

## **MEMORANDUM**

TO: Kevin Beauregard, Assistant Deputy Commissioner, NCDOL OSH Division  
CC: Victoria Voight, Section Head, NCDOJ  
FROM: Jill F. Cramer  
DATE: March 4, 2015

### **RE: Inspections Related to Work Place Violence Complaints at NC Mental Hospitals**

Pursuant to the *Cherry Hospital* ALJ decision issued in January 2015, you have submitted a request for legal guidance on whether or not NCDOL/OSH should conduct future complaint inspections at any state mental hospital upon the receipt of similar employee\* workplace violence (hereinafter “WPV”) complaints.

A simplified response is that NCDOL/OSH must respond to employee complaints. Pursuant to CPL 02-01-052 (Sept. 8, 2011), any reported attack on a staff member by a patient should result in an inspection. The basis for this is:

1. There is a known risk factor of an employee working with a volatile person in a healthcare setting;
2. Industry recognition (vast bodies of research/numerous prior incidents/case law)
3. Existence of feasible means of abatement.

The *Cherry Hospital* decision clearly stated that the hospital facility had feasible methods in place to abate the hazard of patient aggression. Therefore, the focus of this memorandum is what information must be obtained during a future inspection to support a contested GDC citation when there are complaints of or actual reported incidents of WPV.

For clarification, it should be noted that the *NC Workplace Violence Prevention Act* does **not** come into play for patients in mental hospitals or other treatment facilities. (*NCGS, Article 23 of Chapter 95*) The act allows employers to pursue protection on behalf of employees; the act also prohibits employment discrimination or retaliation against employees who must miss work as a result of domestic violence or other harassment.

This is an issue that OSH will continue to be forced to address. Healthcare and social assistance is the largest industry sector in the United States, with an estimated 18.9 million workers. In the last decade healthcare workers represented two thirds of nonfatal workplace violence injuries. These workers have a five-times greater risk for requiring time off due to assault (CDC, 2013).

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\*There are four classifications of WPV. This memorandum will only focus on Type II -- Customer/Client/Patient relations; Type II applies to school teachers, health care workers, social workers, and public transportation operators.

A review of case law, various state OSH WPV articles, scholarly WPV articles, and statistics establishes that concerted efforts must be made within a facility to reduce Type II workplace violence. The adoption of the Crisis Prevention Institute (hereinafter “CPI”) method is highly touted throughout the country as the primary method by which to manage violent patient behavior. Cherry Hospital utilized, among other procedures, the “gold standard” method – the Nonviolent Crisis Intervention® program from CPI – to manage aggressive patient behavior. See:

[http://www.crisisprevention.com/getattachment/News-Blog/News/July-2014/Type-2-Violence-in-Hospitals/JSM\\_Fall12\\_Jacobsen.pdf](http://www.crisisprevention.com/getattachment/News-Blog/News/July-2014/Type-2-Violence-in-Hospitals/JSM_Fall12_Jacobsen.pdf)

OSHA case law from around the country has established that mental hospitals housing aggressive patients must develop:

1. An Injury and Illness Prevention Program (IIPP);
2. A stand-alone, written violence prevention program for the entire facility to include:
  - a. Management commitment
  - b. Employee participation
  - c. Hazard identification
  - d. Effective safety and health Training, especially relating to potential physical assaults and recognition of stalking behavior;
  - e. Hazard prevention, control and reporting;
  - f. Recordkeeping;
  - g. Program evaluation.
3. Environmental Designs;
4. Engineering and Administrative Controls;
5. Behavior Modification;
6. An annual, site specific WPV analysis to identify hazards, conditions, operations and situations that could lead to patient violence, and the ER must address and correct any identified deficiencies;
7. Evaluation of staff communication logs to identify patients who exhibit violent behavior;
8. Measures that reduce the likelihood of patients communicating violence to employees;
9. Sufficient security presence or effective police presence on facility floors in the event of an assault on hospital property;
10. Establishment of open communication between security and other employees to help identify problematic patients and situations that could result in an incident;
11. An effective employee alarm system, including personal alarms.
12. Create and disseminate a clear policy of zero tolerance for WPV, verbal and nonverbal threats and related actions.

References:

- I. BHC Freemont Hospital, Inc., Docket 13 R1D2-0204-  
<https://www.dir.ca.gov/oshab/DECISIONS-ALJ/2014/BHC-FREMONT-HOSPITAL.13-0204.pdf>; employer argued that it took steps to reduce the hazards to employees, however, the court found, among other things, that the steps were not adequate.

