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UCLA LABOR OCCUPATIONAL SAFETY AND HEALTH (LOSH) PROGRAM
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Dave Thomas, Chairman
Occupational Safety and Health Standards Board
Department of Industrial Relations
#350 - 2520 Venture Oaks Way
Sacramento, California 95833

Via email: oshsb@dir.ca.gov

February 18, 2014

Re: California Safe Care Standard

Dear Chairman Thomas and Board members:

The UCLA Labor Occupational Safety and Health (LOSH) Program is submitting this letter in regard to the SEIU Local 121RN and SEIU Nurse Alliance of California efforts to establish a workplace violence prevention standard via the California Safe Care Standard.

The UCLA LOSH Program is a university-based organization that provides outreach, education and other health and safety programs to labor unions, labor-management programs, and community organizations with limited access to health and safety resources. Over the last decade, we have presented workplace violence prevention training to hundreds of employees in Southern California in the retail, education, health care, and transportation sectors. We have heard first-hand accounts from workers who have been held up at gun point, assaulted by patients or their family members, held hostage by customers, and exposed to crime through their employment.

Our work in the health care sector has been characterized by a growing concern among patient care providers about the prevalence of violence. Public health nurses report exposures to neighborhood crime and domestic abusers. Some have individually sought resources from local law enforcement and developed ad hoc measures to improve their personal safety. Behavioral health workers report being assaulted on a regular basis, particularly male employees who find themselves acting as bodyguards for their female coworkers. State hospital workers report delays on critical facility security measures, experience patient assaults regularly, and report that there is no standardized post incident procedure to ensure risk reduction or to provide psychological support for affected employees. Reports indicate that employer responses are inconsistent and incomplete. Traumatized employees may be forced to return to the workplace in an impaired capacity or to seek alternate employment. The economic burden of this problem has not been adequately assessed.

The reasons for the growing incidence of violence in health care have been well documented. Reduced funding for in-patient psychiatric treatment programs combined with limited staffing and resources for community based treatment programs results in violent and erratic behavior by patients seeking treatment in urgent care facilities (NIOSH, 2013). The mandated reduction in State prison populations have increased the number of patient transfers from the criminal justice system to the State mental hospitals, where facilities are outdated and security programs are understaffed (Cal/OSHA Reporter, 2011). These are two examples of policy decisions that have increased the severity of this problem for workers in the California health care sector.

Furthermore the culture of health care prioritizes patient health and satisfaction over worker health and safety which contributes to this problem. As care providers, health care workers express empathy for patients and the pressure to perform to quality of care standards, and may suffer from a lack of support or incomplete evidence to document patient assaults (Elliot, 1997). Health care workers also report that violent events are too frequent to report individually or that there is a lack of response when the effort is taken. Some fear that reporting will reflect poorly on them, or believe that patients can't be held accountable for their violent actions (NACNEP 5th Report). As a result, it has been estimated that half of verbal and physical assaults go unreported (Elliot, 1997). However, statistics show that these less severe assaults can lead to serious consequences, with 45% of nonfatal assaults resulting in lost work time (BLS, 2001 & 2006), and one third of these lost work time injuries resulting from 'low risk' behavior, such as hitting, kicking, squeezing, pinching, scratching, and biting (CDC/NIOSH 2009). As a result, more consistent reporting mechanisms (including near miss reporting) would lead to better hazard management.

It is apparent that a more protective workplace violence prevention standard is warranted. Although DOSH may enforce violence prevention using the existing Injury and Illness Prevention Program (IIPP) standard, experience indicates that employers' IIPP programs do not appear to be effectively addressing this hazard. A more detailed standard that mandates effective training, detailed incident analysis and hazard control, facility security inspections, and a violence prevention program would provide the elements necessary for improved management of the problem.

SEIU has taken important steps to document this risk affecting their membership and to propose a policy that will contribute to protecting all workers in the health care industry. A workplace violence prevention standard for health care would be a small step towards addressing this recognized and well documented hazard for all workers.

Please feel free to contact me with any questions at ldelp@ucla.edu. Thank you for considering our comments to further the protection of health care workers from these preventable incidents.

Sincerely,

Linda Delp, PdD, MPH
Director, UCLA LOSH

Cc: Kathy Hughes, RN, SEIU Nurse Alliance Liaison
Richard Negri, SEIU 121RN Health & Safety Director