cross-disciplinary tools and strategies that have been found to be effective in reducing violence?

Question V.35: Have you made modifications of your facility to reduce risks of workplace violence? If so, what were they and how effective have those modifications been? Please provide cost for each modification made. Please specify the type of impact the modification made and whether the modification resulted in a safer workplace.

Question V.36: Does your facility have controls for workplace violence prevention (security equipment, alarms, or other devices)? If so, what kind of equipment does your facility use to prevent workplace violence? Where is the equipment located? Are there any barriers that prevent using the equipment? What labor requirements or other operating costs does this equipment have (e.g., have you hired security guards to monitor video cameras)?

Question V.37: Who is usually involved in selecting the equipment? If a committee, please list the titles of the committee members. Is new equipment tested before purchase, and if so, by whom? Are there any pieces of equipment purchased that are rarely used? If so, why?

Question V.38: Is there a process for evaluating the effectiveness of controls once they are implemented? What are the evaluation criteria?

Question V.39: What best practices are in use in your facility for workplace violence prevention?

Question V.40: How do you assure that the program is followed and controls are used? What are the ramifications for not following the program or using the equipment? If OSHA were to issue a standard, how might compliance with hazard prevention and control be determined?

Question V.41: Do you have information on changes in work practices or administrative controls (other than engineering controls and devices) that have been shown to reduce or prevent workplace violence either in your facility or elsewhere?

Question V.42: Do you have a zero tolerance policy? If so please share it. Do you think it has been successful in reducing workplace violence incidents? Why or why not?

Question V.43: If you have a policy for reporting workplace violence incidents, what steps have you taken to assure that all incidents are reported? What requirements do you have to ensure that adequate information about the incident is shared with coworkers? Do you think these policies have been effective in improving the reporting and communication about workplace violence incidents? Why or why not?

Question V.44: What factors do you consider in staffing your security department? What are the responsibilities of your security staff?

Question V.45: Have you instituted policies or procedures to identify patients with a history of violence, either before they are admitted or upon admission? If so, what costs are associated with this? How is this information used and conveyed to staff? Whose responsibility is it and what is the process? Has it been effective?

4. Questions on safety and health training

Question V.46: What kind of training on workplace violence prevention is provided to the

healthcare and/or social assistance workers at your facility? If this is copyrighted/branded training, please provide the name.

Question V.47: What is the scope and format of the training, and how often is workplace violence prevention training conducted?

Question V.48: What occupations (e.g., registered nurses, nursing assistants, etc.) attend the training sessions? Are the staff members required to attend the training sessions or is attendance voluntary? Are staff paid for the time they spend in training? Who administers the training sessions? Are they in-house training staff or a contractor? How is the effectiveness of the training measured? What is the duration of the training sessions or cost of the contractor?

Question V.49: Do all employees have education or training on hazard recognition and controls?

Question: V.50: Are contract and per diem employees trained?

Question V.51: Are patients educated on the workplace violence prevention program and, if so, how?

Question V.52: Does training cover workers' rights (including non-retaliation) and incident reporting procedures?

Question V.54: If OSHA were to require workplace violence prevention training, how might compliance be assessed?

5. Questions on recordkeeping and program evaluation

Question V.55: Does your facility have an injury and illness recordkeeping policy and/or standard operating procedures? Please describe how it works. How are records maintained; online, paper, in person?

Question V.56: Who is responsible for injury and illness recordkeeping in your facility?

Question V.57: Does your facility use a workers' compensation form, the OSHA 301 or another form to collect detailed information on injury and illness cases?

Question V.58: Where are the OSHA 300 log(s) kept at your facility? Are they kept on each unit, each floor, or are they centrally located for the entire facility?

Question V.59: Would the OSHA 300 Log alone serve as a valuable or sufficient tool for evaluating workplace violence prevention programs? Why or why not?

Question V.60: Are you aware of any issues with reporting (either underreporting or over-reporting) of OSHA recordables and/or "accidents" or other incidents related to workplace violence in your facility and if so, what types of issues? If you have addressed them, how did you address them?

