Appendix B

Guidelines For Preventing Workplace Violence for Health Care and Social Service Workers

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U.S. Department of Labor
Alexis M. Herman, Secretary

Occupational Safety and Health Administration
Charles N. Jeffress, Assistant Secretary

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Notice

These guidelines are **not** a new standard or regulation. They are advisory in nature, informational in content, and are intended for use by employers seeking to provide a safe and healthful workplace through effective workplace violence prevention programs adapted to the needs and resources of each place of employment. The guidelines are not intended to address issues related to patient care. The guidelines are performance-oriented and the implementation of the recommendations will be different based upon an establishment's hazard analysis.

Violence inflicted upon employees may come from many sources — i.e., patients, third parties such as robbers or muggers — and may include co-worker violence. These guidelines address only the violence inflicted by patients or clients against staff. It is suggested, however, that workplace violence policies indicate a zero-tolerance for violence of any kind.

The Occupational Safety and Health Act of 1970 (OSH Act)[1] mandates that, in addition to compliance with hazard-specific standards, all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm. OSHA will rely on Section 5(a) of the OSH Act, the "General Duty Clause,"[2] for enforcement authority. Employers can be cited for violating the General Duty Clause if there is a recognized hazard of workplace violence in their establishments and they do nothing to prevent or abate it. Failure to implement these guidelines is not in itself a violation of the General Duty Clause of the OSH Act. OSHA will not cite employers who have effectively implemented these guidelines.

Further, when Congress passed the OSH Act, it did so based on a finding that job-related illnesses and injuries were imposing both a hindrance and a substantial burden upon interstate commerce, "in terms of lost production, wage loss, medical expenses, and disability compensation payments."[3]

At the same time, Congress was mindful of the fact that workers' compensation systems provided state specific remedies for job-related injuries and illnesses. Issues on what constitutes a compensable claim and what the rate of compensation should be were left up to the states, their legislatures, and their courts to determine. Congress acknowledged this point in Section 4(b)(4) of the OSH Act, when it stated categorically: "Nothing in this chapter shall be construed to supersede or in any manner affect any workmen's compensation law . . . ."[4] Therefore, these non-mandatory guidelines should not be viewed as enlarging or diminishing the scope of work-related injuries and are intended for use in any state and without regard to whether the injuries or fatalities, if any, are later deemed to be compensable.

[1] Public Law 91-596, December 29, 1970; and as amended by P.L. 101-552, Section 3101, November 5, 1990.
[2] "Each employer shall furnish to each of his 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 his employees."
[3] 29 U.S.C. 651(a).
[4] 29 U.S.C. 653(b)(4).

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Many persons, including health care, social services, and employee assistance experts; researchers, educators; unions, and other stakeholders; OSHA professionals; and the National Institute for Occupational Safety and Health (NIOSH) contributed to these guidelines.

Also, several states have developed relevant standards or recommendations, such as the California OSHA (CAL/OSHA), *CAL/OSHA Guidelines for Workplace Security*, and *Guidelines for Security and Safety of Health Care and Community Service Workers*; the Joint Commission on Accreditation of Health Care Organizations, *1995 Accreditation Manuals for Hospitals*; Metropolitan Chicago Healthcare Council, *Guidelines for Dealing with Violence in Health Care*; New Jersey Public Employees Occupational Safety and Health (PEOSH), *Guidelines on Measures and Safeguards in Dealing with Violent or Aggressive Behavior in Public Sector Health Care Facilities*; and the State of Washington Department of Labor and Industries, *Violence in Washington Workplaces, and Study of Assaults on Staff in Washington State Psychiatric Hospitals*. Information is available from these and other agencies to assist employers.

Introduction

For many years, health care and social service workers have faced a significant risk of job-related violence. Assaults represent a serious safety and health hazard for these industries, and violence against their employees continues to increase.

OSHA'S new violence prevention guidelines provide the agency's recommendations for reducing workplace violence developed following a careful review of workplace violence studies, public and private violence prevention programs, and consultations with and input from stakeholders.
OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults. Although not every incident can be prevented, many can, and the severity of injuries sustained by employees reduced. Adopting practical measures such as those outlined here can significantly reduce this serious threat to worker safety.

OSHA'S Commitment

The publication and distribution of these guidelines is OSHA'S first step in assisting health care and social service employers and providers in preventing workplace violence. OSHA plans to conduct a coordinated effort consisting of research, information, training, cooperative programs, and appropriate enforcement to accomplish this goal.

