Working with District Attorneys and Law Enforcement For Workplace Violence Prevention

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Working with District Attorneys and Law Enforcement for

Workplace Violence Prevention

Workplace violence is a significant cause of injuries for many PEF members, especially those who work in state agencies with institutional settings such as OMH, OPWDD, OCFS and DOCCS. Law enforcement and/or district attorneys may be reluctant to arrest and prosecute perpetrators of violence from these institutions due to age or mental capacity. One way to address this problem is for PEF leaders and political action liaisons to meet with local law enforcement and District Attorneys (DAs) to encourage them to work with assault victims, public employers, and labor leaders to prosecute criminal assault cases in New York State facilities. In fact, the Workplace Violence Prevention Law requires that "Employers at sites where there is a developing pattern of workplace violence incidents which may involve criminal conduct or a serious injury shall attempt to develop a protocol with the District Attorney or Police to insure that violent crimes committed against employees in the workplace are promptly investigated and appropriately prosecuted." In this workshop we will discuss the challenges facing our members in the prosecution of perpetrators, current practices for working with law enforcement, and strategies for developing cooperative agreements with criminal justice authorities.

WORKING WITH DISTRICT ATTORNEYS AND LAW ENFORCEMENT FOR WORKPLACE VIOLENCE PREVENTION

PEF Region 5 Office - 305 Vestal Parkway West, Vestal, NY 13850

Monday 8/15/16 5:30 – 7:30

AGENDA

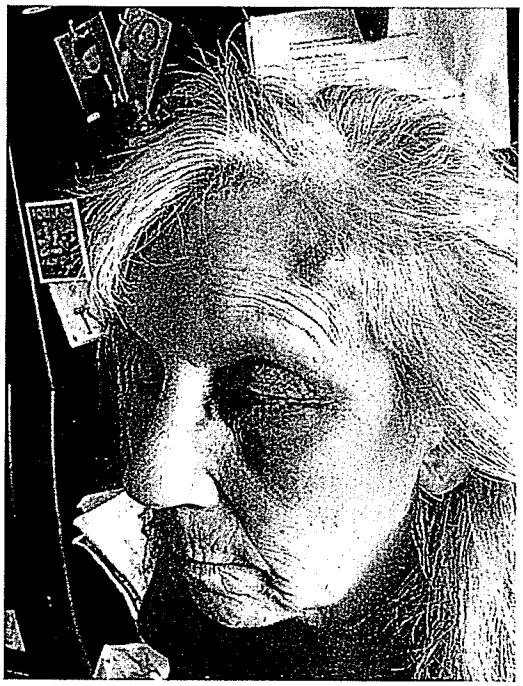
1) Introduction
   a) Intro panel
   b) DA
   c) Case Study

2) Challenges facing worksites
   a) Combative clients/residents
   b) Multiple diagnosis
   c) New drugs (k-2)
   d) Incomplete reporting by management to police
      i) Patient history of violence
   e) Assault vs. Harassment
      i) "significant" injuries: broken bones, deep tissue injuries

3) Why are Authorities reluctant to file charges?
   a) Mental capacity
   b) Age
   c) Perception: patients vs. offender
   d) Expense:
      i) Jails: OT, segregation, 1-to-1 observation
      ii) Pre-prosecution costs
         (1) Determining competency

4) Union Leadership – back at the workplace
   a) Cooperative Agreements
   b) Review of WV Program and incident reports
   c) How to support members after an assault
      i) Workers Compensation
      ii) ATAC Insurance: Assault, Trauma, and Attack Coverage
      iii) Encourage reporting to police and agency
      iv) Using the WVP and RN Felony laws
      v) Medical and/or social services referral
      vi) Return to work issues
      vii) Working with assailants
      viii) Reaching out to injured members
   d) How to generate interest in the work place

5) Wrap-up & Evaluation forms



Working With Criminal Justice **Authorities for Workplace Violence Prevention**

Linda's Story

Linda is a Nurse 2 for OPWDD and a member of the NYS Public Employees Federation (PEF). She was assaulted by a consumer at a DDSO home in May, 2015. She suffered multiple contusions to her head and face. When she attempted to file charges against her assailant she was told by criminal justice authorities that was not possible. She and her PEF representatives advocated for justice and eventually prevailed in having charges filed. Here is her story:

When asked to summarize my experience with the various law enforcement agencies I came in contact with after my assault on May 22 2015, I decided not to expound on the tedious task of identifying each and every contact and phone call. It will suffice to say that I spent weeks of embarrassment and discomfort with my face and eye badly bruised while my injuries resolved. I was in a constant flux of resentment, hopelessness for lack of recourse and unexplained panic.

I have been a Nurse for many years and have spent my career working with mentally ill and potentially aggressive individuals. I was employed at Monroe Co hospital worked the brain injury unit for 10 years, Industry Secure Center working with violent offenders for 4 years and at the Monroe Co Developmental Center forensic units since 2011. I have been assaulted several times in my career and never once considered pressing charges on my assailant due to my understanding of their illness and the level of control they were able to exert over their behavior. I knew this assault was different. The resident that struck me had demonstrated to me his level of self-control and his understanding of right and wrong on many occasions. I believe his choice to hit me me was based in part by his knowledge of the lack of consequences he would be made to suffer as a result.

I was told that the DA could not prosecute and therefore would not charge my assailant based on his opinion that my assailant was not competent due to his Mental illness and MR diagnosis.

It was clear to me that I was being denied the protection of the law and being made to feel like a nuisance. One criminal justice authority seemed to be annoyed with my constant phone calls and efforts to understand his position that residence in a group home shielded criminal behavior. Two months after the incident he finally filed charges of Harassment on my assailant, though I didn't feel the charge was sufficient. The feeling of my assailants' fist hitting my head didn't feel a bit like mere harassment. It felt more like I was trying to stay conscious and keep myself alive.

When the Developmental Center closed most of the residents housed there came out into the Community houses as did the Nursing and Direct Care staff. Many of those residents made a successful transition to community life but others did not and it changed the nature of the work and level of safety that the staff had previously been afforded.

It concerns me beyond description that criminal justice authorities disqualify some people from prosecution because of their residence in a Group home setting. And, that Nurses do not seem to be afforded the same consideration that law enforcement officers allow themselves in terms of prosecution for assault on their persons.

It's my understanding that the accused is being evaluated for competence and I am satisfied that the legal process is being worked out regardless of the outcome. It is a shame that so much time and anguish needed to be spent by myself, my PEF representatives and my Senator's office on accomplishing what should have been done on the day of the incident.

I liken the DA's attitude to that of a Nurse walking away from an injured patient because at first glance there appears to be no way to help. A good nurse steps up every time and tries to turn things around even when the odds are against her because any effort is better than nothing.

Criminal Justice Authorities need to step up. Walking away serves no one, and at times encourages aggressive behavior because of the lack of consequences. Even if no conviction can take place, anything is better than nothing at all.

Published in the Evening Sun- December 9, 2015

County on the hook for treatment of CIT consumer

By Shawn Magrath
Sun Staff Writer
smagrath@ovesun.com

CHENANGO – Chenango County is on the hook for more than $48,000 in inpatient hospitalization and treatment for a Valley Ridge Center for Intensive Treatment (CIT) consumer, despite claims of promises to local officials that county taxpayers would never incur any costs of the state-run CIT facility in Norwich.

The issue was brought before members of the Chenango County Health and Human Services Committee at their December monthly meeting. Chenango Behavioral Health Services Director Ruth Roberts said that her department has been billed $48,699 for intensive treatment received by a CIT consumer while in custody at the Chenango County jail.

Roberts explained that the issue stems from an incident that occurred in December, 2014, in which a CIT consumer was arraigned in Norwich Town Court on charges of assault to a Valley Ridge CIT employee. That consumer was ordered to the Chenango County Correctional Facility.

"Somewhere along that progression, it was determined that he required inpatient hospitalization, so he had to be moved," said Roberts.

He was relocated to the Sunmount Developmental Center in Franklin County for treatment, per judge's orders. Like Valley Ridge, the Sunmount facility is operated under the auspices of the New York State Office of People with Developmental Disabilities.

"He remained there for restorative services until the District Attorney was able to bring him back," said Roberts, also noting that under New York mental hygiene law, the county is responsible for 50 percent of the charges of an individual's intensive treatment while in Department of Corrections custody (total cost of treatment in this case was $140,332).

"I don't know if we're going to get any relief for those charges at the county level," she added. "I have to admit, I'm not real hopeful that we're going to be able to avoid them."

Roberts also pointed to a bigger conversation that's being had by mental hygiene directors across the state.

"There's talk about these types of expenses that many counties are incurring for mental hygiene services, and the increase of these types of

Continued on Page 3

...Continued Evening Sun Article

Bill for treatment of CIT consumer –

CONTINUED FROM PAGE 1

activities that are occurring ... There are fewer institutions, developmental centers are closing, and there are more and more individuals in need of help who end up living at the community level where they get into trouble with the criminal justice system. Some conversations are about how we can prevent these people from ending up in court."

For now, the county is stuck with the bill for the Valley Ridge CIT consumer.

"We need to have a meeting with somebody who can explain to a Board of Supervisors, who are very unhappy that this charge is made, what's happening," said German Town Supervisor Richard Schlagg, who serves on the county's Health and Human Services Committee. "We were told prior to this facility being built that there would be no expenses for these people. There would be no local cost – there are a number of people who could attest to that. Now here we are with a local cost."

The committee agreed to sit on the bill in hopes that they can organize a meeting with state officials concerning the increasing expenses of mental hygiene services at the local level. More specifically, committee members are taking aim at Valley Ridge CIT.

"The only way to keep this discussion open is to keep that bill open," said Committee Chairman Jeffrey Blanchard.

Said Roberts, "It's my opinion that just because Valley Ridge sits in Chenango County, Chenango County should not take on the burden related to these costs."

The Health and Human Services Committee hopes to eventually have state and Valley Ridge CIT representatives address the full Board of Supervisors.

PEFactsheet

Workplace Violence Prevention

Working With District Attorneys and Law Enforcement

Workplace violence is a significant cause of injuries for many PEF members, especially those who work in state agencies who work with psychiatric, behavioral, developmental or youth populations such as OMH, OPWDD, OCFS or DOCCS. Law enforcement and/or district attorneys may be reluctant to arrest and prosecute perpetrators of violence from these settings due to age or mental capacity. One way to address this problem is for PEF leaders and political action liaisons to meet with local law enforcement and District Attorneys (DAs) to encourage them to work with assault victims, public employers, and labor leaders to prosecute criminal assault cases in state facilities.

What follows are some key points to make with management, law enforcement agencies and DAs on addressing this issue.

- Assault and violence-related injuries result in thousands of often very severe injuries to NYS employees each year. According to the Annual Report of New York State Government Employees Workers Compensation Claims (http://www.cs.ny.gov/pio/WorkersCompAnnualReport2015.pdf) , there are many categories of workplace violence incidents. And those are just the ones that are reported. Many other incidents of workplace violence go unreported each year.

Causes of Workplace Violence Incidents	**Workplace Violence Injuries**					
	2014/ 2015	**2013/ 2014**	**2012/ 2013**	**2011/ 2012**	**2010/ 2011**	**2009/ 2010**
Assaults and Violent Acts by Person(s)	593	789	816	680	595	636
Assault by Patient	601	591	372	355	328	343
Assaults and Violent Acts	509	411	320	406	393	405
Hitting, Kicking, Beating	428	393	413	540	485	439
Assaults and Violent Acts by Person(s), Unspecified	125	167	120	114	136	113
Biting	152	154	186	185	164	206
Assault by Inmate	274	144	82	82	91	65
Patient Pushing Staff	42	45	47	50	49	36
Assaults and Violent Acts by Person(s)/Not Elsewhere Classified	72	43	70	150	185	209

- Some state officials and criminal justice authorities have said that violence towards workers in facilities is just "part of the job" and have been reluctant to prosecute. PEF believes that violence cannot be tolerated regardless of where it occurs. Otherwise, the criminal justice system is setting a separate lower standard for public employees who are assaulted in state institutions.
- Get to know your local DA. Advocate for a contact/liaison in the DAs office and in local law enforcement entities that understand the issues and problems faced by PEF members on the job.
- Protocols with DAs and local law enforcement are required in certain circumstances by the NYS Workplace Violence Prevention Law **12 NYCRR PART 800.6(i)(2)** requires:
  "Employers at sites where there is a developing pattern of workplace violence incidents which may involve criminal conduct or a serious injury shall attempt to develop a protocol with the District Attorney or Police to insure that violent crimes committed against employees in the workplace are promptly investigated and appropriately prosecuted. The employer shall provide information on such protocols and contact information to employees who wish to file a criminal complaint after a workplace violence incident."
- In some locations, PEF and management representatives have jointly developed such agreements with local law enforcement and DAs.
- PEF can offer assistance in providing the DA and local law enforcement with data, access to witnesses, and other helpful information. The DA and local law enforcement can help PEF better support injured members by providing timely information regarding the progress and status of cases.
- Provide copies of the PEF booklet on the Nurse Felony Law. DAs and law enforcement agencies may not be aware of the law which may result in errors in police reports and criminal charges in cases of assaults against nurses.
- Police should respond to each incident and take the reports – assaulted PEF members are the victims of a crime and should be treated with respect
- Notwithstanding the DA's process of evaluating the age and/or mental capacity of the perpetrator on a case by case basis, the responding officer cannot unilaterally decide that the person is too young or not competent to be prosecuted.
- Serious assaults of public employees must be appropriately prosecuted. Staff should not forfeit their rights as a citizen when they enter their workplace.
- Prosecution of these serious crimes safeguards the other consumers and staff, and can serve as a deterrent.

Upon request, the PEF Occupational Health & Safety Department will provide other factsheets, standards, regulations, and other resources. Contact us at healthandsafety@pef.org or 518-785-1900, ext. 254 or 1-800-342-4306, ext. 254.

Produced by the New York State Public Employees Federation

Wayne Spence
President

Kevin Hintz
Secretary-Treasurer

12 NYCRR PART 800.6

PUBLIC EMPLOYER
WORKPLACE VIOLENCE PREVENTION PROGRAMS

800. 6

(a) **Title and Citation:** Within and for the purposes of the Department of Labor, this part may be known as Code Rule 800.6, Public Employer Workplace Violence Prevention Programs, relating to requirements of public employers to develop and implement programs to prevent and minimize the hazards of workplace violence to public employees; allowing any employee or authorized employee representative of employees who believes that a serious violation of this safety or health standard exists, or an imminent danger exists, to request an inspection by the department of labor; and providing for the enforcement of such requirement by the Commissioner of Labor. It may be cited as Code Rule 800.6"Public Employer Workplace Violence Prevention Programs" as an alternative and without prejudice to its designation and citation established by the Secretary of State.