Question V.61: Do you regularly evaluate your program? If so, how often? Is there an additional assessment after a violent event or a near miss? If so, how do you measure the success of your program? How many hours does the evaluation take to complete?

Question V.62: Who is involved in a program evaluation at your facility? Is this the same committee that conducted the workplace analysis and hazard identification?

Question V.63: If you have or are conducting an evaluation of the effectiveness of your workplace violence prevention program, have you been able to demonstrate improved tracking of workplace violence incidents and/or a reduction in the frequency or severity of violent incidents?

Question V.64: What are the most effective parts of your program? What elements of your program need improvement and why?

Question V.65: When conducting program evaluations, do you use the same tools and metrics you used for the initial worksite assessment? If not, please explain.

Question V.66: If OSHA were to develop a standard to prevent workplace violence and included a requirement for program or policy evaluation, how might compliance be determined?

Question V.67: Could you provide information characterizing the nature and extent of the difficulties in implementing your facility's program or policy?

Question V.68: What actions are taken based on the results of the program evaluation at your facility?

VI. Costs, Economic Impacts, and Benefits

As part of the Agency's consideration of a possible workplace violence standard, OSHA is interested in the costs, economic impacts, and benefits of related practices. OSHA is also interested in the benefits of such practices in terms of reduced injuries, deaths, and compromised operations (i.e., emotional distress, staffing turnover, and unexpected reallocation of resources).

Workplace violence exacts a high cost today. It harms workers often both physically and emotionally, and employers also bear several costs. A single serious injury can lead to workers' compensation losses of thousands of dollars, along with thousands of dollars in additional costs for overtime, temporary staffing, or recruiting and training a replacement. Even if a worker does not have to miss work, violence can still lead to "hidden costs" such as higher turnover and deterioration of productivity and morale. In the study of Washington state's workers' compensation data (1997-2007), the average cost claim per time-lost was \$32,963, with an annual average of at least 2,247 claims related to workplace violence in Washington State for the

period from 1997- 2007. Similar costs were cited by McGovern et al. (2000) who found costs per case for assaults was \$31,643 for registered nurse and \$17,585 for licensed practical nurses.

These costs included medical expenses, lost wages, legal fees insurance administrative costs, lost fringe benefits, and household production costs.

In addition to the out-of-pocket costs by the employer and employee, healthcare workers who experience workplace violence have reported short term and long term emotional effects which can negatively impact productivity. It was found by Gates et al. (2003; 2006) that nursing assistants employed in long term care, who had been assaulted suffered a range of occupational stressors including job dissatisfaction, decreased safety, and fear of future assaults. Caldwell (1992) and Gerberich et al. (2004) found emergency department (ED) workers to have post-traumatic stress disorder or symptom of the disorder at rates between 12 percent to 20 percent; the 12-month prevalence rate for the general U.S. adult population is about 3.5 percent (<http://www.nimh.nih.gov/health/statistics/prevalence/post-traumatic-stress-disorder-among-adults.shtml>). The impact of PTSD caused by workplace violence on productivity was studied by Gates, Gillespie and Succop (2011), where they found those who suffered from PTSD symptoms or experienced emotional distress reported difficulty thinking, withdrawal from patients, absenteeism, and higher job turnover. The results also found that, although emergency department nurses with PTSD symptoms continued to work, they had trouble remaining cognitively focused, and had “difficulty managing higher level work demands that required attention to detail or communication skills.”

OSHA requests any workers’ compensation data related to workplace violence. Any other information on your facility’s experience would also be appreciated.

Several studies have evaluated the effectiveness of various engineering and administrative workplace violence controls in a variety of settings (e.g., hospitals, nursing homes). The implementation of a comprehensive workplace violence prevention program that includes administrative and engineering controls has been shown to lead to lower injury rates and workers' compensation costs (Foley and Rauser, 2012, updated data provided to OSHA by the authors in 2015).

A. Questions for Costs, Economic Impacts, and Benefits

The following questions are intended to solicit information on the topics covered in this section. Wherever possible, please indicate the title of the person providing the information and the type and number of employees at your healthcare and/or social assistance facility.

Question VI.1: Are there additional data (other than workers' compensation data) from published or unpublished sources that describe or inform about the incidence or prevalence of workplace violence in healthcare occupations or settings?

