OSHA & Worker Safety

Guidelines for Zero Tolerance

New OSHA publication helps prevent violence in the health care setting

According to the Bureau of Labor Statistics, in 2013, 27 of the 100 fatalities that occurred in health care and social service settings were due to assaults and violent acts. Moreover, of all the assaults that occurred between 2011 and 2013 in all workplaces across the country—an average of 24,000 per year—70% to 74% occurred in health care and social service settings.

Now consider this: Research indicates that workplace violence (WPV) is underreported—suggesting that the actual rates may be much higher.

"There's a culture in many health care settings that accepts violence as a part of the job, that expects it when working with a patient or client who has a violent history," says Dionne Williams, director, Office of Health Enforcement for the Occupational Safety and Health Administration (OSHA). "Often, the thinking is, 'Let's not get the patient or client in trouble. Let's not escalate the issue.' It's one of the alarming things we've learned about WPV."

One of the best protections employers can offer their workers is a policy of zero tolerance toward violence in the workplace. A second protection is a well-written and implemented WPV-prevention program.

"Health care organizations rightfully focus significant effort on improving patient outcomes," says Williams. "One measure we see is the avoidance of patient restraints, even for those who act out or become potentially violent. A few states have laws that prohibit restraints. We're trying to come up with recommendations that balance improvement in patient health with employee safety."

New WPV guidelines from OSHA

In 2015, OSHA updated its Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. The 2015 edition makes use of new data, research, and experience to recommend procedures for reducing—or, ideally, eliminating—WPV. The guidelines explain the components of a WPV-prevention program, and they include checklists to identify risk factors.

Williams notes that the new guidelines focus on particulars of the setting and how they relate to causes and controls. Citing epidemiological studies, for example, the guidelines note that "inpatient and acute psychiatric services, geriatric long term care settings, high-volume urban emergency departments, and residential and day social services present the highest risks. Pain, devastating prognoses, unfamiliar surroundings, mind- and mood-altering medications, drugs, and disease progression can all cause agitation and violent behaviors."

Williams particularly mentions the effort OSHA has made to address key differences between settings, remarking that each has its own risk factors, some related to patients or settings—for example, being located in a high-crime area—and others related to the organization—for example, lack of WPV-related training or policies.

The guidelines consider these five settings:

- Hospitals
- Residential treatment facilities, such as nursing homes and other long-term care facilities
- Nonresidential treatment/service centers, such as small neighborhood clinics and mental health centers
- Community care facilities, such as group homes
- Field settings, such as the homes that health care workers or social workers visit

Building blocks for WPV prevention

The new OSHA guidelines recommend the following five components for a violence-prevention program in the workplace:

1. **Leadership commitment and employee participation.** The visible involvement of top management provides motivation and resources for workers and employers to deal effectively with WPV. In addition, a team of employees with appropriate training and skills—and adequate resources—will be in the best position to develop and implement the program. This team should create and disseminate a clear policy of zero tolerance for WPV. This zero tolerance should extend even to verbal and nonverbal threats. Williams emphasizes the importance of both management commitment and employee involvement in the WPV-prevention program.
2. **Worksite analysis and hazard identification.** A team that includes senior management, supervisors, and

Table 1. An Excerpt of Sample Engineering Controls: *For Health Care and Social Service Settings*

	Hospital	Residential Treatment	Nonresidential Treatment/Service	Community Care	Field Workers (Home Health Care, Social Service)
Security/silenced alarm systems	• Panic buttons or paging system at workstations or personal alarm devices worn by employees			• Paging system • GPS tracking* • Cell phones	
	• Security/silenced alarm systems should be regularly maintained, and managers and staff should fully understand the range and limitations of the system.				
Exit routes	• Where possible, rooms should have two exits. • Provide employee "safe room" for emergencies. • Arrange furniture so workers have a clear exit route.		• Where possible, counseling rooms should have two exits. • Arrange furniture so workers have a clear exit route.	• Managers and workers should assess homes for exit routes.	
	• Workers should be familiar with a site and identify the different exit routes available.				
Metal detectors—handheld or installed	• Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for services being provided and the types of barriers put in place. • Metal detectors should be regularly maintained and assessed for effectiveness in reducing the weapons brought into a facility. • Staff should be appropriately assigned and trained to use the equipment and remove weapons.				
Monitoring systems and natural surveillance	• Closed-circuit video—inside and outside • Curved mirrors • Proper placement of nurses' stations to allow visual scanning of areas • Glass panels in doors/walls for better monitoring		• Closed-circuit video—inside and outside • Curved mirrors • Glass panels in doors for better monitoring		
	• Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for services being provided and the types of barriers put in place. • Staff should know if video monitoring is in use and whether someone is always monitoring the video.				

* Employers and workers should determine the most effective method for ensuring the safety of workers without negatively impacting working conditions.

Source: OSHA. Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. (Updated: Apr 2, 2015.) Accessed Jul 1, 2015. https://www.osha.gov/Publications/osha3148.pdf. For a list of engineering controls, see pp. 13–17.

workers should analyze the worksite for potential hazards (*see* p. 30 of the guidelines for checklists). Part of this analysis involves record review to identify patterns of violent incidents. Although leadership is responsible for controlling hazards, workers have a critical role to play in identifying and assessing them—because they are intimately familiar with facility operations, processes, and potential threats. "Having employees involved in doing assessments and coming up with solutions is critical to the success of the program," says Williams. "When they're directly involved, employees trust the system more, and in many cases they provide excellent recommendations for how their jobs can be done more safely."