(b) **Purpose and Intent:** It is the purpose of this part to ensure that the risk of workplace assaults and homicides is evaluated by affected public employers and their employees and that such public employers design and implement protection programs to minimize the hazard of workplace violence to employees.

(c) **Application:** This part shall apply throughout the State of New York to the State, any political subdivision of the state, any public authority, public benefit corporation or any other governmental agency or instrumentality thereof. This part shall not apply to any employer as defined in Section twenty-eight hundred one-a of the Education Law.

(d) **Terms:** As used in or in connection with this part, the following terms mean:

(1) Authorized Employee Representative. An employee authorized by the employees or the designated representative of an employee organization recognized or certified to represent the employees pursuant to Article 14 of the Civil Service Law.

(2) Commissioner. The Commissioner of Labor of the State of New York or his or her duly authorized representative for the purposes of implementing this Part.

(3) Employee. A public employee working for an employer.

(4) Employer. The State, any political subdivision of the State, any public authority public benefit corporation, and any other governmental agency or instrumentality thereof, except that an employer shall not include, for purposes of this part, any employer defined as such in Section twenty-eight hundred one-a (2801a) of the Education Law.

(5) Imminent Danger. Any conditions or practices in any place of employment which are such that a danger exists which could reasonably be expected to cause death or serious physical harm immediately or before the imminence of such danger can be eliminated through the enforcement procedures otherwise provided for by this Part.

(6) Retaliatory Action. The discharge, suspension, demotion, penalization or discrimination against any employee, or other adverse employment action taken against an employee in the terms and conditions of employment.

(7) Serious physical harm. Physical injury which creates a substantial risk of death, or which causes death or serious and protracted disfigurement, protracted impairment of health or protracted loss or impairment of the function of any bodily organ or a sexual offense as defined in Article 130 of the Penal Law.

(8) Serious Violation: A serious violation of the public employer workplace violence prevention program (WVPP) is the failure to:

(a) Develop and implement a program.

(b) Address situations which could result in serious physical harm.

(9) Supervisor. Any person within the employer's organization who has the authority to direct and control the work performance of an employee, or who has the authority to take corrective action regarding the violation of a law, rule or regulation to which an employee submits written notice.

(10) Workplace. Any location away from an employee's domicile, permanent or temporary, where an employee performs any work-related duty in the course of his or her employment by an employer.

(11) Workplace Violence. Any physical assault or acts of aggressive behavior occurring where a public employee performs any work-related duty in the course of his or her employment including but not limited to:

(i) An attempt or threat, whether verbal or physical, to inflict physical injury upon an employee;

(ii) Any intentional display of force which would give an employee reason to fear or expect bodily harm;

(iii) Intentional and wrongful physical contact with a person without his or her consent that entails some injury;

(iv) Stalking an employee with the intent of causing fear of material harm to the physical safety and health of such employee when such stalking has arisen through and in the course of employment.

(12) Workplace Violence Prevention Program. An employer program designed to prevent, minimize and respond to any workplace violence, the development and implementation of which is required by Article 2, Section 27-b of the New York State Labor Law.

(e) **Management Commitment and Employee Involvement**

(1) Workplace Violence Policy Statement: The employer shall develop and implement a written policy statement on the employer's workplace violence prevention program goals and objectives and provide for full employee participation through an authorized employee representative.

(i) The workplace violence policy statement shall be posted where notices to employees are normally posted.

(ii) The policy statement shall briefly indicate the employer's workplace violence prevention policy and incident alert and notification policies for employees to follow in the event of a workplace violence incident.

(2) The responsibility and authority for preparing, determining the content of and implementing the requirements of this part remains with the employer. Local governments and all other public employers may elect to share resources in the development and implementation of their workplace violence prevention programs.

(f) **Risk Evaluation and Determination**

(1) Record Examination:
The employer shall examine any records relevant to the purposes of this Part in its possession, including records compiled in the previous year under Labor Law Section 27a, that concern workplace violence incidents to identify patterns in the type and cause of injuries. The examination shall look to identify patterns of injuries in particular areas of the workplace or incidents which involve specific operations or specific individuals.

(2) Administrative Risk Factors
The employer shall assess relevant policies, work practices, and work procedures that may impact the risk of workplace violence.

(3) Evaluation of Physical Environment
The employer, with the participation of the authorized employee representatives, shall evaluate the workplace to determine the presence of factors which may place employees at risk of workplace violence. The Department of Labor has tools to aid employers in performing this evaluation which will be posted on the Department's web-site. Factors which might place an employee at risk include but are not limited to:

(i) Working in public settings (e.g. Social Service Workers, Police Officers, Firefighters, Teachers, Public Transportation Drivers, Health Care Workers, other Governmental Workers or Service Workers);

(ii) Working late night or early morning hours;

(iii) Exchanging money with the public;

(iv) Working alone or in small numbers;

(v) Working in a location with uncontrolled public access to the workplace; or

(vi) Areas of previous security problems.

(g) **The Workplace Violence Prevention Program**

(1) Employers with 20 or more full time permanent employees, with the participation of the authorized employee representative, shall develop a written workplace violence prevention program. Such participation shall include soliciting input from the authorized employee representative as to those situations in the workplace that pose a threat of workplace violence, and on the workplace violence prevention program the employer intends to implement under these regulations. Safety and health programs developed and implemented to meet other federal, state or local regulations, laws or ordinances are considered acceptable in meeting this requirement if those programs cover or are modified to cover the topics required in this paragraph. An additional or separate safety and health program is not required by this paragraph.

(2) The workplace violence prevention program shall include the following:

(i) A list of the risk factors identified in the workplace examination;

(ii) The methods the employer will use to prevent the incidence of workplace violence incidents;

(iii) A hierarchy of controls to which the program shall adhere as follows: engineering controls, work practice controls, and finally personal protective equipment;

(iv) The methods and means by which the employer shall address each specific hazard identified in the workplace evaluation;

(v) A system designed and implemented by the employer to report any workplace violence incidents that occur in the workplace. The reports must be in writing and maintained for the annual program review;

(vi) A written outline or lesson plan for employee program training;

(vii) A plan for program review and update on at least an annual basis. Such review and update shall set forth any mitigating steps taken in response to any incident of workplace violence.

(viii) Nothing in this part shall require the disclosure of information otherwise kept confidential for security reasons. Such information may include information which, if disclosed:

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(a) Would interfere with law enforcement investigations or judicial proceedings;

(b) Would deprive a person of a right to a fair trial or impartial adjudication;

(c) Would identify a confidential source or disclose confidential information relating to a criminal investigation;

(d) Would reveal criminal investigative techniques or procedures, except routine techniques and procedures; or

(e) Would endanger the life or safety of any person.

(h) **Employee Information and Training**

(1) Upon completion of the workplace violence prevention program, every employer shall provide each employee with information and training on the risks of workplace violence in their workplace or workplaces at the time of the employee's initial assignment and at least annually thereafter. Such information as necessary shall be provided to affected employees whenever significant changes are made to the workplace violence program. At a minimum training shall address the following:

(i) Employers shall inform employees of the requirements of this Part and the risk factors in their workplace that were identified in the risk evaluation and determination, except that nothing in this part shall require the disclosure of the information otherwise kept confidential for security reasons as identified in paragraph (g)(2)(viii).

(ii) Employers shall inform employees of the measures that employees can take to protect themselves from the identified risks including specific procedures that the employer has implemented to protect employees such as incident alert and notification procedures, appropriate work practices, emergency procedures, and use of security alarms and other devices;

(iii) Employers with 20 or more full-time permanent employees shall inform employees of the location of the written workplace violence program and how to obtain a copy, and shall make it available for reference to employees, authorized employee representatives and the Commissioner in the work area during the regularly scheduled shift.

(i) **Recordkeeping and Recording Of Workplace Violence Incidents**

(1) Employers shall establish and implement reporting systems for incidents of workplace violence. Reporting systems developed and implemented to meet other federal state or local regulations, laws or ordinances are considered acceptable in meeting this requirement if they cover or are modified to cover the information required in this paragraph. An additional or separate reporting system is not required by this paragraph.

(2) Employers at sites where there is a developing pattern of workplace violence incidents which may involve criminal conduct or a serious injury shall attempt to develop a protocol with the District Attorney or Police to insure that violent crimes committed against employees in the workplace are promptly investigated and appropriately prosecuted. The employer shall provide information on such protocols and contact information to employees who wish to file a criminal complaint after a workplace violence incident.

(3) Systems for reporting instances of workplace violence.

(i) The employer shall develop and maintain a Workplace Violence Incident Report that can be in any format but, at a minimum, shall contain the following relating to the incident being reported:

(a) Workplace location where incident occurred;

(b) Time of day/ shift when incident occurred;

(c) A detailed description of the incident, including events leading up to the incident and how the incident ended;

(d) Names and job titles of involved employees;

(e) Name or other identifier of other individual(s) involved;

(f) Nature and extent of injuries arising from the incident; and

(g) Names of witnesses.

(ii)

(a) If the case is a "privacy concern case" as defined below, the employer shall still be liable for developing a Workplace Violence

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Incident Report as set forth above. However, before sharing a copy of such Report with any party other than the Commissioner, the employer shall remove the name of the employee who was the victim of the workplace violence and shall instead enter "PRIVACY CONCERN CASE" in the space normally used for the employee's name.

(b) The employer shall treat incidents involving the following injuries or illnesses as privacy concern cases:

(1) An injury or illness to an intimate body part or the reproductive system;

(2) An injury or illness resulting from a sexual assault;

(3) Mental illness;

(4) HIV infection;

(5) Needle stick injuries and cuts from sharp objects that are or may be contaminated with another person's blood or other potentially infectious material; and

(6) Other injuries or illnesses, if the employee independently and voluntarily requests that his or her name not be entered on the Report.

(4) The Workplace Violence Incident Report must be maintained for use in annual program review and updates. This requirement does not relieve an employer of the recordkeeping requirements of 12NYCRR Part 801.

(5) The employer, with the participation of the authorized employee representative, shall conduct a review of the Workplace Violence Incident Reports at least annually to identify trends in the types of incidents in the workplace and review of the effectiveness of the mitigating actions taken.

(j) **Employee Reporting Of Workplace Violence Prevention Concerns or Incidents**

(1) Any employee or his or her authorized employee representative who believes that a serious violation of the employer's workplace violence

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protection program exists, or that a workplace violence imminent danger exists, shall bring such matter to the attention of a supervisor in the form of a written notice and shall afford the employer a reasonable opportunity to correct such activity, policy or practice.

(2) Written notice to an employer shall not be required where workplace violence imminent danger exists to the safety of a specific employee or to the general health of a specific patient and the employee reasonably believes in good faith that reporting to a supervisor would not result in corrective action.

(3) If, following a referral of such matter to the employee's supervisor and after a reasonable opportunity to correct such activity, policy or practice, the matter has not been resolved and the employee or the authorized employee representative still believes that a serious violation of a workplace violence prevention program remains or that an imminent danger exists, such employee may request an inspection by notifying the Commissioner of Labor of the alleged violation. Such notice and request shall be in writing, shall set forth with reasonable particularity the ground(s) for the notice and shall be signed by such employee or their authorized employee representative. A copy of the written notice shall be provided by the Commissioner to the employer or the person in charge no later than the time of inspection, except that at the request of the person giving such notice, such person's name and the names of individual employees or authorized employee representatives of employees shall be withheld. Such inspection shall be made forthwith by the Commissioner.

(4) The authority of the Commissioner to inspect premises pursuant to such employee complaint shall not be limited to the alleged violation contained in such complaint. The Commissioner may inspect any other area of the premises in which he or she has reason to believe that a serious violation of this section exists.

(5) The Commissioner may, upon his or her own initiative, conduct an inspection of any premises occupied by an employer if he or she has reason to believe that a violation of this section has occurred. The current PESH administrative plan will be used for the enforcement of this section, including a general schedule of inspections, which provides a rational administrative basis for such inspection.

(6) No employer shall take retaliatory action against any employee because the employee exercises any right accorded him or her by this Part.

(k) **Effective Dates**

(1) The Employer's Policy Statement required by section (e) of this Part shall be completed within 30 days after the effective date of this Part.

(2) The workplace risk evaluation and determination required by section (f) of this Part shall be completed within 60 days of the effective date of this Part.

(3) The workplace violence prevention program required by section (g) of this Part shall be complete within 75 days of the effective date of this Part.

(4) Employers shall be in compliance with the entire Part within 120 days of the effective date of this Part.

SAMPLE AGREEMENT

Agreement between _____ Psychiatric Center, the _____police department, and the _____ County District Attorney, made this _____ day of _____, 20___.

WHEREAS, the Directors of State Psychiatric Centers, police, and district attorneys share an important and legitimate interest in protecting the safety of patients and employees, in assuring that serious crimes are appropriately prosecuted, and in avoiding criminal prosecution of patients for minor criminal offenses when clinical considerations outweigh law enforcement interests; and

WHEREAS, the Directors of State Psychiatric Centers are required, under Section 7.21(b) of the New York State Mental Hygiene Law, to notify local district attorneys or other appropriate law enforcement official when it appears that a crime may have occurred at the facility; and

WHEREAS, the Psychiatric Center is committed to protecting the privacy of its patients; and

WHEREAS federal regulations governing the privacy of individually identifiable health information permit disclosures where such disclosures are required by law, or when they are made to a law enforcement official if an entity subject to such regulations (i.e., "covered entity") believes in good faith that the information so disclosed constitutes evidence of criminal conduct that occurred on the premises of the covered entity (45 C.F.R.§164.512(a), (f)(5)), and the Office of Mental Health has determined that it is a covered entity in accordance with these regulations.

NOW, THEREFORE, the parties agree to the following:

1. Serious incidents, particularly homicides, homicide attempts, aggravated assaults, sexual assaults, or other incidents which may involve criminal conduct and in which a serious injury is sustained will be immediately reported by telephone to local police. Local police will respond immediately. The scene of the incident will be preserved until their arrival. The police will determine the extent of their involvement in the investigation. The Psychiatric Center will

cooperate with the police in every way possible.

2. Assaults, sexual contact between patients who may be incompetent, and other incidents which may be crimes, but which do not involve serious injuries, will be reported by forwarding a copy of the incident report to the local police within 3 business days of the incident. These incidents will be fully investigated by the Psychiatric Center in accordance with Office of Mental Health Policy Directive QA-510, or its most recent iteration.

3. The local police and district attorney will each establish confidential files of reports by the Psychiatric Center in which patients are identified. The identity of patients, and confidential information obtained about patients in the course of a police investigation, shall not be a public record and shall not be revealed. It is understood that records of criminal proceedings against patients may be public records.