Question VI.2: As the Agency considers possible actions to address the prevention and control of workplace violence, what are the potential economic impacts associated with the promulgation of a standard specific to the risk of workplace violence? Describe these impacts in terms of benefits from the reduction of incidents; effects on revenue and profit; and any other relevant impact measure.

Question VI.3: If you have implemented a workplace violence prevention program or policy, what was the cost of implementing the program or policy, in terms of both time and expenditures for supplies and equipment? Please describe in detail the resource requirements and associated costs expended to initiate the program(s) and to conduct the program(s) annually. If you have any other estimates of the costs of preventing or mitigating workplace violence, please provide them. It would be helpful to OSHA to learn both overall totals and specific components of the

program (e.g., cost of equipment, equipment installation, equipment maintenance, training programs, staff time, facility redesign).

Question VI.4: What are the ongoing operating and maintenance costs for the program?

Question VI.5: Has your program reduced incidents of workplace violence and by how much? Can you identify which elements of your program most reduced incidents? Which elements did not seem effective?

Question VI.6: Has your program reduced costs for your facility (e.g., reduced insurance premiums, workers' compensation costs, fewer lost workdays)? Please quantify these reductions, if applicable.

Question VI.7: Has your program reduced indirect costs for your facility (e.g., reductions in absenteeism and worker turnover; increases in reported productivity, satisfaction, and level of safety in the workplace)?

Question VI.8: If you are in a state with standards requiring programs and/or policies to reduce workplace violence, how did implementing the program and/or policy affect the facility's budget and finances?

Question VI.9: What changes, if any, in market conditions would reasonably be expected to result from issuing a standard on workplace violence prevention? Describe any changes in market structure or concentration, and any effects on services, that would reasonably be expected from issuing such a standard.

B. Impacts on Small Entities

As part of the Agency's consideration of a workplace violence prevention standard, OSHA is concerned whether its actions will have a significant economic impact on a substantial number of small businesses. Injury and illness incident rates are known to vary by establishment

size in the healthcare industry, where establishments between 50 and 999 employees had a rate of 5.4 per 10,000 full time works, while establishments under 50 employees had a rate of 2.8 and lower in 2014 (BLS Table Q1, October 2015).

If the Agency pursues development of a standard that would have such impacts on small businesses, OSHA is required to develop a regulatory flexibility analysis and convene a Small Business Advocacy Review (SBAR) under the Small Business Regulatory Enforcement Fairness Act (SBREFA) Panel prior to publishing a proposal. Regardless of the significance of the impacts, OSHA seeks ways of minimizing the burdens on small businesses consistent with OSHA's statutory and regulatory requirements and objectives (Regulatory Flexibility Act, 5 U.S.C 601 et seq.).

C. Questions for Impacts on Small Entities

Question VI.10: How many, and what type of small firms, or other small entities, have a workplace violence prevention training, or a program, and what percentage of their industry (NAICS code) do these entities comprise? Please specify the types of workplace violence risks you face.

Question VI.11: How, and to what extent, would small entities in your industry be affected by a potential OSHA standard to prevent workplace violence? Do special circumstances exist that make preventing workplace violence more difficult or more costly for small entities than for large entities? Describe these circumstances.

Question VI.12: How many, and in what type of small healthcare entities, is workplace violence a threat, and what percentage of their industry (NAICS code 622) do these entities comprise?

Question VI.13: How, and to what extent, would small entities in your industry be affected by an OSHA standard regulating workplace violence? Are there conditions that make controlling

workplace violence more difficult for small entities than for large entities? Describe these circumstances.

Question VI.14: Are there alternative approaches OSHA could use to mitigate possible impacts on small entities?

Question VI.15: For very small entities, what types of workplace violence threats are faced by workers? Does your experience with workplace violence reflect the lower rates reported by BLS?

Question VI.16: For very small entities, what are the unique challenges establishments face in addressing workplace violence, including very small non-profit healthcare facilities and at small jurisdictions?

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Signed at Washington, DC, on December 1, 2016.

David Michaels,
Assistant Secretary of Labor for Occupational Safety and Health

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