3. **Hazard prevention and control.** Once the worksite analysis is complete, the organization should take the following five steps:
   a. Identify and evaluate control options for existing workplace hazards. Controls can be categorized as the following:
      – Substitution—for example, transferring a patient to a more appropriate facility if the client has a history of violent behavior
      – Engineering controls, which are physical changes that either remove the hazard from the workplace or create a barrier between the worker and the hazard. (*See* Table 1, above, for examples geared to each work setting.)
      – Administrative and work practice controls, such as establishing policies related to WPV response or training. (*See* Table 2, page 10, for examples geared to each work setting.)
   b. Select effective and feasible controls to eliminate or reduce hazards.
   c. Implement these controls.
   d. Follow up to confirm that the controls are being used and maintained properly.

(continued on page 10)

Table 2. An Excerpt of Sample Administrative and Work-Practice Controls: *For Health Care and Social Service Settings*

	Hospital	Residential Treatment	Nonresidential Treatment/Service	Community Care	Field Workers (Home Health Care, Social Service)
Workplace violence response policy	• Clearly state to patients, clients, visitors, and workers that violence is not permitted and will not be tolerated. • Such a policy makes it clear to workers that assaults are not considered part of the job or acceptable behavior.				
Tracking workers*		Traveling workers should: • Have specific log-in and log-out procedures • Be required to contact the office after each visit; managers should have procedures to follow up if workers fail to do so		Workers should: • Have specific log-in and log-out procedures • Be required to contact the office after each visit; managers should have procedures to follow up if workers fail to do so • Be given discretion as to whether or not they begin or continue a visit if they feel threatened or unsafe	
	• Log-in/log-out procedures should include: ▪ Name and address of client visited ▪ Scheduled time and duration of visit ▪ Contact number ▪ Code word used to inform someone of an incident/threat ▪ Worker's vehicle description and license plate number ▪ Details of any travel plans with client ▪ Contacting office/supervisor with any changes				
Tracking clients with a known history of violence	• Supervise the movement of patients throughout the facility • Update staff in shift report about violent history or incident		• Update staff in shift report about violent history or incident	• Report all violent incidents to employer	

* Massachusetts Department of Mental Health Task Force on Staff and Client Safety. (2011) *Report of the Massachusetts Department of Mental Health Task Force on Staff and Client Safety*.

Source: OSHA. Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. (Updated: Apr 2, 2015.) Accessed Jul 1, 2015. https://www.osha.gov/Publications/osha3148.pdf. For a list of administrative and work-practice controls, see pp. 17–22.

OSHA & Worker Safety: Guidelines for Zero Tolerance
(continued from page 9)

e. Evaluate the effectiveness of controls and improve, expand, or update them as needed.

In addition, when a violent incident occurs, organizations should have procedures and services in place for the victim, such as first aid, emergency care, and follow-up that addresses trauma and fears related to returning to work or criticism from supervisors. Employees should be encouraged to promptly report incidents and suggest ways to reduce or eliminate risks, and no employee who reports or experiences WPV should face reprisals. Essential post-incident procedures also include investigations to determine root causes and correct them. When root causes are not addressed, similar incidents inevitably occur.

4. **Safety and health training.** In general, training should cover the facility's procedures as well as de-escalation and self-defense techniques. Both de-escalation and self-defense training should include hands-on components. Training is essential for ensuring that all staff members are aware of potential hazards related to patients and how to protect themselves and their coworkers.

"Training ensures that employees know what the policies are and whom to contact. They should know there's no retaliation for making a complaint," says Williams. Staff who fear retaliation, she points out, suffer rather than make a complaint. "In a number of organizations, WPV training focuses on employee–employee violence and the fact that the organization won't tolerate it. But the programs often make no mention at all of violence from patients or clients."

5. **Recordkeeping and program evaluation.** Accurate records related to incidents and responses determine a program's overall effectiveness and help identify deficiencies or changes that should be made. "All components of this program are important, but tracking and follow-up are vital—not only when someone gets seriously hurt but also for the near-misses—the threats that could escalate," Williams says. "Some serious cases are preceded by threats that went uninvestigated and undocumented." However, if there's a record of such threats, the next worker knows that the situation exists.

Changing the culture

Primarily due to the violent behavior of their patients, clients, and/or residents, health care and social service workers face significant risks of job-related violence. It is OSHA's mission to help employers address these serious hazards. A written program for WPV prevention, incorporated into an organization's overall safety and health program, can reduce or eliminate the risk of violence in the workplace.

"We hear from employees who fear they might lose their jobs or be blamed if they complain," says Williams. "When they experience management complacency related to WPV, when nothing happens in response to an incident or a complaint, they stop complaining. That's why we say that management must communicate and enforce a policy of zero tolerance for violence.

"The majority of our inspections come from complaints related to violent incidents, either from someone who suffered an assault or through a union representative," adds Williams. "When we follow up on those complaints, we see that many facilities expect workplace violence. We're trying to change that culture and offer guidance." EC

Resource for article: Occupational Safety and Health Administration. Workplace Violence. Accessed Jul 2, 2015. https://www.osha.gov/SLTC/workplaceviolence/.