4. The local police, district attorney, and Psychiatric Centers have identified the following individuals who will act as liaison officers between them:

Local Police:	_____	_____
	Name	Telephone Number
District Attorney:	_____	_____
	Name	Telephone Number
Psychiatric Center:	_____	_____
	Name	Telephone Number

5. The Psychiatric Center will sometimes suggest that clinical considerations warrant limiting police investigations or justify a decision against prosecution of an act which may be a crime. The Psychiatric Center will inform the local police and district attorney when such circumstances arise. As a general matter, in the absence of the use of physical force or coercion, the Psychiatric Center recommends against police investigation or prosecution for sexual contacts involving patients, even though one or both may be incompetent. Except when a patient is sociopathic, the Psychiatric Center will recommend against criminal prosecution of patients for simple assaults.

6. Individual patients or employees of the Psychiatric Center may wish to file criminal complaints. In such cases, the individual will be given a form asking that he/she identify what happened, where, when, and who was involved. This information will be forwarded to the local police by the Psychiatric Center along with any report of the incident. The Psychiatric Center may also inform the local police if it is believed that a patient/complainant lacks capacity to make a sworn oath, if it appears to the facility that there is a lack of credible evidence to support the complaint, or there are clinical considerations which warrant discretion in investigating or prosecuting the complaint.

   The police or the warrant clerk of the local criminal court will prepare the criminal complaint and return it to the Safety Office of the Psychiatric Center. The Safety Office will then offer the patient or employee the opportunity to sign the complaint. If it is signed, it will be forwarded to the local police for further processing, and issuance of an arrest warrant. Nothing in this Agreement shall be construed to limit the right of a person to make a complaint directly to the police.

7. Warrants for the arrest of any inpatient of the Psychiatric Center will be delivered to the facility Safety Office. In the event that a patient's clinical condition precludes an arrest or court appearance, the local police will be so informed. In such a case, service of the warrant on the patient will be deferred, arraignment on the charges deferred, or other action will be taken by the local police and district attorney to defer criminal proceedings. The Psychiatric Center will notify the local police and district attorney prior to discharging such a patient.

8. Except in an emergency, the local police will be asked to check their weapons at the Psychiatric Center Safety Office before entering the patient care area. The weapons shall be kept under lock and key.

9. The Psychiatric Center will inform the local police of escapes by patients considered likely to be violent, patients committed pursuant to Article 730 or 330 of the Criminal Procedure Law, the Family Court Act, or §517 of the Executive Law. Such disclosures are permissible under federal regulations as either disclosures required by law or disclosures necessary to prevent/lessen a serious and imminent threat to the health or safety of a person or the public (45 C.F.R. §164.512(a),(j)).

10. If the local police locate a missing patient, they will return the patient to the Admissions Office of the Psychiatric Center. The local police will remain at the Center for a sufficient period of time to inform the Psychiatric Center staff of the circumstances under which the patient was located.

11. It is understood that the Psychiatric Center will be operating under the Office of Mental Health Policy Directives QA-510 Clinical Risk Management and Risk Management Plans; QA-515 Reporting Requirements for Alleged Child Abuse and Neglect; Qa-520 Missing Persons; QA-530 Reporting Requirements for Events Which May Be Crimes. Copies of these policy directives are attached.

12. If staff of the Psychiatric Center, the local police, or the district attorney's office are dissatisfied with any aspect of their working relationship, the liaison officers will attempt to resolve the problem. When necessary, the facility director, police chief, or district attorney will be asked to help resolve a dispute.

13. Signatures.

Local Police Department: _____

BY: _____

County District Attorney: _____

BY: _____

Psychiatric Center: _____

BY: _____

GBHC
Greater Binghamton Health Center

MARGARET R. DUGAN, M.A.
EXECUTIVE DIRECTOR

425 Robinson Street
Binghamton, New York 13904-1735
(607) 724-1391
FAX: (607) 773-4387
TTY: (607) 773-4255

August 2, 2013

Gerald F. Mollen, District Attorney
Office of the District Attorney
P.O. Box 1766
Binghamton, NY 13902

Re: Agreement between Greater Binghamton Health Center, Binghamton Police Department, and Broome County District Attorney

Dear Mr. Mollen:

Enclosed is one fully executed original of the above referenced agreement for your files.

If you have any questions, please contact my office at (607) 773-4082.

Sincerely,

Mark E. Stephany /vr

Mark E. Stephany
Acting Executive Director

/vr
Enclosure

AGREEMENT
between
GREATER BINGHAMTON HEALTH CENTER
and
BINGHAMTON POLICE DEPARTMENT
and
BROOME COUNTY DISTRICT ATTORNEY

Agreement between Greater Binghamton Health Center (GBHC), the Binghamton Police Department (BPD), and the Broome County District Attorney (BCDA), made this 22nd day of November 2011.

WHEREAS, the Greater Binghamton Health Center, police and district attorney share an interest in protecting the safety of patients and employees, in assuring that serious crimes are appropriately prosecuted and in avoiding criminal prosecution of patients for minor criminal offenses when clinical considerations outweigh law enforcement interests; and

WHEREAS, the Director of the Greater Binghamton Health Center is required, under Section 7.21(b) of the New York State Mental Hygiene Law, to notify local District Attorneys or other appropriate law enforcement officials when it appears that a crime may have occurred at the facility; and,

WHEREAS, the Greater Binghamton Health Center is also committed to protecting the privacy of its patients; and

WHEREAS, federal regulations governing the privacy of individually identifiable health information permit disclosures where such disclosures are required by law, or when they are made to a law enforcement official if an entity subject to such regulations (i.e., "covered entity") believes in good faith that the information so disclosed constitutes evidence of criminal conduct that occurred on the premises of the covered entity (45 C.F.R.§164.512(a), (f) 5), and the Office of Mental Health has determined that it is a covered entity in accordance with these regulations.

NOW, THEREFORE, the parties agree to the following:

1. Serious incidents, including but not limited to: homicides, homicide attempts, aggravated assaults, sexual assaults, or other incidents which may involve criminal conduct and in which a serious injury is sustained will be immediately reported by telephone to local police. Local police will respond immediately. The scene of the incident will be preserved until their arrival. The police will determine the extent of their involvement in the investigation. GBHC will cooperate with the police in every way possible. These incidents include the following:

   PATIENT ABUSE: Any allegation that a non-patient has physically assaulted a patient, thereby causing serious physical injury to the patient. Any allegation that a non-patient has sexually assaulted a patient. Any allegation that neglect of a patient has resulted in serious physical injury to the patient. Any sexual contact between a patient and a staff member.

   PHYSICAL ASSAULTS: Any assault upon a patient or employee involving a weapon or dangerous instrument, or which results in serious physical injury.

   DEATHS: Any suicide, homicide or attempted homicide, or unexplained death.

   ARSON: Any damage caused to a building or vehicle by an intentionally caused fire or explosion.

   SEXUAL OR ATTEMPTED SEXUAL ASSAULTS: (1) Any allegation or evidence that a completed act or attempted act of sexual intercourse, oral sexual conduct or anal sexual conduct has occurred without the consent of the patient. The lack of consent may be the result (a) forcible compulsion; (b) the mental disability of the patient; (c) the fact that the perpetrator is a health care provider or mental health care provider for the patient; or (d) the patient is less than 17 years of age.

(2) Any allegation or evidence that a patient has been subjected to sexual contact without the consent of the patient when the lack of consent is the result of (a) forcible compulsion; (b) the mental disability of the patient; (c) the fact that the perpetrator is a health care provider or mental health care provider for the patient; (d) the patient is between the ages of 14 and 17 and the perpetrator is more than five years older than the patient.

If the patient does not have the capacity to consent, alleges the act was not consensual, or if the patient is a minor, the Binghamton Police Department will be immediately notified by GBHC Safety Department.

2. Effective November 22, 2011 allegations of the following crimes when the alleged crime includes a patient, an employee, intern, volunteer, consultant, contractor, or visitor, are required to be reported as soon as possible but no later than 24 hours. Reports will be made by forwarding a copy of the GBHC Safety 250 Report to the local police.

Conduct that caused physical injury

Conduct that subjected the patient to unauthorized sexual contact

Conduct that appears to be the crime of Endangering the Welfare of an Incompetent or Physically Disabled Person (Penal Law section 260.25) or

Any felony under state or federal law

3. Incidents which may be crimes, but which are not specified above in section #2, will be reported by forwarding a copy of the GBHC Safety 250 Report to the local police within 3 business days of the incident. These incidents will be fully investigated by GBHC in accordance with Office of Mental Health Policy Directive QA-510, or its most recent iteration. These incidents include the following:

PATIENT ABUSE: Any allegation that a non-patient has verbally harassed a patient (this includes lewd behavior or sexual harassment). Any allegation that a non-patient has physically assaulted a patient, resulting in no physical injury to the patient. Any allegation of patient neglect that does not involve serious physical injury to the patient.

~~ALL SUICIDE ATTEMPTS~~

PHYSICAL ASSAULTS: Any assault upon a patient or employee which does not result in physical injury.

4. The identity of patients and confidential information obtained about patients in the course of a Safety Office and/or police investigation shall be disclosed to the police and District Attorney for law enforcement purposes. In the event any of these records are kept or maintained by BPD or BCDAO, they will be kept confidential and will not be disclosed to the public except as authorized and/or required by law. It is understood that records of criminal proceedings against patients may be public records.

5. The local police, District Attorney, and GBHC have identified the following individuals who will act as liaison officers between them:

Binghamton Police:	**Assistant Chief William Yeager**	**772-7080**
Broome County District Attorney:	**Joann Rose Parry**	**778-2423**
Greater Binghamton Health Center:	**Mary Ann Fritsch**	**773-4082**

6. GBHC will sometimes suggest that clinical considerations warrant limiting police investigations or justify a decision against prosecution of an act which may be a crime. GBHC will inform the local police and District Attorney when such circumstances arise.

7. In those cases in which a patient or staff member of GBHC may wish to file a criminal charge, GBHC will advise the BPD of that fact by forwarding to BPD a copy of the Safety 250 Report. GBHC may also inform the BPD as to the opinion of the treating physician or other appropriate staff member whether: (1) a patient seeking to file a charge has the capacity to understand and appreciate the nature of an oath; (2) a patient who is the victim of an alleged sexual assault has the capacity to consent to sexual contact: (3) a patient against whom the criminal charge may be filed has the capacity to know or appreciate the nature and consequences of his conduct and that such conduct was wrong; (4) a patient against whom a criminal charge may be filed has the capacity to understand the proceedings and to assist in his own defense; (5) there is a lack of credible evidence to support the charge; and/or (6) there are clinical considerations which warrant discretion in investigating or prosecuting the charge.

If, after reviewing the information contained in the Safety 250 Report and any other additional information obtained, the BPD and/or BCDA is satisfied that a criminal charge is warranted, a BPD Officer will prepare and sign the accusatory instrument to be filed with the court; BPD will also prepare the necessary supporting depositions for the witnesses to sign and, if needed, the Safety Officers will assist by contacting the witnesses to sign the depositions and returning them to BPD to be attached to the accusatory instrument.

For Safety 250 Reports involving Children & Adolescents. If, after reviewing the information contained in the Safety 250 Report and any other additional information obtained, the BPD and/or BCDA is satisfied that a referral to the Broome County Attorney's Office is warranted, the report and additional information may be forwarded to that office for review and appropriate action.

In those cases in which a patient or staff member of GBHC may wish to file a criminal charge against an adolescent patient, GBHC will advise the BPD of that fact by forwarding to BPD a copy of the Safety 250 Report. If after reviewing the information contained in the Safety 250 Report and any other additional information obtained, the BPD and/or BCDA is satisfied that a referral to the Broome County Attorney's Office is warranted, the report and additional information may be forwarded to that office for review and appropriate action.

8. If, in the opinion of the treating physician or other appropriate staff member, the patient's clinical condition precludes an appearance in court, BPD will be so informed. In such case, BPD will consult with the BCDA to decide whether and when criminal charges should be filed or deferred. GBHC will notify BPD as soon as the patient's clinical condition has improved to the extent that a court appearance can be scheduled. At that time, the decision whether to file the criminal charge will be made.

In all other cases, after filing an accusatory instrument charging a patient at GBHC with a criminal offense, BPD will request the issuance of a criminal summons. The summons will be delivered to the GBHC Safety Office, and arrangements will be made to produce the patient in court on the date scheduled for arraignment.

When a subpoena is issued for a GBHC patient, the BPD officer serving the subpoena will contact the Executive Director and ask a Safety Officer to "facilitate" service of the subpoena on the patient by bringing the patient to the officer so service can be completed.

When a subpoena is issued for a GBHC staff member, the BPD officer will contact the Personnel/HR Department and request someone there to "facilitate" service of the subpoena on the staff member by arranging for the staff member to meet the officer privately to accept the service of the subpoena.

9. Except in an emergency, the local police will be asked to check their weapons at the GBHC Safety Office before entering the patient care area. The weapons shall be kept under lock and key.

10. GBHC will inform the local police of escapes by patients considered likely to be violent, patients committed pursuant to Article 730 or 330 of the Criminal Procedure Law, the Family Court Act, or §517 of the Executive Law. Such disclosures are permissible under federal regulations as either disclosures required by law or disclosures necessary to prevent/lessen a serious and imminent threat to the health or safety of a person or the public (45 C.F.R.§164.512(a),(j)).

11. If the local police locate a missing patient, they will return the patient to the Admissions Office of GBHC. The local police will remain at GBHC for a sufficient period of time to inform GBHC staff of the circumstances under which the patient was located.

12. It is understood that GBHC will be operating under the Office of Mental Health Policy Directives QA-510 Clinical Risk Management and Risk Management Plans; QA-515 Reporting Requirements for Alleged Child Abuse and Neglect; QA-520 Missing Persons; and QA-530 Reporting Requirements for Events which May be Crimes. Copies of these policy directives are attached.

13. If staff of GBHC, the local police, or the district attorney's office are dissatisfied with any aspect of their working relationship, the liaison officers will attempt to resolve the problem. When necessary, the facility director, police chief or, or district attorney will be asked to help resolve a dispute.

14. Nothing in this agreement will be construed to limit the right of a patient or an employee of the Greater Binghamton Health Center to make a complaint directly to the police.

Joseph T Zikuski 5/23/13

Chief Joseph Zikuski Date
City of Binghamton Police Department

Gerald F. Mollen Date
Broome County District Attorney

4-22-13

Mark E. Stephany Date
Acting Executive Director
Greater Binghamton Health Center

SAMPLE LETTER TO DISTRICT ATTORNEY

NYS ANY AGENCY

August 10, 2011

Dear Mr. Smith,

I am writing to request your assistance regarding a matter that recently occurred within your jurisdiction to one of your constituents. On 6/26/2011, Sally Mae, Registered Nurse employed by the NYS Any Agency was physically assaulted while on duty at her assigned work location located in Any Town, New York.