The guidelines are **not** a new standard or regulation. They are advisory in nature, informational in content, and intended for use by employers in providing a safe and healthful workplace through effective violence prevention programs, adapted to the needs and resources of each place of employment.

Extent of Problem

Today, more assaults occur in the health care and social services industries than in any other. For example, Bureau of Labor Statistics (BLS) data for 1993 showed health care and social service workers having the highest incidence of assault injuries (BLS, 1993). Almost two-thirds of the nonfatal assaults occurred in nursing homes, hospitals, and establishments providing residential care and other social services (Toscano and Weber, 1995).

Assaults against workers in the health professions are not new. According to one study (Goodman et al., 1994), between 1980 and 1990, 106 occupational violence-related deaths occurred among the following health care workers: 27 pharmacists, 26 physicians, 18 registered nurses, 17 nurses' aides, and 18 health care workers in other occupational categories. Using the National Traumatic Occupational Fatality database, the study reported that between 1983 and 1989, there were 69 registered nurses killed at work. Homicide was the leading cause of traumatic occupational death among employees in nursing homes and personal care facilities.

A 1989 report (Cannel and Hunter) found that the nursing staff at a psychiatric hospital sustained 16 assaults per 100 employees per year. This rate, which includes any assault-related injuries, compares with 8.3 injuries of **all** types per 100 full-time workers in all industries and 14.2 per 100 full-time workers in the construction industry (BLS, 1991). Of 121 psychiatric hospital workers sustaining 134

injuries, 43 percent involved lost time from work with 13 percent of those injured missing more than 21 days from work.

Of greater concern is the likely underreporting of violence and a persistent perception within the health care industry that assaults are part of the job. Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them, or employee fears that employers may deem assaults the result of employee negligence or poor job performance.

Risk Factors

Health care and social service workers face an increased risk of work-related assaults stemming from several factors, including:

- The prevalence of handguns and other weapons-as high as 25 percent[5] — among patients, their families, or friends. The increasing use of hospitals by police and the criminal justice systems for criminal holds and the care of acutely disturbed, violent individuals.

- The increasing number of acute and chronically mentally ill patients now being released from hospitals without follow-up care, who now have the right to refuse medicine and who can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others.

- The availability of drugs or money at hospitals, clinics, and pharmacies, making them likely robbery targets.

- Situational and circumstantial factors such as unrestricted. movement of the public in clinics and hospitals; the increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members; long waits in emergency or clinic areas, leading to client frustration over an inability to obtain needed services promptly.

- Low staffing levels during times of specific increased activity such as meal times, visiting times, and when staff are transporting patients.

- Isolated work with clients during examinations or treatment.

- Solo work, often in remote locations, particularly in high-crime settings, with no back-up or means of obtaining assistance such as communication devices or alarm systems.

[5]According to a 1989 report (Wasserberger), 25 percent of major trauma patients treated in the emergency room carried weapons. Attacks in emergency rooms in gang-related shootings as well as planned escapes from police custody have been documented in hospitals. A 1991 report (Goetz et al.) also found that 17.3 percent of psychiatric patients searched were carrying weapons.

- Lack of training of staff in recognizing and managing escalating hostile and assaultive behavior.

- Poorly lighted parking areas.

Overview of Guidelines

In January 1989, OSHA published voluntary, generic safety and health program management guidelines for all employers to use as a foundation for their safety and health programs, which can include a workplace violence prevention program.[6] OSHA'S violence prevention guidelines build on the 1989 generic guidelines by identifying common risk factors and describing some feasible solutions. Although not exhaustive, the new workplace violence guidelines include policy recommendations and practical corrective methods to help prevent and mitigate the effects of workplace violence.

The goal is to eliminate or reduce worker exposure to conditions that lead to death or injury from violence by implementing effective security devices and administrative work practices, among other control measures.

The guidelines cover a broad spectrum of workers who provide health care and social services in psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment clinics, pharmacies, community care facilities, and long-term care facilities. They include physicians, registered nurses, pharmacists, nurse practitioners, physicians' assistants, nurses' aides, therapists, technicians, public health nurses, home health care workers, social/welfare workers, and emergency medical care personnel. Further, the guidelines may be useful in reducing risks for ancillary personnel such as maintenance, dietary, clerical, and security staff employed in the health care and social services industries.

