Feature

Unique Challenges for Behavioral Health Providers in Protecting Health Care Workers While Balancing the Needs of Patients

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As front-line health care workers battle the COVID-19 pandemic, a silent epidemic of violence against them continues to rise. According to the Occupational Safety and Health Administration (OSHA), 75% of all workplace assaults happen to health care workers, making it one of the most dangerous professions in the United States. Certain settings, such as the emergency department (ED) and psychiatric units, are particularly vulnerable. Recent surveys show 78% of ED physicians reported being targets of workplace violence in the past year, and 75%–100% of nurses on psychiatric units reported being assaulted by a patient at some point in their career.[1]

While these statistics are startling, the actual number is likely higher given that health care workers tend to underreport incidents of violence, viewing it as part of the job. Studies have shown that on average, nurses report only 20%–60% of workplace violence incidents.[2] Even in the ED, where violence is prevalent, only 30% of nurses and 26% of physicians reported incidents of violence according to a national survey.[3]

Although health care employers have responded by prioritizing violence prevention efforts, they still face many challenges in creating a safe workplace, particularly within the behavioral health setting. One of those challenges, and the focus of this article, is balancing the need to provide patients with access to quality care in a nondiscriminatory manner, while also ensuring the safety of health care workers who deliver that care.

Regulatory Requirements Facing Health Care Employers

Like most aspects of health care, there are multiple entities enforcing various regulations, guidelines, and recommendations that seek to address these issues. This article addresses two of those entities—OSHA and The Joint Commission.[4]

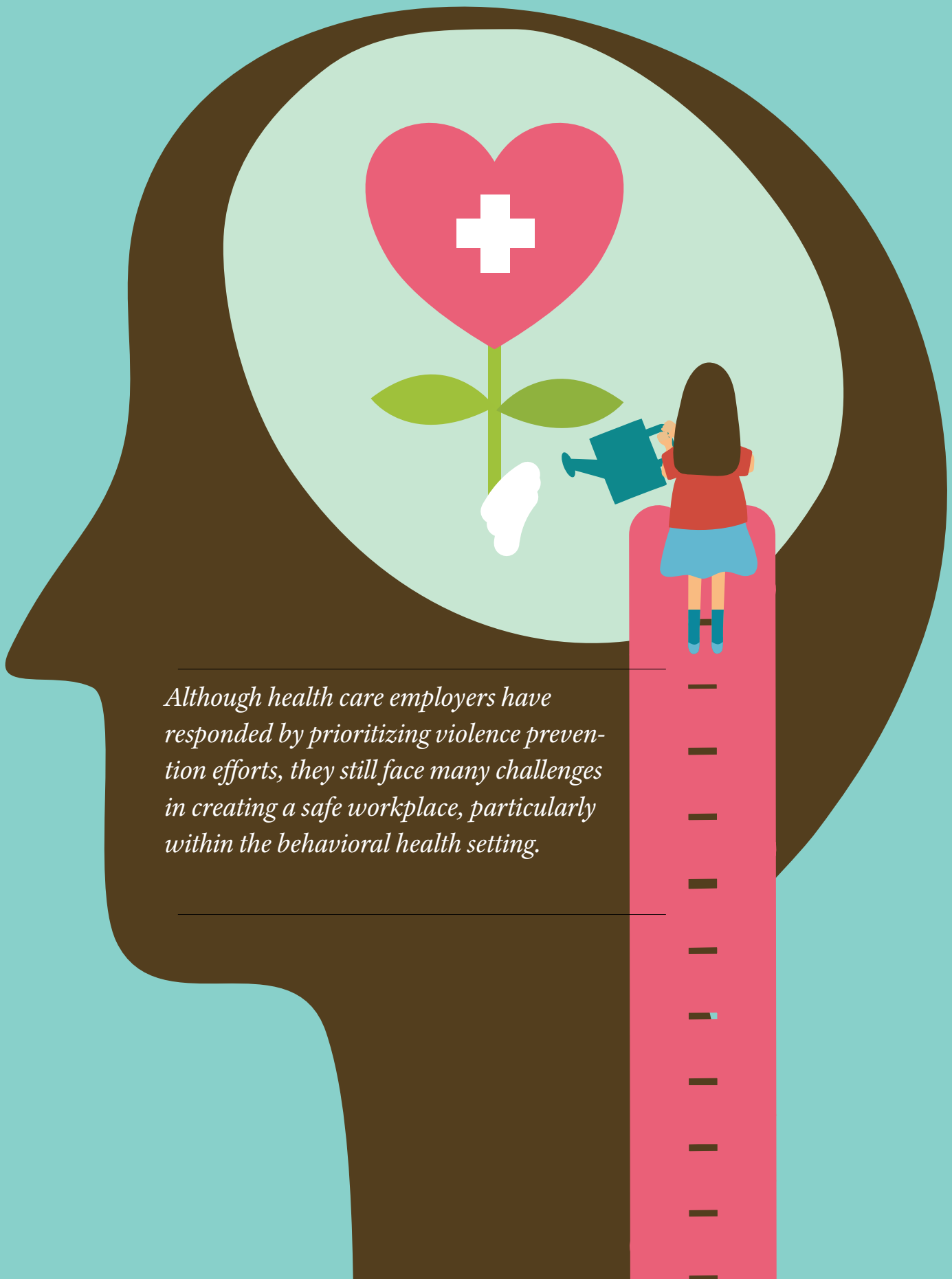
OSHA Workplace Violence Guidelines and Enforcement Through the General Duty Clause