Ms. Mae contacted the Any Town Police Department, however they advised her that per their discussions with the District Attorney's office, they were not going to arrest or charge the individual since he was mentally ill/developmentally disabled and not competent to stand trial. As the local union leader who represents Ms. Mae, I am very concerned that criminal justice authorities would summarily dismiss a case solely because they involve an assailant with mental illness or other disability. Ms. Mae also informed me that neither the police officer or Assistant District Attorney she spoke with were familiar with the "Violence against Nurses" law which took effect in 2010, when amendments were made to subdivisions 3 and 11 of Section 120.05 of the Penal law by adding Registered Nurses and Licensed Practical Nurses to the listed occupations. As a result of this change, cases that had previously been charged as Assault 3rd degree misdemeanors could be charged as Class D Felonies, when and if circumstances warrant.

In advocating for employees who have been assaulted on the job, we have learned that many police and District Attorneys are not familiar with the above changes to the law or how to best address calls that involve the mentally ill/ developmentally disabled. This has resulted in inconsistencies in filing of police reports and outcomes that are not beneficial to the mentally ill or disabled individual, the employees or the public. Unfortunately, it is likely that this problem may worsen, with increased calls to 911, as NYS Any Agency continues to close inpatient facilities around the state and move an increased number of individuals with high risk and sometimes, criminal behaviors directly into community based locations.

We greatly appreciate the work of the District Attorneys and police agencies and recognize their important role in community safety. We would like to work collaboratively to address the above concerns. I am asking that you contact me at (555) 555-5555 to schedule a time to meet in person. You may also contact Ms. Mae directly at (XXX) XXX-XXXX for more details regarding the assault. I look forward to hearing from you and thank you for your anticipated assistance in this matter.

Sincerely,

Patricia Holmes

Title/contact information

cc: Sally Mae

PEFactsheet

Workplace Violence Prevention

Working With District Attorneys and Law Enforcement

Workplace violence is a significant cause of injuries for many PEF members, especially those who work in state agencies who work with psychiatric, behavioral, developmental or youth populations such as OMH, OPWDD, OCFS or DOCCS. Law enforcement and/or district attorneys may be reluctant to arrest and prosecute perpetrators of violence from these settings due to age or mental capacity. One way to address this problem is for PEF leaders and political action liaisons to meet with local law enforcement and District Attorneys (DAs) to encourage them to work with assault victims, public employers, and labor leaders to prosecute criminal assault cases in state facilities.

What follows are some key points to make with management, law enforcement agencies and DAs on addressing this issue.

- Assault and violence-related injuries result in thousands of often very severe injuries to NYS employees each year. According to the Annual Report of New York State Government Employees Workers Compensation Claims (http://www.cs.ny.gov/pio/WorkersCompAnnualReport2016.pdf) , there are many categories of workplace violence incidents. And those are just the ones that are reported. Many other incidents of workplace violence go unreported each year.

Causes of Workplace Violence Incidents	**Workplace Violence Injuries**						
	2015/ 2016	**2014/ 2015**	**2013/ 2014**	**2012/ 2013**	**2011/ 2012**	**2010/ 2011**	**2009/ 2010**
Assaults and Violent Acts by Person(s)	690	593	789	816	680	595	636
Assault by Patient	806	601	591	372	355	328	343
Assaults and Violent Acts	423	509	411	320	406	393	405
Hitting, Kicking, Beating	288	428	393	413	540	485	439
Assaults and Violent Acts by Person(s), Unspecified	226	125	167	120	114	136	113
Biting	126	152	154	186	185	164	206
Assault by Inmate	312	274	144	82	82	91	65
Patient Pushing Staff	33	42	45	47	50	49	36
Assaults and Violent Acts by Person(s)/Not Elsewhere Classified	76	72	43	70	150	185	209

- Some state officials and criminal justice authorities have said that violence towards workers in facilities is just "part of the job" and have been reluctant to prosecute. PEF believes that violence cannot be tolerated regardless of where it occurs. Otherwise, the criminal justice system is setting a separate lower standard for public employees who are assaulted in state institutions.
- Get to know your local DA. Advocate for a contact/liaison in the DAs office and in local law enforcement entities that understand the issues and problems faced by PEF members on the job.
- Protocols with DAs and local law enforcement are required in certain circumstances by the NYS Workplace Violence Prevention Law **12 NYCRR PART 800.6(i)(2)** requires:
  "Employers at sites where there is a developing pattern of workplace violence incidents which may involve criminal conduct or a serious injury shall attempt to develop a protocol with the District Attorney or Police to insure that violent crimes committed against employees in the workplace are promptly investigated and appropriately prosecuted. The employer shall provide information on such protocols and contact information to employees who wish to file a criminal complaint after a workplace violence incident."
- In some locations, PEF and management representatives have jointly developed such agreements with local law enforcement and DAs.
- PEF can offer assistance in providing the DA and local law enforcement with data, access to witnesses, and other helpful information. The DA and local law enforcement can help PEF better support injured members by providing timely information regarding the progress and status of cases.
- Provide copies of the PEF booklet on the Nurse Felony Law. DAs and law enforcement agencies may not be aware of the law which may result in errors in police reports and criminal charges in cases of assaults against nurses.
- Police should respond to each incident and take the reports – assaulted PEF members are the victims of a crime and should be treated with respect
- Notwithstanding the DA's process of evaluating the age and/or mental capacity of the perpetrator on a case by case basis, the responding officer cannot unilaterally decide that the person is too young or not competent to be prosecuted.
- Serious assaults of public employees must be appropriately prosecuted. Staff should not forfeit their rights as a citizen when they enter their workplace.
- Prosecution of these serious crimes safeguards the other consumers and staff, and can serve as a deterrent.

Upon request, the PEF Occupational Health & Safety Department will provide other factsheets, standards, regulations, and other resources. Contact us at healthandsafety@pef.org or 518-785-1900, ext. 254 or 1-800-342-4306, ext. 254.

Produced by the New York State Public Employees Federation

Wayne Spence
President

Kevin Hintz
Secretary-Treasurer

2015

CREATING A SAFE WORKPLACE

WORKPLACE VIOLENCE PREVENTION ASSESSMENT/RISK EVALUATION

New York State Office of Mental Retardation Developmental Disabilities
Finger Lakes Developmental Disabilities Service Office

Site Location:_____

Assessment Completed By:_____

Date of Assessment:_____

POLICIES AND TRAINING:	YES	NO	N/A	COMMENTS
1. Is the Violence in the Workplace Policy Statement posted at the site?				
2. Is the Violence in the Workplace Prevention Plan available to staff?				
3. When applicable, has training occurred when new clients have been transferred to the work site?				
4. Are staff aware of:				
a. violence scenarios				
b. steps to reduce risks				
c. contacts to be made if a workplace violence episode occurs				
d. crisis intervention available if needed				
e. reporting procedures				
f. notification procedures				
g. complaint procedures				
WORK ENVIRONMENT:				
1. Is the evacuation and floor plan current and posted?				
2. Where appropriate, have the following Environmental Controls been implemented				
a. door controls				

b. panic buttons				
	YES	**NO**	**N/A**	**COMMENTS**
c. door detectors				
d. closed circuit camera (DC ONLY)				
e. stationary metal detector (DC ONLY)				
f. sound detection (DC ONLY)				
g. intrusion panel (DC ONLY)				
h. monitors (DC ONLY)				
i. VCR/compact disk recorder (DC ONLY)				
j. hand held metal detector (DC ONLY)				
k. structural modification (DC ONLY) If yes, please list				
l. Other				
3. Have the following internal controls been implemented if appropriate?				
a. sign-in procedure for visitors				
b. internal control of distribution of keys				
ENVIRONMENTAL CHECK: (Safety)				
1. Have the following work practice controls been implemented :				
a. desk clear of potentially dangerous objects				
b. unobstructed office exits				
c. reception area available (LIT/RIT)				
d. visitor(s)/consumer(s) escorted				
e. counter top to separate consumers from work area				
f. all entrances alarmed				
g. separate interview area(s)				
h. ID Badges used				

i. emergency phone numbers posted				
	YES	**NO**	**N/A**	**COMMENTS**
j. Internal Phone system (DC ONLY)				
m. internal procedures for conflict (problem) situations				
n. parking areas well lighted				
o. other				
DEVELOPMENTAL CENTER ONLY:				
1. Are Safety Officers used at this Facility? If yes, how many				
a. at entrance(s)				
b. Building Patrol				
c. Area Patrol				
INDIVIDUALS SERVED: (Residential/Day Services Only)				
1. For individuals with a history of assaultive and/or dangerous behaviors, have the following been addressed?				
a. Are they tracked by the High Risk Committee?				
b. Is there a current Behavior Support Plan?				
c. Have staff been trained on current BSP?				
d. Are the designated environmental supports present?				
e. Are the designated staffing supports available?				
RESPONSE TO WORK PLACE VIOLENCE				
1. Have there been work place violence reports in the past year?				
2. If so, were corrective actions taken?				

3. Were these recommendations completed?				
4. Have these recommendations been successful?				

COMMENTS AND RECOMMENDATIONS BASED UPON THE EVALUATION:

_____

_____

RESOLUTION: (if applicable)

_____

_____

Annual Review Date: _____ Reviewer: _____

COMMENTS AND RECOMMENDATIONS BASED UPON THE EVALUATION:

_____

_____

_____

RESOLUTION: (if applicable)

_____

_____

_____

Annual Review Date: _____ Reviewer: _____

COMMENTS AND RECOMMENDATIONS BASED UPON THE EVALUATION:

_____

_____

RESOLUTION: (if applicable)

_____

_____

_____

Annual Review Date: _____ Reviewer: _____

Guidelines for Preventing

workplace violence

for Healthcare and Social Service Workers

OSHA®

Occupational Safety and Health Administration

www.osha.gov

OSHA 3148-04R 2015

www.osha.gov

Occupational Safety and Health Act of 1970
"To assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health..."

This publication provides a general overview of worker rights under the *Occupational Safety and Health Act* (OSH Act). This publication does not alter or determine compliance responsibilities which are set forth in OSHA standards and the OSH Act. Moreover, because interpretations and enforcement policy may change over time, for additional guidance on OSHA compliance requirements the reader should consult current administrative interpretations and decisions by the Occupational Safety and Health Review Commission and the courts.

This information will be made available to sensory-impaired individuals upon request. Voice phone: (202) 693-1999; teletypewriter (TTY) number: 1-877-889-5627.

Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers

U.S. Department of Labor
Occupational Safety and Health Administration

OSHA 3148-04R 2015

U.S. Department of Labor

This guidance document is advisory in nature and informational in content. It is not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by the Occupational Safety and Health Administration (OSHA) standards or the *Occupational Safety and Health Act of 1970* (OSH Act or Act). Pursuant to the OSH Act, employers must comply with safety and health standards and regulations issued and enforced either by OSHA or by an OSHA-approved state plan. In addition, the Act's General Duty Clause, Section 5(a)(1), requires employers to provide their workers with a workplace free from recognized hazards that are causing or likely to cause death or serious physical harm. In addition, Section 11(c)(1) of the Act provides that "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." Reprisal or discrimination against an employee for reporting an incident or injury related to workplace violence, related to this guidance, to an employer or OSHA would constitute a violation of Section 11(c) of the Act. In addition, 29 CFR 1904.36 provides that Section 11(c) of the Act prohibits discrimination against an employee for reporting a work-related fatality, injury or illness.

Table of Contents

Overview of the Guidelines

Healthcare and social service workers face significant risks of job-related violence and it is OSHA's mission to help employers address these serious hazards. This publication updates OSHA's 1996 and 2004 voluntary guidelines for preventing workplace violence for healthcare and social service workers. OSHA's violence prevention guidelines are based on industry best practices and feedback from stakeholders, and provide recommendations for developing policies and procedures to eliminate or reduce workplace violence in a range of healthcare and social service settings.

These guidelines reflect the variations that exist in different settings and incorporate the latest and most effective ways to reduce the risk of violence in the workplace. Workplace setting determines not only the types of hazards that exist, but also the measures that will be available and appropriate to reduce or eliminate workplace violence hazards.

For the purpose of these guidelines, we have identified five different settings:

- **Hospital** settings represent large institutional medical facilities;
- **Residential Treatment** settings include institutional facilities such as nursing homes, and other long-term care facilities;
- **Non-residential Treatment/Service** settings include small neighborhood clinics and mental health centers;
- **Community Care** settings include community-based residential facilities and group homes; and
- **Field work** settings include home healthcare workers or social workers who make home visits.

Indeed, these guidelines are intended to cover a broad spectrum of workers, including those in: psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment centers, pharmacies, community-care centers, and long-term care facilities. Healthcare and social service workers covered by these guidelines include: registered nurses, nurses' aides, therapists, technicians, home healthcare workers,

social workers, emergency medical care personnel, physicians, pharmacists, physicians' assistants, nurse practitioners, and other support staff who come in contact with clients with known histories of violence. Employers should use these guidelines to develop appropriate workplace violence prevention programs, engaging workers to ensure their perspective is recognized and their needs are incorporated into the program.

Violence in the Workplace: The Impact of Workplace Violence on Healthcare and Social Service Workers

Healthcare and social service workers face a significant risk of job-related violence. The National Institute for 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."[1] According to the Bureau of Labor Statistics (BLS), 27 out of the 100 fatalities in healthcare and social service settings that occurred in 2013 were due to assaults and violent acts.

While media attention tends to focus on reports of workplace homicides, the vast majority of workplace violence incidents result in non-fatal, yet serious injuries. Statistics based on the Bureau of Labor Statistics (BLS) and National Crime Victimization Survey (NCVS)[2] data both reveal that workplace violence is a threat to those in the healthcare and social service settings. BLS data show that the majority of injuries from assaults at work that required days away from work occurred in the healthcare and social services settings. Between 2011 and 2013, workplace assaults ranged from 23,540 and 25,630 annually, with 70 to 74% occurring in healthcare and social service settings. For healthcare workers, assaults comprise 10-11% of workplace injuries involving days away from work, as compared to 3% of injuries of all private sector employees.