Violence Prevention Program Elements

There are four main components to any effective safety and health program that also apply to preventing workplace violence, (1) management commitment and employee involvement, (2) worksite analysis, (3) hazard prevention and control, and (4) safety and health training.

Management Commitment and Employee Involvement

Management commitment and employee involvement are complementary and essential elements of an effective safety and health program. To ensure an effective program, management and front-line employees must work together, perhaps through a team or committee approach. If employers opt for this strategy, they must be careful to comply with the applicable provisions of the National Labor Relations Act.[7]

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[6]OSHA's Safety and Health Program Management Guidelines (Fed Reg 54 (16):3904-3916, January 26, 1989), provide for comprehensive safety and health programs containing these major elements. Employers with such programs can include workplace violence prevention efforts in that context.

[7]Title 29 U.S.C., Section 158(a)(2).

Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence, and should include the following:

- Demonstrated organizational concern for employee emotional and physical safety and health.
- Equal commitment to worker safety and health and patient/client safety.
- Assigned responsibility for the various aspects of the workplace violence prevention program to ensure that all managers, supervisors, and employees understand their obligations.
- Appropriate allocation of authority and resources to all responsible parties.
- A system of accountability for involved managers, supervisors, and employees.
- A comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents.
- Commitment to support and implement appropriate recommendations from safety and health committees.

Employee involvement and feedback enable workers to develop and express their own commitment to safety and health and provide useful information to design, implement, and evaluate the program.

Employee involvement should include the following:

- Understanding and complying with the workplace violence prevention program and other safety and security measures.
- Participation in an employee complaint or suggestion procedure covering safety and security concerns.
- Prompt and accurate reporting of violent incidents.
- Participation on safety and health committees or teams that receive reports of violent incidents or security problems, make facility inspections, and respond with recommendations for corrective strategies.
- Taking part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior, or criminal intent, and discusses appropriate responses.

Written Program

A written program for job safety and security, incorporated into the organization's overall safety and health program, offers an effective approach for larger organizations. In smaller establishments, the program need not be written or heavily documented to be satisfactory. What is needed are clear goals and objectives to prevent workplace violence suitable for the size and complexity of the workplace operation and adaptable to specific situations in each establishment.

The prevention program and start-up date must be communicated to all employees. At a minimum, workplace violence prevention programs should do the following:

- Create and disseminate a clear policy of zero- tolerance for workplace violence, verbal and nonverbal threats, and related actions. Managers, supervisors, co-workers, clients, patients, and visitors must be advised of this policy.

- Ensure that no reprisals are taken against an employee who reports or experiences workplace violence.[8]

- Encourage employees to promptly report incidents and to suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and to measure progress.

- Outline a comprehensive plan for maintaining security in the workplace, which includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.

- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. The written plan should ensure that there are adequate resources available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.

- Affirm management commitment to a worker- supportive environment that places as much importance on employee safety and health as on serving the patient or client.

- Set up a company briefing as part of the initial effort to address such issues as preserving safety, supporting affected employees, and facilitating recovery.

[8]Section 11 (c)(1) of the OSHA Act, which also applies to protected activity involving the hazard of workplace violencce as it does for other health and safety matters: "No person shall discharge or in any manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding or because of the exercise by such employee on behalf of himself or others of any right afforded by this Act."

Worksite Analysis

Worksite analysis involves a step-by-step, common sense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific locales where hazards may develop.

A "Threat Assessment Team," "Patient Assault Team," similar task force, or coordinator may assess the vulnerability to workplace violence and determine the appropriate preventive actions to be taken. Implementing the workplace violence prevention program then may be assigned to this group. The team should include representatives from senior management, operations, employee assistance, security, occupational safety and health, legal, and human resources staff.
The team or coordinator can review injury and illness records and workers' compensation claims to identify patterns of assaults that could be prevented by workplace adaptation, procedural changes, or employee training. As the team or coordinator identifies appropriate controls, these should be instituted.

The recommended program for worksite analysis includes, but is not limited to, analyzing and tracking records, monitoring trends and analyzing incidents, screening surveys, and analyzing workplace security.