II. Two CA Dept of Mental Health/Napa State Hospital cases:

*Both cases below received a written order issued by an ALJ after a pre-hearing conference in which CA-OSH and the Employer agreed to settle an appeal without a hearing:*

- *CA Dept. of Mental Health/Napa State Hospital*, Dockets 2011-R1D5-1527, 2011-R1D5-1528 and 2011-R1D5-1529; December 11, 2010 an employee was assaulted by an inmate while he was escorting him off the ward. The employee was found wandering the grounds by co-workers and was taken to the hospital and treated for severe head injuries.
- *CA Dept of Mental Health/Napa State Hospital*, Dockets 2011-R1D5-0938, 2011-R1D5-0939, 2011-R1D5-0940, 2011-R1D5-0941, 2011-R1D5-0942 and 2011-R1D5-0943; October 24, 2010, an employee had apparently been attacked while on a break and asphyxiated, and a patient at the hospital was arrested in her death.
  - o See: [https://www.dir.ca.gov/dosh/citation\\_archive.html](https://www.dir.ca.gov/dosh/citation_archive.html) for citations in both cases.

3. Renaissance Project, Ellenville, NY 2011
4. Acadia Hospital, Bangor, ME
5. Danbury Hospital, Danbury, Conn, July 2010.'
6. Corizon Health Inc./ Rikers Island Correctional Facility, NY, Aug 8, 2014.
7. Lakeview Neurorehab Center Midwest, Inc., Wisconsin May 2012
8. *USDOL v. North Suffolk Mental Health Assoc*, Docket 2011-2132  
[http://www.americanbar.org/content/dam/aba/events/labor\\_law/am/2014/1e\\_northsuffolk\\_agree.authcheckdam.pdf](http://www.americanbar.org/content/dam/aba/events/labor_law/am/2014/1e_northsuffolk_agree.authcheckdam.pdf)

A mental health facility must put forth extensive efforts to train employees and provide them – at a minimum -- with information on aggressive patients, shift reports, safety updates and meetings, safety sweeps for potential weapons, a reporting system to track incidents, video camera or CCTV monitors in appropriate areas that display at manned locations, body alarms or preferably voice-operated badge linked to security systems/emergency broadcast systems, a buddy system and a workplace safety committee.

Should a facility already have such programs in place, NCDOL/OSH needs to discern whether all the policies and programs are **fully enforced**. Simply having an IIPP and/or a stand-alone written violence prevention program is not enough. Therefore, inspecting CSHO's must look for any **patterns of lack of: enforcement, effective training, effective communication, effective management involvement or commitment, appropriate steps taken by the ER to correct recognized hazards. etc.**

During inspections, the CSHO should focus on:

1. Documenting any lack of adequacy of ER's actions taken to reduce hazards;
2. Verifying existence of written documentation of changes to procedures or changes to engineering controls that have been implemented in response to any increase in EE injuries;
3. Documenting any lack of managerial concern for EE emotional or physical safety;
4. Noting any lack of medical or psychological counseling programs for injured employees;
5. Documenting inadequate staff on some shifts;
6. Documenting any failure to report violent incidents to police.
7. Documenting any effort by the ER to differentiate between "patient aggression" (unwanted physical contact by a patient without the actual intent by patient to harm the employee/unintentional) that results in EE injuries and actual patient assaults (patient, who knew right from wrong, acting with a high level of force toward the employee).

Federal OSHA recommends establishing a zero-tolerance policy toward workplace violence that covers all workers, patients, clients, visitors and contractors. They also recommend that all employees should be made fully aware that all claims of workplace violence will be investigated.

#### NCDOL v. NC DHHS Cherry Hospital, OSHNC 2012-5366

Cherry Hospital, a state psychiatric hospital with 950 employees, was cited for a GDC violation and two PPE violations (no PPE provided and no assessment of hazards). Four instances of EE injuries were provided during the hearing. NCDOL recommended 8 methods of abatement:

1. Conduct hazard assessment of violence to identify risks and abatement strategies.
2. Maintain system of recordkeeping and reporting that tracks all violence.
3. Increase frequency and quality of CPI training.
4. Establish overall hospital policy addressing EE safety with emphasis on recognizing potential interactions as hazard to employees.
5. Use case management meetings to address social/medical/medication needs with goal toward minimizing violence.
6. Provide adequate resources, including staffing in sufficient numbers/buddy system.
7. Include B-Alert Code on paperwork staff members use when conducting patient checks (15 min intervals) with picture ID of patient. Extend B-Alert status to patients with a history of aggression outside confines of Cherry Hospital.
8. Initiate a program that gives patients and employees joint ownership of violence (Dr. Marilyn Lanza work)

According to the ALJ's opinion, in 2008 Cherry Hospital identified an increase in employee injuries. Cherry Hospital initiated a "Performance Improvement Team" to reduce EE injuries. There was another increase in 2010. The implemented WPV policy included:

1. New EE orientation and training
2. Upon admission, patient assessment for violence history, including detailed treatment plan and a determination if patient should be placed on B-Alert status.
3. Kardex system containing all patient info.
4. Adoption of CPI (Crisis Prevention Institute), to manage aggressive patient behavior (Training + visual aids + annual refresher training)

5. Community meetings and Unit Safety Meetings
6. Patient Care Shift records
7. Precaution Flow Sheets
8. RN Shift Notes
9. Ward Reports
10. Safety Sweeps
11. Aggressive Protocol Policy
12. QUANTROS (reporting system to track incidents)
13. Video review of patient aggression with management and staff
14. Formation of Workplace Safety Committee
15. Assaulted Staff Action Program (“ASAP”)
16. Town Hall Meetings
17. Management Rounds
18. Environmental Safety Rounds (surveys on every unit after every shift)
19. Aggressive Protocol Policy
20. Staff equipped with Body Alarms, Whistles and Walkie-Talkies
21. Red Phones (emergency phones in community courtyard)
22. Restrictive intervention (e.g. restraint chairs)
23. “Just Culture” - environmental concerns
24. Adjustments to Patient–Staff ratios when needed
25. Escort Policy (Buddy System)
26. Bolted Beds (2011)

Both NCDOL and Cherry Hospital agreed the recognized hazard to employees was physical assault by patients. NCDOL asserted that Cherry Hospital was more concerned about patients' rights than EE safety. However, from the opinion, there does not appear to have been any testimony regarding possible shortcomings in the WPV program the hospital had initiated. Testimony from Cherry Hospital administration stated that it used a “balanced approach” and that patient and EE safety could not be separated. The court found Cherry Hospital had feasible means of abatement in place. The ALJ held that the only *absolute* means of abatement -- keeping patients physically or chemically restrained at all times -- was not a feasible means of abatement. The ALJ opined that in-place engineering and administrative controls at Cherry Hospital created feasible methods to abate the hazards. However, the opinion did not reflect that testimony was entered that Cherry Hospital was putting forth sufficient effort to enforce the WPV program in its entirety.

Numerous articles indicate that federal OSHA and various states are considering adoption of specific WPV standards. California took steps to implement WPV standards on September 29, 2014, when California Governor Jerry Brown signed legislation (S.B. 1299) requiring the Occupational Safety and Health Standards Board, by July 1, 2016, to enact standards obligating specified types of hospitals (general acute care hospital or acute psychiatric hospital) to adopt a workplace violence prevention plan as part of the hospital's injury and illness prevention plan to protect health care workers and other facility personnel from aggressive and violent behavior. The bill requires standards to include prescribed requirements for a plan. It also requires Cal OSHA to post a report on its website regarding violent incidents at hospitals. The bill exempts

certain state-operated hospitals, including corrections and hospitals. The law went into effect January 1, 2015. The text of California SB 1299 on Workplace Violence can be found at:  
[http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill\\_id=201320140SB1299](http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB1299)

See also:

<https://www.osha.gov/Publications/osha3148.pdf>

***OSHA Guidelines for Preventing Workplace Violence for Health Care & Social Service Worker***

<http://www.cdc.gov/niosh/docs/2006-144/pdfs/2006-144.pdf>

***2002 CDC Prevention Strategies for Employers***

[http://www.oshrc.gov/decisions/pdf\\_1995/93-2879.pdf](http://www.oshrc.gov/decisions/pdf_1995/93-2879.pdf)

Megawest Financial, Inc., 1995 OSAHRC LEXIS 80, OSHRC Docket No. 93-2879, May 8, 1995; OSHA cited the ER when a potential renter attacked leasing personnel; the ALJ found that the apartment management industry, although a service industry, is not identified as a high-risk employer, and that the ER could not anticipate and prevent criminal behavior on the part of non-employees.

Additionally, the American National Standards Institute (ANSI) and American Industrial Hygiene Association (AIHA) have published a voluntary consensus standard, ANSI/AIHA Z10 – 20101 Occupational Safety and Health Management Systems. This system addresses the process that management should follow for overall improvement of occupational safety and health as opposed to specific actions relating to WPV. Internationally, the Occupational Health and Safety Assessment Series (OHSAS) Project Group (a consortium of selected Registrars, national standards bodies, professional associations and research institutes) has produced a similar document, OHSAS 18001 – 2007 Occupational Health and Safety Management Systems.

A more detailed version of this memorandum is available should you require specific case information in relation to future inspections; including CDC guidelines, case law, and scholarly articles. If additional research or information is needed regarding this topic, please contact me.