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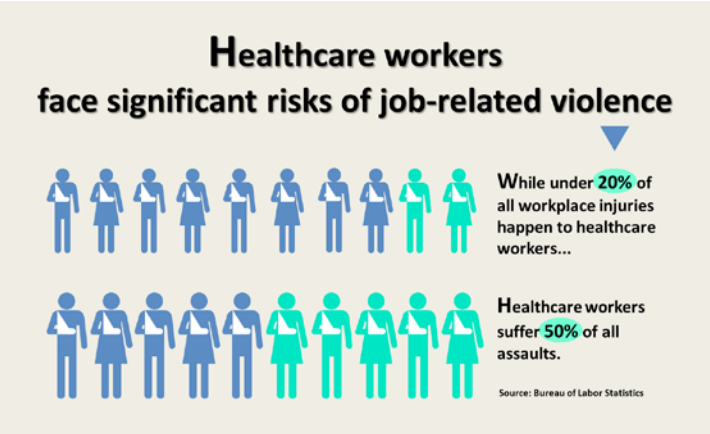
[1] CDC/NIOSH. Violence. Occupational Hazards in Hospitals. 2002.

[2] Cited in the U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics report, Workplace Violence, 1993-2009 National Crime Victimization Survey and the Census of Fatal Occupational Injuries. March 2011. (www.bjs.gov/content/pub/pdf/wv09.pdf)

In 2013, a large number of the assaults involving days away from work occurred at healthcare and social assistance facilities (ranging for 13 to 36 per 10,000 workers). By comparison, the days away from work due to violence for the private sector as a whole in 2013 were only approximately 3 per 10,000 full-time workers. The workplace violence rates highlighted in BLS data are corroborated by the NCVS, which estimates that between 1993 and 2009 healthcare workers had a 20% (6.5 per 1,000) overall higher rate of workplace violence than all other workers (5.1 per 1,000).[3] In addition, workplace violence in the medical occupations represented 10.2% of all workplace violence incidents. It should also be noted that research has found that workplace violence is underreported—suggesting that the actual rates may be much higher.

Risk Factors: Identifying and Assessing Workplace Violence Hazards

Healthcare and social service workers face an increased risk of work-related assaults resulting primarily from violent behavior of their patients, clients and/or residents. While no specific diagnosis or type of patient predicts future violence, epidemiological studies consistently demonstrate that inpatient and acute psychiatric services, geriatric long term care settings,



[3] The report defined medical occupations as: physicians, nurses, technicians, and other medical professionals.

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 and drugs, and disease progression can also cause agitation and violent behaviors.

While the individual risk factors will vary, depending on the type and location of a healthcare or social service setting, as well as the type of organization, some of the risk factors include:

Patient, Client and Setting-Related Risk Factors

- Working directly with people who have a history of violence, abuse drugs or alcohol, gang members, and relatives of patients or clients;
- Transporting patients and clients;
- Working alone in a facility or in patients' homes;
- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident;
- Poorly lit corridors, rooms, parking lots and other areas;[4]
- Lack of means of emergency communication;
- Prevalence of firearms, knives and other weapons among patients and their families and friends; and
- Working in neighborhoods with high crime rates.

Organizational Risk Factors

- 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;
- High worker turnover;
- Inadequate security and mental health personnel on site;

[4] CDC/NIOSH. Violence. Occupational Hazards in Hospitals. 2002.

- Long waits for patients or clients and overcrowded, uncomfortable waiting rooms;
- Unrestricted movement of the public in clinics and hospitals; and
- Perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges.

Violence Prevention Programs

A written program for workplace violence prevention, incorporated into an organization's overall safety and health program, offers an effective approach to reduce or eliminate the risk of violence in the workplace. The building blocks for developing an effective workplace violence prevention program include:

(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.

A violence prevention program focuses on developing processes and procedures appropriate for the workplace in question.

Specifically, a workplace's violence prevention program should have clear goals and objectives for preventing workplace violence, be suitable for the size and complexity of operations and be adaptable to specific situations and specific facilities or units. The components are interdependent and require regular reassessment and adjustment to respond to changes occurring within an organization, such as expanding a facility or changes in managers, clients, or procedures. And, as with any occupational safety and health program, it should be evaluated and reassessed on a regular basis. Those developing a workplace violence prevention program should also check for applicable state requirements. Several states have passed legislation and developed requirements that address workplace violence.

1. Management Commitment and Worker Participation

Management commitment and worker participation are essential elements of an effective violence prevention program. The leadership of management in providing full support for the development of the workplace's program, combined with worker involvement is critical for the success of the program. Developing procedures to ensure that management and employees are involved in the creation and operation of a workplace violence prevention program can be achieved through regular meetings—possibly as a team or committee.[5]

Effective management leadership begins by recognizing that workplace violence is a safety and health hazard.

Effective management leadership begins by recognizing that workplace violence is a safety and health hazard. Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources for workers and employers to deal effectively with workplace violence. This commitment should include:

- Acknowledging the value of a safe and healthful, violence-free workplace and ensuring and exhibiting equal commitment to the safety and health of workers and patients/clients;
- Allocating appropriate authority and resources to all responsible parties. Resource needs often go beyond financial needs to include access to information, personnel, time, training, tools, or equipment;
- Assigning responsibility and authority for the various aspects of the workplace violence prevention program to ensure that all managers and supervisors understand their obligations;
- Maintaining a system of accountability for involved managers, supervisors and workers;
- Supporting and implementing appropriate recommendations from safety and health committees;

[5] If employers take this approach, they should consult and follow the applicable provisions of the *National Labor Relations Act*—29 U.S.C. 151-169.

- Establishing a comprehensive program of medical and psychological counseling and debriefing for workers who have experienced or witnessed assaults and other violent incidents and ensuring that trauma-informed care is available; and
- Establishing policies that ensure the reporting, recording, and monitoring of incidents and near misses and that no reprisals are made against anyone who does so in good faith.

Additionally, management should: (1) articulate a policy and establish goals; (2) allocate sufficient resources; and (3) uphold program performance expectations.

Through involvement and feedback, workers can provide useful information to employers to design, implement and evaluate the program. In addition, workers with different functions and at various organizational levels bring a broad range of experience and skills to program design, implementation, and assessment. Mental health specialists have the ability to appropriately characterize disease characteristics but may need training and input from threat assessment professionals. Direct care workers, in emergency departments or mental health, may bring very different perspectives to committee work. The range of viewpoints and needs should be reflected in committee composition. This involvement should include:

- Participation in the development, implementation, evaluation, and modification of the workplace violence prevention program;
- Participation in safety and health committees that receive reports of violent incidents or security problems, making facility inspections and responding to recommendations for corrective strategies;
- Providing input on additions to or redesigns of facilities;
- Identifying the daily activities that employees believe put them most at risk for workplace violence;
- Discussions and assessments to improve policies and procedures—including complaint and suggestion programs designed to improve safety and security;

- Ensuring that there is a way to report and record incidents and near misses, and that issues are addressed appropriately;
- Ensuring that there are procedures to ensure that employees are not retaliated against for voicing concerns or reporting injuries; and
- Employee training and continuing education programs.

2. 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. Cooperation between workers and employers in identifying and assessing hazards is the foundation of a successful violence prevention program. The assessment should be made by a team that includes senior management, supervisors and workers. Although management is responsible for controlling hazards, workers have a critical role to play in helping to identify and assess workplace hazards, because of their knowledge and familiarity with facility operations, process activities and potential threats. Depending on the size and structure of the organization, the team may also include representatives from operations; employee assistance; security; occupational safety and health; legal; and human resources staff. The assessment should include a records review, a review of the procedures and operations for different jobs, employee surveys and workplace security analysis.

Cooperation between workers and employers in identifying and assessing hazards is the foundation of a successful violence prevention program.

Once the worksite analysis is complete, it should be used to identify the types of hazard prevention and control measures needed to reduce or eliminate the possibility of a workplace violence incident occurring. In addition, it should assist in the identification or development of appropriate training. The assessment team should also determine how often and under

what circumstances worksite analyses should be conducted. For example, the team may determine that a comprehensive annual worksite analysis should be conducted, but require that an investigative analysis occur after every incident or near miss.

Additionally, those conducting the worksite analysis should periodically inspect the workplace and evaluate worker tasks in order to identify hazards, conditions, operations and situations that could lead to potential violence. The advice of independent reviewers, such as safety and health professionals, law enforcement or security specialists, and insurance safety auditors may be solicited to strengthen programs. These experts often provide a different perspective that serves to improve a program.

Information is generally collected through: (1) records analysis; (2) job hazard analysis; (3) employee surveys; and (4) patient/client surveys.

Records analysis and tracking

Records review is important to identify patterns of assaults or near misses that could be prevented or reduced through the implementation of appropriate controls. Records review should include medical, safety, specific threat assessments, workers' compensation and insurance records. The review should also include the OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300) if the employer is required to maintain one. In addition, incident/near-miss logs, a facility's general event or daily log and police reports should be reviewed to identify assaults relative to particular:

- Departments/Units;
- Work areas;
- Job titles;
- Activities—such as transporting patients between units or facilities, patient intake; and
- Time of day.

Possible Findings from Records Review:

	Hospital	Residential Treatment	Non-residential Treatment/ Service	Community Care	Field Workers (Home Healthcare and Social Service)
Departments/ Units	· Emergency Department · Psychiatric Unit · Geriatric Unit	· Dementia Unit · Adolescent Unit			
Work areas	· Waiting room · Nurses' station · Hallway · Treatment rooms	· Therapy room · Patient's room · Dining area · Van/Car transport	· Waiting area · Therapy room	· Kitchen · Car	· Kitchen · Car · Bedroom
Job titles	· Security guard · Nurse · Therapist · Doctor · Receptionist · Health aide · Technician	· Social worker · Therapist · Nurse · Health aide · Security guard · Driver · Technician	· Social worker · Behavioral health specialist · Nurse · Technician	· Social worker · Therapist · Health aide	· Social worker · Health aide · Child Support services · Emergency medical personnel
Activities	· Patient intake · Transferring patients from one floor to another · Meal time · Bathing · Changing of staff · Scanning for weapons	· Conducting therapy · Transitioning patients from one area to another · Driving patients · Feeding patient	· Therapy room · Client intake	· Conducting therapy · Bathing/ changing/ feeding client · Administering meds · Driving patient	· Bathing/ changing/ feeding client · Administering meds · Driving patient · Interacting with clients' families
Time of day	· After 10 PM · Meal times	· Late afternoon and evening	· No pattern	· Entry or exit	· Entry or exit · Meal times

Job Hazard Analysis

A job hazard analysis is an assessment that focuses on job tasks to identify hazards. Through review of procedures and operations connected to specific tasks or positions to identify if they contribute to hazards related to workplace violence and/or can be modified to reduce the likelihood of violence occurring, it examines the relationship between the employee, the task, tools, and the work environment. Worker participation is an essential component of the analysis. As noted in OSHA's publication on job hazard analyses,[6] priority should be given to specific types of job. For example, priority should be given to:

- Jobs with high assault rates due to workplace violence;
- Jobs that are new to an operation or have undergone procedural changes that may increase the potential for workplace violence; and
- Jobs that require written instructions, such as procedures for administering medicine, and steps required for transferring patients.

After an incident or near miss, the analysis should focus on:

- Analyzing those positions that were affected;
- Identifying if existing procedures and operations were followed and if not, why not (in some instances, not following procedures could result in more effective protections);
- Identifying if staff were adequately qualified and/or trained for the tasks required; and
- Developing, if necessary, new procedures and operations to improve staff safety and security.

Employee surveys

Employee questionnaires or surveys are effective ways for employers to identify potential hazards that may lead to violent incidents, identify the types of problems workers face in their daily activities, and assess the effects of changes in

[6] OSHA 3071-2002 (Revised). *Job Hazard Analysis.*

work processes. Detailed baseline screening surveys can help pinpoint tasks that put workers 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. The periodic review process should also include feedback and follow-up. The following are sample questions:

- What daily activities, if any, expose you to the greatest risk of violence?
- What, if any, work activities make you feel unprepared to respond to a violent action?
- Can you recommend any changes or additions to the workplace violence prevention training you received?
- Can you describe how a change in a patient's daily routine affected the precautions you take to address the potential for workplace violence?

Client/Patient Surveys

Clients and patients may also have valuable feedback that may enable those being served by the facility to provide useful information to design, implement, and evaluate the program. Clients and patients may be able to participate in identifying triggers to violence, daily activities that may lead to violence, and effective responses.

3. Hazard Prevention and Control

After the systematic worksite analysis is complete, the employer should take the appropriate steps to prevent or control the hazards that were identified. To do this, the employer should: (1) identify and evaluate control options for workplace hazards; (2) select effective and feasible controls to eliminate or reduce hazards; (3) implement these controls in the workplace; (4) follow up to confirm that these controls are being used and maintained properly; and (5) evaluate the effectiveness of controls and improve, expand, or update them as needed.

In the field of industrial hygiene, these steps are generally categorized, in order of effectiveness, as (1) substitution; (2) engineering controls; and (3) administrative and work practice controls. These principles, which are described in more detail below, can also be applied to the field of workplace violence. In addition, employers should ensure that, if an incident of workplace violence occurs, post-incident procedures and services are in place and/or immediately made available.

Substitution

The best way to eliminate a hazard is to eliminate it or substitute a safer work practice. While these substitutions may be difficult in the therapeutic healthcare environment, an example may be transferring a client or patient to a more appropriate facility if the client has a history of violent behavior that may not be appropriate in a less secure therapeutic environment.

Engineering controls and workplace adaptations to minimize risk

Engineering controls are physical changes that either remove the hazard from the workplace or create a barrier between the worker and the hazard. In facilities where it is appropriate, there are several engineering control measures that can effectively prevent or control workplace hazards. Engineering control strategies include: (a) using physical barriers (such as enclosures or guards) or door locks to reduce employee exposure to the hazard; (b) metal detectors; (c) panic buttons, (d) better or additional lighting; and (e) more accessible exits (where appropriate). The measures taken should be site-specific and based on the hazards identified in the worksite analysis appropriate to the specific therapeutic setting. For example, closed circuit videos and bulletproof glass may be appropriate in a hospital or other institutional setting, but not in a community care facility. Similarly, it should be noted that services performed in the field (e.g., home health or social services) often occur in private residences where some engineering controls may not be possible or appropriate.

If new construction or modifications are planned for a facility, assess any plans to eliminate or reduce security hazards.

The following are possible engineering controls that could apply in different settings. Note that this is a list of suggested measures whose appropriateness will depend on a number of factors.