Records Analysis and Tracking

This activity should include reviewing medical, safety, workers' compensation and insurance records — including the OSHA 200 log, if required — to pinpoint instances of workplace violence. Scan unit logs and employee and police reports of incidents or near-incidents of assaultive behavior to identify and analyze trends in assaults relative to particular departments, units, job titles, unit activities, work stations, and/or time of day. Tabulate these data to target the frequency and severity of incidents to establish a baseline for measuring improvement.

Monitoring Trends and Analyzing Incidents

Contacting similar local businesses, trade associations, and community and civic groups is one way to learn about their experiences with workplace violence and to help identify trends. Use several years of data, if possible, to trace trends of injuries and incidents of actual or potential workplace violence.

Screening Surveys

One important screening tool is to give employees a questionnaire or survey to get their ideas on the potential for violent incidents and to identify or confirm the need for improved security measures. Detailed baseline screening surveys can help pinpoint tasks that put employees at risk. Periodic surveys — conducted at least annually or whenever operations change or incidents of workplace violence occur — help identify new or previously unnoticed risk factors and deficiencies or failures in work practices, procedures, or controls. Also, the surveys help assess the effects of changes in the work processes (see Appendix A for a sample survey used in the State of Washington). The periodic review process should also include feedback and follow-up.

Independent reviewers, such as safety and health professionals, law enforcement or security specialists, insurance safety auditors, and other qualified persons may offer advice to strengthen programs. These experts also can provide fresh perspectives to improve a violence prevention program.

Workplace Security Analysis

The team or coordinator should periodically inspect the workplace and evaluate employee tasks to identify hazards, conditions, operations, and situations that could lead to violence. To find areas requiring further evaluation, the team or coordinator should do the following:

- Analyze incidents, including the characteristics of assailants and victims, an account of what happened before and during the incident, and the relevant details of the situation and its outcome. When possible, obtain police reports and recommendations.

- Identify jobs or locations with the greatest risk of violence as well as processes and procedures that put employees at risk of assault, including how often and when.

- Note high-risk factors such as types of clients or patients (e.g., psychiatric conditions or patients disoriented by drugs, alcohol, or stress); physical risk factors of the building; isolated locations/job activities; lighting problems; lack of phones and other communication devices, areas of easy, unsecured access; and areas with previous security problems. (See sample checklist for assessing hazards in Appendix B.)

- Evaluate the effectiveness of existing security measures, including engineering control measures. Determine if risk factors have been reduced or eliminated, and take appropriate action.

Hazard Prevention and Control

After hazards of violence are identified through the systematic worksite analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these hazards. If violence does occur, post-incidence response can be an important tool in preventing future incidents.

Engineering Controls and Workplace Adaptation

Engineering controls, for example, remove the hazard from the workplace or create a barrier between the worker and the hazard. There are several measures that can effectively prevent or control workplace hazards, such as those actions presented in the following paragraphs. The selection of any measure, of course, should be based upon the hazards identified in the workplace security analysis of each facility.

- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.

- Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones, and private channel radios where risk is apparent or may be anticipated, and arrange for a reliable response system when an alarm is triggered.

- Provide metal detectors — installed or hand-held, where appropriate — to identify guns, knives, or other weapons, according to the recommendations of security consultants.

- Use a closed-circuit video recording for high-risk areas on a 24-hour basis. Public safety is a greater concern than privacy in these situations.

- Place curved mirrors at hallway intersections or concealed areas.

- Enclose nurses' stations, and install deep service counters or bullet-resistant, shatter-proof glass in reception areas, triage, admitting, or client service rooms.

- Provide employee "safe rooms" for use during emergencies.

- Establish "time-out" or seclusion areas with high ceilings without grids for patients acting out and establish separate rooms for criminal patients.

- Provide client or patient waiting rooms designed to maximize comfort and minimize stress.

- Ensure that counseling or patient care rooms have two exits.

- Limit access to staff counseling rooms and treatment rooms controlled by using locked doors.

- Arrange furniture to prevent entrapment of staff. In interview rooms or crisis treatment areas, furniture should be minimal, lightweight, without sharp comers or edges, and/or affixed to the floor. Limit the number of pictures, vases, ashtrays, or other items that can be used as weapons.

- Provide lockable and secure bathrooms for staff members separate from patient-client, and visitor facilities.

- Lock all unused doors to limit access, in accordance with local fire codes.

- Install bright, effective lighting indoors and outdoors.

- Replace burned-out lights, broken windows, and locks.

- Keep automobiles, if used in the field, well-maintained. Always lock automobiles.