Possible engineering controls for different healthcare and social service settings

<table>
<tr><th></th><th>Hospital</th><th>Residential Treatment</th><th>Non-residential Treatment/ Service</th><th>Community Care</th><th>Field Workers (Home Healthcare, Social Service)</th></tr>
<tr><td rowspan="2">Security/ silenced alarm systems</td><td colspan="3">· Panic buttons or paging system at workstations or personal alarm devices worn by employees</td><td colspan="2">· Paging system
· GPS tracking[7]
· Cell phones</td></tr>
<tr><td colspan="5">· Security/silenced alarm systems should be regularly maintained and managers and staff should fully understand the range and limitations of the system.</td></tr>
<tr><td rowspan="2">Exit routes</td><td colspan="2">· Where possible, rooms should have two exits
· Provide employee ‘safe room’ for emergencies
· Arrange furniture so workers have a clear exit route</td><td>· Where possible, counseling rooms should have two exits
· Arrange furniture so workers have a clear exit route</td><td colspan="2">· Managers and workers should assess homes for exit routes</td></tr>
<tr><td colspan="5">· Workers should be familiar with a site and identify the different exit routes available.</td></tr>
<tr><td>Metal detectors – hand-held or installed</td><td colspan="5">· 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.</td></tr>
<tr><td rowspan="2">Monitoring systems & natural surveillance</td><td colspan="2">· 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</td><td>· Closed-circuit video – inside and outside
· Curved mirrors
· Glass panels in doors for better monitoring</td><td></td><td></td></tr>
<tr><td colspan="5">· 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 or not and whether someone is always monitoring the video or not.</td></tr>
</table>

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

	Hospital	Residential Treatment	Non-residential Treatment/ Service	Community Care	Field Workers (Home Healthcare, Social Service)
Barrier protection	· Enclosed receptionist desk with bulletproof glass · Deep counters at nurses' stations · Lock doors to staff counseling and treatment rooms · Provide lockable (or keyless door systems) and secure bathrooms for staff members (with locks on the inside)—separated from patient/client and visitor facilities · Lock all unused doors to limit access, in accord with local fire codes	· Deep counters in offices · Provide lockable (or keyless door systems) and secure bathrooms for staff members (with locks on the inside)—separated from patient/client and visitor facilities · Lock all unused doors to limit access, in accord with local fire codes	· Deep counters · Provide lockable (or keyless door systems) and secure bathrooms for staff members (with locks on the inside)—separated from patient/client and visitor facilities		
	· Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for the services being provided and the types of barriers put in place.				

<table>
<tr><th></th><th>Hospital</th><th>Residential Treatment</th><th>Non-residential Treatment/ Service</th><th>Community Care</th><th>Field Workers (Home Healthcare, Social Service)</th></tr>
<tr><td rowspan="2">Patient/client areas</td><td>· Establish areas for patients/ clients to de-escalate
· Provide comfortable waiting areas to reduce stress
· Divide waiting areas to limit the spreading of agitation among clients/ visitors</td><td>· Establish areas for patients/ clients to de-escalate
· Provide comfortable waiting areas to reduce stress
· Assess staff rotations in facilities where clients become agitated by unfamiliar staff</td><td>· Provide comfortable waiting areas to reduce stress</td><td>· Establish areas for patients/ clients to de-escalate</td><td>· Establish areas for patients/ clients to de-escalate</td></tr>
<tr><td colspan="5">· Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for the services being provided and the types of barriers put in place.</td></tr>
<tr><td rowspan="2">Furniture, materials & maintenance</td><td colspan="3">· Secure furniture and other items that could be used as weapons
· Replace open hinges on doors with continuous hinges to reduce pinching hazards
· Ensure cabinets and syringe drawers have working locks
· Pad or replace sharp edged objects (such as metal table frames)
· Consider changing or adding materials to reduce noise in certain areas
· Recess any hand rails, drinking fountains and any other protrusions
· Smooth down or cover any sharp surfaces</td><td>· When feasible, secure furniture or other items that could be used as weapons
· Ensure cabinets and syringe drawers have working locks
· Pad or replace sharp edged objects (such as metal table frames)
· Ensure carrying equipment for medical equipment, medicines and valuables have working locks</td><td>· Ensure carrying equipment for medical equipment, medicines and valuables have working locks</td></tr>
<tr><td colspan="5">· Employers and workers will have to establish a balance between creating the appropriate atmosphere for the services being provided and securing furniture.</td></tr>
</table>

	Hospital	Residential Treatment	Non-residential Treatment/ Service	Community Care	Field Workers (Home Healthcare, Social Service)
Lighting	· Install bright, effective lighting—both indoors and outdoors on the grounds, in parking areas and walkways			· Ensure lighting is adequate in both the indoor and outdoor areas	· Work with client to ensure lighting is adequate in both the indoor and outdoor areas
	· Ensure burned out lights are replaced immediately. · While lighting should be effective it should not be harsh or cause undue glare.				
Travel vehicles	· Ensure vehicles are properly maintained · Where appropriate, consider physical barrier between driver and patients			· Ensure vehicles are properly maintained	

Administrative and work practice controls

Administrative and work practice controls are appropriate when engineering controls are not feasible or not completely protective. These controls affect the way staff perform jobs or tasks. Changes in work practices and administrative procedures can help prevent violent incidents. As with engineering controls, the practices chosen to abate workplace violence should be appropriate to the type of site and in response to hazards identified.

In addition to the specific measures listed below, training for administrative and treatment staff should include therapeutic procedures that are sensitive to the cause and stimulus of violence. For example, research has shown that Trauma Informed Care is a treatment technique that has been successfully instituted in inpatient psychiatric units as a way to reduce patient violence, and the need for seclusion and restraint. As explained by the Substance Abuse and Mental Health Services Administration, trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma for survivors and can be more supportive than traditional service delivery approaches, thus avoiding re-traumatization.[8]

[8] Referenced on the Substance Abuse and Mental Health Services Administration's website on February 25, 2013 (www.samhsa.gov/nctic).

The following are possible administrative controls that could apply in different settings.

Possible administrative and work practice controls for different healthcare and social service settings

<table>
<tr><th></th><th>Hospital</th><th>Residential Treatment</th><th>Non-residential Treatment/Service</th><th>Community Care</th><th>Field Workers (Home Healthcare, Social Service)</th></tr>
<tr><td>Workplace violence response policy</td><td colspan="5">· 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.</td></tr>
<tr><td rowspan="2">Tracking workers[9]</td><td></td><td>Traveling workers should:
· have specific log-in and log-out procedures
· be required to contact the office after each visit and managers should have procedures to follow-up if workers fail to do so</td><td></td><td colspan="2">Workers should:
· have specific log-in and log-out procedures
· be required to contact the office after each visit and 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</td></tr>
<tr><td colspan="5">· Log-in/log-out procedures should include:
· the name and address of client visited;
· the scheduled time and duration of visit;
· a contact number;
· a 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.</td></tr>
<tr><td>Tracking clients with a known history of violence</td><td colspan="2">· Supervise the movement of patients throughout the facility
· Update staff in shift report about violent history or incident</td><td>· Update staff in shift report about violent history or incident</td><td colspan="2">· Report all violent incidents to employer</td></tr>
</table>

[9] 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.

<table>
<tr><th></th><th>Hospital</th><th>Residential Treatment</th><th>Non-residential Treatment/Service</th><th>Community Care</th><th>Field Workers (Home Healthcare, Social Service)</th></tr>
<tr><td></td><td colspan="5">· Determine the behavioral history of new and transferred patients and clients to learn about any past violent or assaultive behaviors.
· Identify any event triggers for clients, such as certain dates or visitors.
· Identify the type of violence including severity, pattern and intended purpose.
· Information gained should be used to formulate individualized plans for early identification and prevention of future violence.
· Establish a system—such as chart tags, log books or verbal census reports—to identify patients and clients with a history of violence and identify triggers and the best responses and means of de-escalation.
· Ensure workers know and follow procedures for updates to patients' and clients' behavior.
· Ensure patient and client confidentiality is maintained.
· Update as needed.
· If stalking is suspected, consider varying check-in and check-out times for affected workers and plan different travel routes for those workers.</td></tr>
<tr><td rowspan="2">Working alone or in secure areas</td><td>· Treat and interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality
· Ensure workers are not alone when performing intimate physical examinations of patients
· Advise staff to exercise extra care in elevators and stairwells
· Provide staff members with security escorts to parking areas during evening/ late hours— Ensure these areas are well lit and highly visible</td><td>· Advise staff to exercise extra care in elevators, stairwells
· Provide staff members with security escorts to parking areas during evening/ late hours. Ensure these areas are well lit and highly visible</td><td>· Ensure workers have means of communication—either cell phones of panic buttons
· Develop policy to determine when a buddy system should be implemented</td><td>· Advise staff to exercise extra care in unfamiliar residences
· Workers should be given discretion to receive backup assistance by another worker or law enforcement officer
· Workers should be given discretion as to whether or not they begin or continue a visit if they feel threatened or unsafe
· Ensure workers have means of communication—either cell phones or panic buttons</td></tr>
<tr><td colspan="4">· Limit workers from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable.
· Establish policies and procedures for secured areas and emergency evacuations.
· Use the "buddy system," especially when personal safety may be threatened.</td></tr>
<tr><td>Reporting</td><td colspan="5">· Require workers to report all assaults or threats to a supervisor or manager (for example, through a confidential interview). Keep logbooks and reports of such incidents to help determine any necessary actions to prevent recurrences.
· Establish a liaison with local police, service providers who can assist (e.g., counselors) and state prosecutors. When needed, give police physical layouts of facilities to expedite investigations.</td></tr>
</table>

	Hospital	Residential Treatment	Non-residential Treatment/Service	Community Care	Field Workers (Home Healthcare, Social Service)
Entry procedures	· Provide responsive, timely information to those waiting; adopt measures to reduce waiting times · Institute sign-in procedures and visitor passes · Enforce visitor hours and procedures for being in the hospital · Have a "restricted visitors" list for patients with a history of violence/ gang activity; make copies available to security, nurses, and sign-in clerk	· Institute sign-in procedures with passes for visitors · Enforce visitor hours and procedures · Establish a list of "restricted visitors" for patients with a history of violence or gang activity; make copies available at security checkpoints, nurses' stations and visitor sign-in areas	· Provide responsive, timely information to those waiting; adopt measures to reduce waiting times	· Ensure workers determine how best to enter facilities	· Ensure workers determine how best to enter clients' homes
Incident response/ high risk activities	· Use properly trained security officers and counselors to respond to aggressive behavior; follow written security procedures · Ensure that adequate and qualified staff members are available at all times, especially during high-risk times such as patient transfers, emergency responses, mealtimes and at night · Ensure that adequate and qualified staff members are available to disarm and de-escalate patients if necessary · Assess changing client routines and activities to reduce or eliminate the possibility of violent outbursts		· Use properly trained security officers and counselors to respond to aggressive behavior; follow written security procedures		· Ensure assistance if children will be removed from the home

	Hospital	Residential Treatment	Non-residential Treatment/Service	Community Care	Field Workers (Home Healthcare, Social Service)
	• Advise workers of company procedures for requesting police assistance or filing charges when assaulted—and assist them in doing so if necessary. • Provide management support during emergencies. Respond promptly to all complaints. • Ensure that adequately trained staff members and counselors are available to de-escalate a situation and counsel patients. • Prepare contingency plans to treat clients who are "acting out" or making verbal or physical attacks or threats. • Emergency action plans should be developed to ensure that workers know how to call for help or medical assistance.				
Employee uniforms/ dress	• Provide staff with identification badges, preferably without last names, to readily verify employment. • Discourage workers from wearing necklaces or chains to help prevent possible strangulation in confrontational situations. • Discourage workers from wearing expensive jewelry or carrying large sums of money. • Discourage workers from carrying keys or other items that could be used as weapons. • Encourage the use of head netting/cap so hair cannot be grabbed and used to pull or shove workers.				
Facility & work procedures	• Survey facility periodically to remove tools or possessions left by visitors or staff that could be used inappropriately by patients • Survey facilities regularly to ensure doors that should be locked are locked—smoking policies should not allow these doors to be propped open • Keep desks and work areas free of items, including extra pens and pencils, glass photo frames, etc.		• Survey facility periodically to remove tools or possessions left by visitors or staff that could be used inappropriately by patients • Keep desks and work areas free of items, including extra pens and pencils, glass photo frames, etc.	• Survey facility periodically to remove tools or possessions left by visitors or staff that could be used inappro-priately by patients • Establish daily work plans to keep a designated contact person informed about employees' whereabouts throughout the workday; have a contact person follow up if an employee does not report in as expected	• Have clear contracts on how home visits will be conducted, the presence of others in the home during visits and the refusal to provide services in clearly hazardous situations • Establish daily work plans to keep a designated contact person informed about employees' whereabouts throughout the workday; have a contact person follow up if an employee does not report in as expected

	Hospital	Residential Treatment	Non-residential Treatment/Service	Community Care	Field Workers (Home Healthcare, Social Service)
Transportation procedures	· Develop safety procedures that specifically address the transport of patients. · Ensure that workers transporting patients have an effective and reliable means of communicating with their home office			· Develop safety procedures that specifically address the transport of patients. · Ensure that workers transporting patients have an effective and reliable means of communicating with their home office	

Post-incident procedures and services

Post-incident response and evaluation are important components to an effective violence prevention program. Investigating incidents of workplace violence thoroughly will provide a roadmap to avoiding fatalities and injuries associated with future incidents. The purpose of the investigation should be to identify the "root cause" of the incident. Root causes, if not corrected, will inevitably recreate the conditions for another incident to occur.

When an incident occurs, the immediate first steps are to provide first aid and emergency care for the injured worker(s) and to take any measures necessary to prevent others from being injured. All workplace violence programs should provide comprehensive treatment for workers who are victimized personally or 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 its severity—free of charge. Also, injured workers should be provided transportation to medical care if not available on site.

Victims of workplace violence could suffer a variety of consequences in addition to their actual physical injuries. These may include:

- Short- and long-term psychological trauma;
- Fear of returning to work;
- Changes in relationships with coworkers and family;
- Feelings of incompetence, guilt, powerlessness; and
- Fear of criticism by supervisors or managers.

Consequently, a strong follow-up program for these workers will not only help them address these problems but also help prepare them to confront or prevent future incidents of violence.

Several types of assistance 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. As explained by the Substance Abuse and Mental Health Services Administration, trauma-informed services are based on an understanding of the vulnerabilities or triggers of trauma for survivors and can be more supportive than traditional service delivery approaches, thus avoiding re-traumatization.[10] Whether the support is trauma-informed or not, certified employee assistance professionals, psychologists, psychiatrists, clinical nurse specialists or social workers should provide this counseling. Alternatively, the employer may refer staff victims to an outside specialist. In addition, the employer may establish an employee counseling service, peer counseling, or support groups.

Counselors should 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, this type of counseling educates staff about workplace violence and positively influences workplace and organizational cultural norms to reduce trauma associated with future incidents.

Investigation of Incidents

Once these immediate needs are taken care of, the investigation should begin promptly. The basic steps in conducting incident investigations are:

1. *Report as required*. Determine who needs to be notified, both within the organization and outside (e.g., authorities), when there is an incident. Understand what types of

[10] Referenced on the Substance Abuse and Mental Health Services Administration's website on February 25, 2013 (www.samhsa.gov/nctic).

incidents must be reported, and what information needs to be included. If the incident involves hazardous materials additional reporting requirements may apply.

2. *Involve workers in the incident investigation.* The employees who work most closely in the area where the event occurred may have special insight into the causes and solutions.

3. *Identify Root Causes:* Identify the root causes of the incident. Don't stop an investigation at "worker error" or "unpredictable event." Ask "why" the patient or client acted, "why" the worker responded in a certain way, etc.

4. *Collect and review other information*. Depending on the nature of the incident, records related to training, maintenance, inspections, audits, and past incident reports may be relevant to review.

5. *Investigate Near Misses.* In addition to investigating all incidents resulting in a fatality, injury or illness, any near miss (a situation that could potentially have resulted in death, injury, or illness) should be promptly investigated as well. Near misses are caused by the same conditions that produce more serious outcomes, and signal that some hazards are not being adequately controlled, or that previously unidentified hazards exist.

Identify the root causes of the incident. Don't stop an investigation at "worker error" or "unpredictable event." Ask "why" the patient or client acted, "why" the worker responded in a certain way, etc.

4. Safety and Health Training

Education and training are key elements of a workplace violence protection program, and help ensure that all staff members are aware of potential hazards and how to protect themselves and their coworkers through established policies and procedures. Such training can be part of a broader type of instruction that includes protecting patients and clients (such as training on de-escalation techniques). However, employers should ensure that worker safety is a separate component that is thoroughly addressed.

Training for all workers

Training can: (1) help raise the overall safety and health knowledge across the workforce, (2) provide employees with the tools needed to identify workplace safety and security hazards, and (3) address potential problems before they arise and ultimately reduce the likelihood of workers being assaulted. The training program should involve all workers, including contract workers, supervisors, and managers. Workers who may face safety and security hazards should receive formal instruction on any specific or potential hazards associated with the unit or job and the facility. Such training may include information on the types of injuries or problems identified in the facility and the methods to control the specific hazards. It may also include instructions to limit physical interventions in workplace altercations whenever possible.

Every worker should understand the concept of "universal precautions for violence"— that is, that violence should be expected but can be avoided or mitigated through preparation. In addition, workers should understand the importance of a culture of respect, dignity, and active mutual engagement in preventing workplace violence.

New and reassigned workers should receive an initial orientation before being assigned their job duties. All workers should receive required training annually. In high-risk settings and institutions, refresher training may be needed more frequently, perhaps monthly or quarterly, to effectively reach and inform all workers. Visiting staff, such as physicians, should receive the same training as permanent staff and contract workers. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role-playing, simulations and drills.

Training topics

Training topics may include management of assaultive behavior, professional/police assault-response training, or personal safety training on how to prevent and avoid assaults.

A combination of training programs may be used, depending on the severity of the risk.

In general, training should cover the policies and procedures for a facility as well as de-escalation and self-defense techniques. Both de-escalation and self-defense training should include a hands-on component. The following provides a list of possible topics:

- The workplace violence prevention policy;
- Risk factors that cause or contribute to assaults;
- Policies and procedures for documenting patients' or clients' change in behavior;
- The location, operation, and coverage of safety devices such as alarm systems, along with the required maintenance schedules and procedures;
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults;
- Ways to recognize, prevent or diffuse volatile situations or aggressive behavior, manage anger and appropriately use medications;
- Ways to deal with hostile people other than patients and clients, such as relatives and visitors;
- Proper use of safe rooms—areas where staff can find shelter from a violent incident;
- A standard response action plan for violent situations, including the availability of assistance, response to alarm systems and communication procedures;
- Self-defense procedures where appropriate;
- Progressive behavior control methods and when and how to apply restraints properly and safety when necessary;
- 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, trauma-informed care, counseling, workers' compensation or legal assistance after a violent episode or injury.

Training for supervisors and managers

Supervisors and managers must be trained to recognize high-risk situations, so they can ensure that workers are not placed in assignments that compromise their safety. Such training should include encouraging workers to report incidents and to seek the appropriate care after experiencing a violent incident.

Supervisors and managers must be trained to recognize high-risk situations, so they can ensure that workers are not placed in assignments that compromise their safety.

Supervisors and managers should learn how to reduce safety hazards and ensure that workers receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and make any necessary changes in the physical plant, patient care treatment program and staffing policy, and procedures to reduce or eliminate the hazards.

Training for security personnel

Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, and ways to handle aggression and defuse hostile situations.

Evaluation of training

The training program should also include an evaluation. At least annually, the team or coordinator responsible for the program should review its content, methods and the frequency of training. Program evaluation may involve supervisor and employee interviews, testing, observing and reviewing reports of behavior of individuals in threatening situations.

5. Recordkeeping and Program Evaluation

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

Accurate records of injuries, illnesses, incidents, assaults, hazards, corrective actions, patient histories and training can help employers determine the severity of the problem; identify any developing trends or patterns in particular locations, jobs or departments; evaluate methods of hazard control; identify training needs and develop solutions for an effective program. Records can be especially useful to large organizations and for members of a trade association that "pool" data. Key records include:

- *OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300).* Covered employers are required to prepare and maintain records of serious occupational injuries and illnesses, using the OSHA 300 Log. As of January 2015, all employers must report: (1) all work-related fatalities within 8 hours and (2) all work-related inpatient hospitalizations, all amputations and all losses of an eye within 24 hours. Injuries caused by assaults must be entered on the log if they meet the recording criteria.[11]
- *Medical reports of work injury, workers' compensation reports and supervisors' reports for each recorded assault.* These records should describe the type of assault, such as an 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, lost work time that resulted and the nature of injuries sustained. These medical records are confidential documents and should be kept in a locked location under the direct responsibility of a healthcare professional.
- *Records of incidents of abuse, reports conducted by security personnel, verbal attacks or aggressive behavior that may be threatening*, such as pushing or shouting and acts of aggression toward other clients. This may be kept as part of an assaultive incident report. Ensure that the affected department evaluates these records routinely.
- *Information on patients with a history of past violence, drug abuse or criminal activity recorded on the patient's chart.* Anyone who cares for a potentially aggressive, abusive or

[11] 29 CFR Part 1904, revised 2014.

violent client should be aware of the person's background and history, including triggers and de-escalation responses. Log the admission of violent patients to help determine potential risks. Log violent events on patients' charts and flagged charts.[12]

- *Documentation of minutes of safety meetings, records of hazard analyses and corrective actions recommended and taken.*
- *Records of all training programs, attendees, and qualifications of trainers.*

Elements of a program 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 its success. Responsible parties (including managers, supervisors and employees) should reevaluate policies and procedures on a regular basis to identify deficiencies and take corrective action.

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

All reports should protect worker and patient confidentiality either by presenting only aggregate data or by removing personal identifiers if individual data are used.

Processes involved in an evaluation include:

- 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 illnesses, injuries or fatalities caused by violence relative to initial or "baseline" rates;
- Measuring improvement based on lowering the frequency and severity of workplace violence;

[12] Proper patient confidentiality must be maintained.

- Keeping up-to-date records of administrative and work practice changes 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 determine their effectiveness;
- Tracking recommendations through to completion;
- Keeping abreast of new strategies available to prevent and respond to violence in the healthcare and social service fields as they develop;
- Surveying workers periodically to learn if they experience hostile situations in performing their jobs;
- Complying with OSHA and state requirements for recording and reporting injuries, illnesses, and fatalities; and
- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving worker safety.

Workplace Violence Program Checklists

These checklists can help you or your workplace violence/crime prevention committee evaluate the workplace and job tasks to identify situations that may place workers at risk of assault. It is not designed for a specific industry or occupation, and may be used for any workplace. Adapt the checklist to fit your own needs. It is very comprehensive and not every question will apply to your workplace—if the question does not apply, either delete or write "N/A" in the NOTES column. Add any other questions that may be relevant to your worksite.

1. RISK FACTORS FOR WORKPLACE VIOLENCE

Cal/OSHA and NIOSH have identified the following risk factors that may contribute to violence in the workplace. If you have one or more of these risk factors in your workplace, there may be a potential for violence.

	YES	NO	Notes/Follow-up Action
Do employees have contact with the public?			
Do they exchange money with the public?			
Do they work alone?			
Do they work late at night or during early morning hours?			
Is the workplace often understaffed?			
Is the workplace located in an area with a high crime rate?			
Do employees enter areas with a high crime rate?			
Do they have a mobile workplace (patrol vehicle, work van, etc.)?			
Do they deliver passengers or goods?			
Do employees perform jobs that might put them in conflict with others?			
Do they ever perform duties that could upset people (deny benefits, confiscate property, terminate child custody, etc.)?			
Do they deal with people known or suspected of having a history of violence?			
Do any employees or supervisors have a history of assault, verbal abuse, harassment, or other threatening behavior?			
Other risk factors – please describe:			

2. INSPECTING WORK AREAS

- Who is responsible for building security?_____
  _____
- Are workers told or can they identify who is responsible for security? Yes No

You or your workplace violence/crime prevention committee should now begin a "walkaround" inspection to identify potential security hazards. This inspection can tell you which hazards are already well controlled, and what control measures need to be added. Not all of the following questions may be answered through simple observation. You may also need to talk to workers or investigate in other ways.

	All Areas	Some Areas	Few Areas	No Areas	NOTES/FOLLOW-UP ACTION
Are nametags or ID cards required for employees (omitting personal information such as last name and home address)?					
Are workers notified of past violent acts in the workplace?					
Are trained security and counseling personnel accessible to workers in a timely manner?					
Do security and counseling personnel have sufficient authority to take all necessary action to ensure worker safety?					
Is there an established liaison with state police and/or local police and counseling agencies?					
Are bullet-resistant windows or similar barriers used when money is exchanged with the public?					
Are areas where money is exchanged visible to others who could help in an emergency? (For example, can you see cash register areas from outside?)					
Is a limited amount of cash kept on hand, with appropriate signs posted?					
Could someone hear a worker who calls for help?					
Can employees observe patients or clients in waiting areas?					
Do areas used for patient or client interviews allow co-workers to observe any problems?					
Are waiting areas and work areas free of objects that could be used as weapons?					
Are chairs and furniture secured to prevent their use as weapons?					
Is furniture in waiting areas and work areas arranged to prevent entrapment of workers?					
Are patient or client waiting areas designed to maximize comfort and minimize stress?					

	All Areas	Some Areas	Few Areas	No Areas	NOTES/FOLLOW-UP ACTION
Are patients or clients in waiting areas clearly informed how to use the department's services so they will not become frustrated?					
Are waiting times for patient or client services kept short to prevent frustration?					
Are private, locked restrooms available for employees?					
Is there a secure place for workers to store personal belongings?					

3. INSPECTING EXTERIOR BUILDING AREAS

	Yes	No	NOTES/FOLLOW-UP ACTION
Do workers feel safe walking to and from the workplace?			
Are the entrances to the building clearly visible from the street?			
Is the area surrounding the building free of bushes or other hiding places?			
Is lighting bright and effective in outside areas?			
Are security personnel provided outside the building?			
Is video surveillance provided outside the building?			
Are remote areas secured during off shifts?			
Is a buddy escort system required to remote areas during off shifts?			
Are all exterior walkways visible to security personnel?			

4. INSPECTING PARKING AREAS

	Yes	No	NOTES/FOLLOW-UP ACTION
Is there a nearby parking lot reserved for employees only?			
Is the parking lot attended or otherwise secured?			
Is the parking lot free of blind spots and is landscaping trimmed back to prevent hiding places?			
Is there enough lighting to see clearly in the parking lot and when walking to the building?			
Are security escorts available to employees walking to and from the parking lot?			

5. SECURITY MEASURES

Does the workplace have:	In Place	Should Add	Doesn't Apply	NOTES/FOLLOW-UP ACTION
Physical barriers (plexiglass partitions, bullet-resistant customer window, etc.)?				
Security cameras or closed-circuit TV in high-risk areas?				
Panic buttons?				
Alarm systems?				
Metal detectors?				
Security screening device?				
Door locks?				
Internal telephone system to contact emergency assistance?				
Telephones with an outside line programmed for 911?				
Two-way radios, pagers, or cellular telephones?				
Security mirrors (e.g., convex mirrors)?				
Secured entry (e.g., "buzzers")?				
Personal alarm devices?				
"Drop safes" to limit the amount of cash on hand?				
Broken windows repaired promptly?				
Security systems, locks, etc. tested on a regular basis and repaired promptly when necessary?				

6. COMMENTS

_____

_____

_____

_____

Checklist completed by: _____ Date: _____

Department/Location: _____

Phone Number: _____

Workplace Violence Prevention Program Assessment Checklist

Use this checklist as part of a regular safety and health inspection or audit to be conducted by the Health and Safety, Crime/Workplace Violence Prevention Coordinator, or joint labor/management committee. If a question does not apply to the workplace, then write "N/A" (not applicable) in the notes column. Add any other questions that may be appropriate.

	Yes	No	NOTES
STAFFING			
Is there someone responsible for building security?			
Who is it?			
Are workers told who is responsible for security?			
Is adequate and trained staffing available to protect workers who are in potentially dangerous situations?			
Are there trained security personnel accessible to workers in a timely manner?			
Do security personnel have sufficient authority to take all necessary action to ensure worker safety?			
Are security personnel provided outside the building?			
Is the parking lot attended or otherwise secure?			
Are security escorts available to walk employees to and from the parking lot?			

	Yes	No	NOTES
TRAINING			
Are workers trained in the emergency response plan (for example, escape routes, notifying the proper authorities)?			
Are workers trained to report violent incidents or threats?			
Are workers trained in how to handle difficult clients or patients?			
Are workers trained in ways to prevent or defuse potentially violent situations?			
Are workers trained in personal safety and self-defense?			
FACILITY DESIGN			
Are there enough exits and adequate routes of escape?			
Can exit doors be opened only from the inside to prevent unauthorized entry?			
Is the lighting adequate to see clearly in indoor areas?			
Are there employee-only work areas that are separate from public areas?			
Is access to work areas only through a reception area?			
Are reception and work areas designed to prevent unauthorized entry?			
Could someone hear a worker call for help?			
Can workers observe patients or clients in waiting areas?			
Do areas used for patient or client interviews allow co-workers to observe any problems?			
Are waiting and work areas free of objects that could be used as weapons?			
Are chairs and furniture secured to prevent their use as weapons?			
Is furniture in waiting and work areas arranged to prevent workers from becoming trapped?			
Are patient or client areas designed to maximize comfort and minimize stress?			
Is a secure place available for workers to store their personal belongings?			
Are private, locked restrooms available for staff?			