Administrative and Work Practice Controls

Administrative and work practice controls affect the way jobs or tasks are performed. The following examples illustrate how changes in work practices and administrative procedures can help prevent violent incidents.

- State clearly to patients, clients, and employees that violence is not permitted or tolerated.

- Establish liaison with local police and state prosecutors. Report all incidents of violence. Provide police with physical layouts of facilities to expedite investigations.

- Require employees to report all assaults or threats a supervisor or manager (e.g., can be confidential interview). Keep log books and reports of such incidents to help in determining any necessary actions to prevent further occurrences.

- Advise and assist employees, if needed, of company procedures for requesting police assistance or filing charges when assaulted.

- Provide management support during emergencies. Respond promptly to all complaints.

- Set up a trained response team to respond to emergencies.

- Use properly trained security officers, when necessary, to deal with aggressive behavior. Follow written security procedures.

- Ensure adequate and properly trained staff for restraining patients or clients.

- Provide sensitive and timely information to persons waiting in line or in waiting rooms. Adopt measures to decrease waiting time.

- Ensure adequate and qualified staff coverage at all times. Times of greatest risk occur during patient transfers, emergency responses, meal times, and at night. Locales with the greatest risk include admission units and crisis or acute care units. Other risks include admission of patients with a history of violent behavior or gang activity.

- Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.

- Establish a list of "restricted visitors" for patients with a history of violence. Copies should be available at security checkpoints, nurses' stations, and visitor sign-in areas. Review and revise visitor check systems, when necessary. Limit information given to outsiders on hospitalized victims of violence.

- Supervise the movement of psychiatric clients and patients throughout the facility.

- Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.

- Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Employees should never enter seclusion rooms alone.

- Establish policies and procedures for secured areas, and emergency evacuations, and for monitoring high-risk patients at night (e.g., open versus locked seclusion).

- Ascertain the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors. Establish a system-such as chart tags, log books, or verbal census reports — to identify patients and clients with assaultive behavior problems, keeping in mind patient confidentiality and worker safety issues. Update as needed.

- Treat and/or interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (e.g., rooms with removable partitions).

- Use case management conferences with co-workers and supervisors to discuss ways to effectively treat potentially violent patients.

- Prepare contingency plans to treat clients who are "acting out" or making verbal or physical attacks or threats. Consider using certified employee assistance professionals (CEAPs) or in-house social service or occupational health service staff to help diffuse patient or client anger.

- Transfer assaultive clients to "acute care units," "criminal units," or other more restrictive settings.

- Make sure that nurses and/or physicians are not alone when performing intimate physical examinations of patients.

- Discourage employees from wearing jewelry to help prevent possible strangulation in confrontational situations. Community workers should carry only required identification and money.

- Periodically survey the facility to remove tools or possessions left by visitors or maintenance staff which could be used inappropriately by patients.

- Provide staff with identification badges, preferably without last names, to readily verify employment.

- Discourage employees from carrying keys, pens, or other items that could be used as weapons.

- Provide staff members with security escorts to parking areas in evening or late hours. Parking areas should be highly visible, well-lighted, and safely accessible to the building.

- Use the "buddy system," especially when personal safety may be threatened. Encourage home health care providers, social service workers, and others to avoid threatening situations. Staff should exercise extra care in elevators, stairwells and unfamiliar residences; immediately leave premises if there is a hazardous situation; or request police escort if needed.

- Develop policies and procedures covering home health care providers, such as contracts on how visits will be conducted, the presence of others in the home during the visits, and the refusal to provide services in a clearly hazardous situation.

- Establish a daily work plan for field staff to keep a designated contact person informed about workers' whereabouts throughout the workday. If an employee does not report in, the contact person should follow-up.

- Conduct a comprehensive post-incident evaluation, including psychological as-well as medical treatment, for employees who have been subjected to abusive behavior.

Post-Incident Response

Post-incident response and evaluation are essential to an effective violence prevention program. All workplace violence programs should provide comprehensive treatment for victimized employees and employees who may be traumatized by witnessing a workplace violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of severity. (See sample hospital policy in Appendix C). Transportation of the injured to medical care should be provided if care is not available on-site.

Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries. These include short and long-term psychological trauma, fear of returning to work, changes in relationships with co-workers and family, feelings of incompetence, guilt, powerlessness, and fear of criticism by supervisors or managers. Consequently, a strong follow-up program for these employees will not only help them to deal with these problems but also to help prepare them to confront or prevent future incidents of violence (Flannery, 1991, 1993; 1995).