	Yes	No	NOTES
SECURITY MEASURES – Does the workplace have?			
Physical barriers (Plexiglas partitions, elevated counters to prevent people from jumping over them, bullet-resistant customer windows, etc.)?			
Security cameras or closed-circuit TV in high-risk areas?			
Panic buttons – (portable or fixed)			
Alarm systems?			
Metal detectors?			
X-ray machines?			
Door locks?			
Internal phone system to activate emergency assistance?			
Phones with an outside line programmed to call 911?			
Security mirrors (convex mirrors)?			
Secured entry (buzzers)?			
Personal alarm devices?			
OUTSIDE THE FACILITY			
Do workers feel safe walking to and from the workplace?			
Are the entrances to the building clearly visible from the street?			
Is the area surrounding the building free of bushes or other hiding places?			
Is video surveillance provided outside the building?			
Is there enough lighting to see clearly outside the building?			
Are all exterior walkways visible to security personnel?			
Is there a nearby parking lot reserved for employees only?			
Is the parking lot free of bushes or other hiding places?			
Is there enough lighting to see clearly in the parking lot and when walking to the building?			
Have neighboring facilities and businesses experienced violence or crime?			

	Yes	No	NOTES
WORKPLACE PROCEDURES			
Are employees given maps and clear directions in order to navigate the areas where they will be working?			
Is public access to the building controlled?			
Are floor plans posted showing building entrances, exits, and location of security personnel?			
Are these floor plans visible only to staff and not to outsiders?			
Is other emergency information posted, such as the telephone numbers?			
Are special security measures taken to protect people who work late at night (escorts, locked entrances, etc.)?			
Are visitors or clients escorted to offices for appointments?			
Are authorized visitors to the building required to wear ID badges?			
Are identification tags required for staff (omitting personal information such as the person's last name and social security number)?			
Are workers notified of past violent acts by particular clients, patients, etc.?			
Is there an established liaison with local police and counseling agencies?			
Are patients or clients in waiting areas clearly informed how to use the department's services so they will not become frustrated?			
Are waiting times for patient or client services kept short to prevent frustration?			
Are broken windows and locks repaired promptly?			
Are security devices (locks, cameras, alarms, etc.) tested on a regular basis and repaired promptly when necessary?			
FIELD WORK – Staffing:			
Are escorts or "buddies" provided for people who work in potentially dangerous situations?			
Is assistance provided to workers in the field in a timely manner when requested?			
FIELD WORK – Training:			
Are workers briefed about the area in which they will be working (gang colors, neighborhood culture, language, drug activity, etc.)?			

	Yes	No	NOTES
Can workers effectively communicate with people they meet in the field (same language, etc.)?			
Are people who work in the field late at night or early mornings advised about special precautions to take?			
FIELD WORK – Work Environment:			
Is there enough lighting to see clearly in all areas where workers must go?			
Are there safe places for workers to eat, use the restroom, store valuables, etc.?			
Are there places where workers can go for protection in an emergency?			
Is safe parking readily available for employees in the field?			
FIELD WORK – Security Measures:			
Are workers provided two-way radios, pagers, or cellular phones?			
Are workers provided with personal alarm devices or portable panic buttons?			
Are vehicle door and window locks controlled by the driver?			
Are vehicles equipped with physical barriers (Plexiglas partitions, etc.)?			
FIELD WORK – Work Procedures:			
Are employees given maps and clear directions for covering the areas where they will be working?			
Are employees given alternative routes to use in neighborhoods with a high crime rate?			
Does a policy exist to allow employees to refuse service to clients or customers (in the home, etc.) in a hazardous situation?			
Has a liaison with the police been established?			
Do workers avoid carrying unnecessary items that someone could use as weapon against them?			
Does the employer provide a safe vehicle or other transportation for use in the field?			
Are vehicles used in the field routinely inspected and kept in good working order?			
Is there always someone who knows where each employee is?			
Are nametags required for workers in the field (omitting personal information such as last name and social security number)?			
Are workers notified of past violent acts by particular clients, patients, etc.?			

	Yes	No	NOTES
FIELD WORK – Are special precautions taken when workers:			
Have to take something away from people (remove children from the home)?			
Have contact with people who behave violently?			
Use vehicles or wear clothing marked with the name of an organization that the public may strongly dislike?			
Perform duties inside people's homes?			
Have contact with dangerous animals (dogs, etc.)?			

Adapted from the workplace violence prevention program checklist, California Department of Human Resources, see www.calhr.ca.gov/Documents/model-workplace-violence-and-bullying-prevention-program.pdf (last accessed November 25, 2014).

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Workers' Rights

Workers have the right to:

- Working conditions that do not pose a risk of serious harm.
- Receive information and training (in a language and vocabulary the worker understands) about workplace hazards, methods to prevent them, and the OSHA standards that apply to their workplace.
- Review records of work-related injuries and illnesses.
- File a complaint asking OSHA to inspect their workplace if they believe there is a serious hazard or that their employer is not following OSHA's rules. OSHA will keep all identities confidential.
- Exercise their rights under the law without retaliation, including reporting an injury or raising health and safety concerns with their employer or OSHA. If a worker has been retaliated against for using their rights, they must file a complaint with OSHA as soon as possible, but no later than 30 days.

For more information, see OSHA's Workers page.

OSHA Assistance, Services and Programs

OSHA has a great deal of information to assist employers in complying with their responsibilities under OSHA law. Several OSHA programs and services can help employers identify and correct job hazards, as well as improve their injury and illness prevention program.

Establishing an Injury and Illness Prevention Program

The key to a safe and healthful work environment is a comprehensive injury and illness prevention program.

Injury and illness prevention programs are systems that can substantially reduce the number and severity of workplace injuries and illnesses, while reducing costs to employers. Thousands of employers across the United States already manage safety using injury and illness prevention programs, and OSHA believes that all employers can and should do the same. Thirty-four states have requirements or voluntary guidelines for workplace injury and illness prevention programs. Most successful injury and illness prevention programs are based on a common set of key elements. These include management leadership, worker participation, hazard identification, hazard prevention and control, education and training, and program evaluation and improvement. Visit OSHA's Injury and Illness Prevention Programs web page at www.osha.gov/dsg/topics/safetyhealth for more information.

Compliance Assistance Specialists

OSHA has compliance assistance specialists throughout the nation located in most OSHA offices. Compliance assistance specialists can provide information to employers and workers about OSHA standards, short educational programs on specific hazards or OSHA rights and responsibilities, and information on additional compliance assistance resources. For more details, visit www.osha.gov/dcsp/compliance_assistance/cas.html or call 1-800-321-OSHA (6742) to contact your local OSHA office.

Free On-site Safety and Health Consultation Services for Small Business

OSHA's On-site Consultation Program offers free and confidential advice to small and medium-sized businesses in all states across the country, with priority given to high-hazard worksites. Each year, responding to requests from small employers looking to create or improve their safety and health management programs, OSHA's On-site Consultation Program conducts over 29,000 visits to small business worksites covering over 1.5 million workers across the nation.

On-site consultation services are separate from enforcement and do not result in penalties or citations. Consultants from state agencies or universities work with employers to identify workplace hazards, provide advice on compliance with OSHA standards, and assist in establishing safety and health management programs.

For more information, to find the local On-site Consultation office in your state, or to request a brochure on Consultation Services, visit www.osha.gov/consultation, or call 1-800-321-OSHA (6742).

Under the consultation program, certain exemplary employers may request participation in OSHA's **Safety and Health Achievement Recognition Program (SHARP)**. Eligibility for participation includes, but is not limited to, receiving a full-service, comprehensive consultation visit, correcting all identified hazards and developing an effective safety and health management program. Worksites that receive SHARP recognition are exempt from programmed inspections during the period that the SHARP certification is valid.

Cooperative Programs

OSHA offers cooperative programs under which businesses, labor groups and other organizations can work cooperatively with OSHA. To find out more about any of the following programs, visit www.osha.gov/cooperativeprograms.

Strategic Partnerships and Alliances

The OSHA Strategic Partnerships (OSP) provide the opportunity for OSHA to partner with employers, workers, professional or trade associations, labor organizations, and/or other interested stakeholders. OSHA Partnerships are formalized through unique agreements designed to encourage, assist, and recognize partner efforts to eliminate serious hazards and achieve model workplace safety and health practices. Through the Alliance Program, OSHA works with groups committed to worker safety and health to prevent workplace fatalities, injuries and illnesses by developing compliance assistance tools and resources to share with workers and employers, and educate workers and employers about their rights and responsibilities.

Voluntary Protection Programs (VPP)

The VPP recognize employers and workers in private industry and federal agencies who have implemented effective safety and health management programs and maintain injury and illness rates below the national average for their respective industries. In VPP, management, labor, and OSHA work cooperatively and proactively to prevent fatalities, injuries, and illnesses through a system focused on: hazard prevention and control, worksite analysis, training, and management commitment and worker involvement.

Occupational Safety and Health Training

The OSHA Training Institute in Arlington Heights, Illinois, provides basic and advanced training and education in safety and health for federal and state compliance officers, state consultants, other federal agency personnel and private sector employers, workers, and their representatives. In addition, 27 OSHA Training Institute Education Centers at 42 locations throughout the United States deliver courses on OSHA standards and occupational safety and health issues to thousands of students a year.

For more information on training, contact the OSHA Directorate of Training and Education, 2020 Arlington Heights Road, Arlington Heights, IL 60005; call 1-847-297-4810; or visit www.osha.gov/otiec.

OSHA Educational Materials

OSHA has many types of educational materials in English, Spanish, Vietnamese and other languages available in print or online. These include:

- Brochures/booklets that cover a wide variety of job hazards and other topics;
- Fact Sheets, which contain basic background information on safety and health hazards;
- Guidance documents that provide detailed examinations of specific safety and health issues;
- Online Safety and Health Topics pages;

- Posters;
- Small, laminated QuickCards™ that provide brief safety and health information; and
- *QuickTakes*, OSHA's free, twice-monthly online newsletter with the latest news about OSHA initiatives and products to assist employers and workers in finding and preventing workplace hazards. To sign up for *QuickTakes* visit www.osha.gov/quicktakes.

To view materials available online or for a listing of free publications, visit www.osha.gov/publications. You can also call 1-800-321-OSHA (6742) to order publications.

OSHA's web site also has a variety of eTools. These include utilities such as expert advisors, electronic compliance assistance, videos and other information for employers and workers. To learn more about OSHA's safety and health tools online, visit www.osha.gov.

NIOSH Health Hazard Evaluation Program

Getting Help with Health Hazards

The National Institute for Occupational Safety and Health (NIOSH) is a federal agency that conducts scientific and medical research on workers' safety and health. At no cost to employers or workers, NIOSH can help identify health hazards and recommend ways to reduce or eliminate those hazards in the workplace through its Health Hazard Evaluation (HHE) Program.

Workers, union representatives and employers can request a NIOSH HHE. An HHE is often requested when there is a higher than expected rate of a disease or injury in a group of workers. These situations may be the result of an unknown cause, a new hazard, or a mixture of sources. To request a NIOSH Health Hazard Evaluation go to www.cdc.gov/niosh/hhe/request.html. To find out more about the Health Hazard Evaluation Program:

- Call (513) 841-4382, or to talk to a staff member in Spanish, call (513) 841-4439; or
- Send an email to HHERequestHelp@cdc.gov.

OSHA Regional Offices

Region I
Boston Regional Office
(CT*, ME, MA, NH, RI, VT*)
JFK Federal Building, Room E340
Boston, MA 02203
(617) 565-9860 (617) 565-9827 Fax

Region II
New York Regional Office
(NJ*, NY*, PR*, VI*)
201 Varick Street, Room 670
New York, NY 10014
(212) 337-2378 (212) 337-2371 Fax

Region III
Philadelphia Regional Office
(DE, DC, MD*, PA, VA*, WV)
The Curtis Center
170 S. Independence Mall West
Suite 740 West
Philadelphia, PA 19106-3309
(215) 861-4900 (215) 861-4904 Fax

Region IV
Atlanta Regional Office
(AL, FL, GA, KY*, MS, NC*, SC*, TN*)
61 Forsyth Street, SW, Room 6T50
Atlanta, GA 30303
(678) 237-0400 (678) 237-0447 Fax

Region V
Chicago Regional Office
(IL*, IN*, MI*, MN*, OH, WI)
230 South Dearborn Street
Room 3244
Chicago, IL 60604
(312) 353-2220 (312) 353-7774 Fax

Region VI
Dallas Regional Office
(AR, LA, NM*, OK, TX)
525 Griffin Street, Room 602
Dallas, TX 75202
(972) 850-4145 (972) 850-4149 Fax
(972) 850-4150 FSO Fax

Region VII
Kansas City Regional Office
(IA*, KS, MO, NE)
Two Pershing Square Building
2300 Main Street, Suite 1010
Kansas City, MO 64108-2416
(816) 283-8745 (816) 283-0547 Fax

Region VIII
Denver Regional Office
(CO, MT, ND, SD, UT*, WY*)
Cesar Chavez Memorial Building
1244 Speer Boulevard, Suite 551
Denver, CO 80204
(720) 264-6550 (720) 264-6585 Fax

Region IX
San Francisco Regional Office
(AZ*, CA*, HI*, NV*, and American Samoa,
Guam and the Northern Mariana Islands)
90 7th Street, Suite 18100
San Francisco, CA 94103
(415) 625-2547 (415) 625-2534 Fax

Region X
Seattle Regional Office
(AK*, ID, OR*, WA*)
300 Fifth Avenue, Suite 1280
Seattle, WA 98104
(206) 757-6700 (206) 757-6705 Fax

* These states and territories operate their own OSHA-approved job safety and health plans and cover state and local government employees as well as private sector employees. The Connecticut, Illinois, New Jersey, New York and Virgin Islands programs cover public employees only. (Private sector workers in these states are covered by Federal OSHA). States with approved programs must have standards that are identical to, or at least as effective as, the Federal OSHA standards.

Note: To get contact information for OSHA area offices, OSHA-approved state plans and OSHA consultation projects, please visit us online at www.osha.gov or call us at 1-800-321-OSHA (6742).

How to Contact OSHA

For questions or to get information or advice, to report an emergency, report a fatality or catastrophe, order publications, sign up for OSHA's e-newsletter *QuickTakes*, or to file a confidential complaint, contact your nearest OSHA office, visit www.osha.gov or call OSHA at 1-800-321-OSHA (6742), TTY 1-877-889-5627.

For assistance, contact us.
We are OSHA. We can help.

OSHA®
www.osha.gov

U.S. Department of Labor

For more information:

OSHA® Occupational Safety and Health Administration

www.osha.gov (800) 321-OSHA (6742)