There are several types of assistance that can be incorporated into the post-incident response. For example, trauma-crisis counseling, critical incident stress debriefing, or employee assistance programs may be provided to assist victims. Certified employee assistance professionals, psychologists, psychiatrists, clinical nurse specialists, or social workers could provide this counseling, or the employer can refer staff

victims to an outside specialist. In addition, an employee counseling service, peer counseling, or support groups may be established.

In any case, counselors must be well trained and have a good understanding of the issues and consequences of assaults and other aggressive, violent behavior. Appropriate and promptly rendered post-incident debriefings and counseling reduce acute psychological trauma and general stress levels among victims and witnesses. In addition, such counseling educates staff about workplace violence and positively influences workplace and organizational cultural norms to reduce trauma associated with future incidents.

Training and Education

Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their co-workers through established policies and procedures.

All Employees

Every employee should understand the concept of "universal Precautions for Violence," i.e., that violence should be expected but can be avoided or mitigated through preparation. Staff should be instructed to limit physical interventions in workplace altercations whenever possible, unless there are adequate numbers of staff or emergency response teams and security personnel available. Frequent training also can improve the likelihood of avoiding assault (Carrnel and Hunter, 1990).

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards.

The training program should involve all employees, including supervisors and managers. New and reassigned employees should receive an initial orientation prior to being assigned their job duties. Visiting staff, such as physicians, should receive the same training as permanent staff. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations, and drills.

Topics may include Management of Assaultive Behavior Professional Assault Response Training; police assault avoidance programs, or personal safety training such as awareness, avoidance, and how to prevent assaults. A combination of training maybe used depending on the severity of the risk.

Required training should be provided to employees annually. In large institutions, refresher programs may be needed more frequently (monthly or quarterly) to effectively reach and inform all employees.

The training should cover topics such as the following:

- The workplace violence prevention policy.
- Risk factors that cause or contribute to assaults.
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults.
- Ways of preventing or diffusing volatile situations or aggressive behavior, managing anger, and appropriately using medications as chemical restraints.
- Information on multicultural diversity to develop sensitivity to racial and ethnic issues and differences.
- A standard response action plan for violent situations, including availability of assistance, response to alarm systems, and communication procedures.
- How to deal with hostile persons other than patients and clients, such as relatives and visitors.
- Progressive behavior control methods and safe methods of restraint application or escape.
- The location and operation of safety devices such as alarms systems, along with the required maintenance schedules and procedures.
- Ways to protect oneself and coworkers, including use of the "buddy system."
- Policies and procedures for reporting and recordkeeping.
- Policies and procedures for obtaining medical care, counseling, workers' compensation, or legal assistance after a violent episode or injury.

Supervisors, Managers, and Security Personnel

Supervisors and managers should ensure that employees are not placed in assignments that compromise safety and should encourage employees to report incidents. Employees and supervisors should be trained to behave compassionately towards coworkers when an incident occurs.

They should learn how to reduce security hazards and ensure that employees receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and to make any necessary changes in the physical plant, patient care treatment program, and staffing policy and procedures to reduce or eliminate the hazards.
Security personnel need specific training from the hospital or clinic, including the psychological

components of handling aggressive and abusive clients, types of disorders, and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. The content, methods, and frequency of training should be reviewed and evaluated annually by the team or coordinator responsible for implementation. Program evaluation may involve supervisor and/or employee interviews, testing and observing, and/or reviewing reports of behavior of individuals in threatening situations.

Recordkeeping and Evaluation of the Program

Recordkeeping and evaluation of the violence prevention program are necessary to determine overall effectiveness and identify any deficiencies or changes that should be made.

Recordkeeping

Recordkeeping is essential to the success of a workplace violence prevention program. Good records help employers determine the severity of the problem, evaluate methods of hazard control, and identify training needs. Records can be especially useful to large organizations and for members of a business group or trade association who "pool" data. Records of injuries, illnesses, accidents, assaults, hazards, corrective actions, patient histories, and training, among others, can help identify problems and solutions for an effective program.

The following records are important:

- OSHA Log of Injury and Illness (OSHA 200). OSHA regulations require entry on the Injury and Illness Log of any injury that requires more than first aid, is a lost-time injury, requires modified duty, or causes loss of consciousness.[9] (This applies only to establishments required to keep OSHA logs.) Injuries caused by assaults, which are otherwise recordable, also must be entered on the log. A fatality or catastrophe that results in the hospitalization of 3 or more employees must be reported to OSHA within 8 hours. This includes those resulting from workplace violence and applies to all establishments.

- Medical reports of work injury and supervisors' reports for each recorded assault should be kept. These records should describe the type of assault, i.e., unprovoked sudden attack or patient-to-patient altercation; who was assaulted; and all other circumstances of the incident. The records should include a description of the environment or location, potential or actual cost, lost time, and the nature of injuries sustained.

[9]The Occupational Safety and Health Act and recordkeeping regulations in Title 29 Code of Federal Regulations (CFR), Part 1904 provide specific recording requirements that comprise the framework of the occupational safety and health recording system (BLS, 1986a). BLS has issued guidelines that provide official Agency interpretations concerning the recordkeeping and reporting of occupational injuries and illnesses (BLS, 1986B).

- Incidents of abuse, verbal attacks or aggressive behavior-which may be threatening to the worker but do not result in injury, such as pushing or shouting and acts of aggression towards other clients-should be recorded, perhaps as part of an assaultive incident report. These reports should be evaluated routinely by the affected department. (See sample incident forms in Appendix D).

- Information on patients with a history of past violence, drug abuse, or criminal activity should be recorded on the patient's chart. All staff who care for a potentially aggressive, abusive, or violent client should be aware of their background and history. Admission of violent clients should be logged to help determine potential risks.

- Minutes of safety meetings, records of hazard analyses, and corrective actions recommended and taken should be documented.

- Records of all training programs, attendees, and qualifications of trainers should be maintained.

Evaluation

As part of their overall program, employers should evaluate their safety and security measures. Top management should review the program regularly, and with each incident, to evaluate program success. Responsible parties (managers, supervisors, and employees) should collectively reevaluate policies and procedures on a regular basis. Deficiencies should be identified and corrective action taken.

An evaluation program should involve the following:

- Establishing a uniform violence reporting system and regular review of reports.

- Reviewing reports and minutes from staff meetings on safety and security issues.

- Analyzing trends and rates in illness/injury or fatalities caused by violence relative to initial or "baseline" rates.

- Measuring improvement based on lowering the frequency and severity of workplace violence.

- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate their effectiveness.

- Surveying employees before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness.

- Keeping abreast of new strategies available to deal with violence in the health care and social service fields as these develop.

- Surveying employees who experience hostile situations about the medical treatment they received initially and, again, several weeks afterward, and then several months later.

- Complying with OSHA and state requirements for recording and reporting deaths, injuries, and illnesses.

- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving employee safety.

Management should share workplace violence prevention program evaluation reports with all employees. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives, or other employee groups.

Sources of Assistance

Employers who would like assistance in implementing an appropriate workplace violence prevention program can turn to the OSHA Consultation service provided in their state. Primarily targeted at smaller companies, the consultation service is provided at no charge to the employer and is independent of OSHA'S enforcement activity. (See Appendix E.)

OSHA'S efforts to assist employers combat workplace violence are complemented by those of NIOSH (1-800-35 -NIOSH) and public safety officials, trade associations, unions, insurers, human resource, and employee assistance professionals as well as other interested groups. Employers and employees may contact these groups for additional advice and information.

The Occupational Safety and Health Act and recordkeeping regulations in Title 29 Code of Federal Regulations (CFR), Part 1904 provide specific recording requirements that comprise the framework of the occupational safety and health recording system (BLS, 1986a). BLS has issued guidelines that provide official Agency interpretations concerning the recordkeeping and reporting of occupational injuries and illnesses (BLS, 1986b).

Conclusion

OSHA recognizes the importance of effective safety and health program management in providing safe and healthful workplaces. In fact, OSHA'S consultation services help employers establish and maintain safe and healthful workplaces, and the agency's Voluntary Protection Programs were specifically established to recognize worksites with exemplary safety and health programs. (See Appendix E.) Effective safety and health programs are known to improve both morale and productivity and reduce workers' compensation costs.

OSHA'S violence prevention guidelines are an essential component to workplace safety and health programs. OSHA believes that the performance-oriented approach of the guidelines provides employers with flexibility in their efforts to maintain safe and healthful working conditions.