OSHA has issued workplace violence guidelines for health care and social service workers since 1995. These guidelines were revised in 2004 and again in 2015. The 2015 update, entitled *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (Guidelines), is the most recent version.[5] Following its publication, the Department of Labor announced that OSHA would expand enforcement activities to ensure that workplace violence, occurring in specific health care settings, was being addressed. Since then, there have been many reported enforcement actions, a number of the more notable actions involving behavioral health care providers.

While the Guidelines are only "advisory in nature," and do not constitute standards or regulations,[6] they are enforceable by OSHA pursuant to Section 5(a)(1) of the Occupational Safety and Health Act—known as the "General Duty Clause."[7] It requires all employers to provide their employees "with a place of employment [which is] free from recognized hazards that are causing or are likely to cause death or serious physical harm."[8] OSHA's enforcement activities can lead to fines and government oversight; hence, health care employers must address the requirements of the Guidelines. In particular, hospitals; residential treatment facilities; non-residential treatment facilities and related service settings such as clinics and mental health centers; community care settings, including residential facilities and group homes; and field work settings, including health care workers who make home visits, are identified as being the focus of the Guidelines and OSHA enforcement.

The OSHA Guidelines Require a Workplace Violence Assessment and Prevention Plan

To establish a violation of the General Duty Clause, OSHA must show that (1) the employer failed to keep the workplace free of a recognized hazard that was causing or likely to cause death or serious physical harm and (2) there was a feasible and useful method to address it. Under the Guidelines, employers must prepare and implement a Workplace Violence Assessment and Prevention Plan that includes (a) management commitment and worker/employee participation, (b) worksite analysis and hazard identification, (c) identification of controls to eliminate or reduce hazards, (d) safety and training for all personnel, and (e) record keeping and evaluation. The requirements and content for each



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employer's Plan will differ dramatically based on the type of services delivered, where/how such services are delivered, and the perceived and known risks to employees. Employers also should consider OSHA's enforcement manual, *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents*, which identifies those things, in particular, that OSHA inspectors evaluate.[9]

An OSHA inspector has a number of different compliance/enforcement options available following an inspection, including finding no violation, issuing a Hazard Alert Letter (which typically identifies insufficiencies and needed compliance steps without finding a General Duty Clause violation), or issuing a citation (often accompanied by a fine and compliance requirements).

In recent years, OSHA's enforcement actions have arisen in many contexts, several of which have occurred in the behavioral health setting. Examples include OSHA's citation (upheld in 2019) of an Owings Mills, MD-based employer whose employee was stabbed to death by a mental health patient with a violent criminal history during a home visit;[10] an October 2018 citation against an Orefield, PA psychiatric hospital focusing on treating children/young adults for its failure to protect its employees who were routinely kicked, punched, bitten and scratched while delivering care;[11] a May 2018 citation (including more than $71,000 in fines) of a Bradenton, FL inpatient behavioral facility for failing, for two years, to adequately protect employees from a variety of similar injuries;[12] and the March 2018 pursuit of a Portland, OR behavioral health center for failing to properly log, document, or investigate approximately 300 assaults suffered by its employees during its first seven months of operation.[13]

Recent OSHA Enforcement Actions

Recent cases involving OSHA actions against two different psychiatric hospitals highlight the conditions that can arise at behavioral health facilities and provide a side-by-side comparison of steps taken by each to address issues of workplace violence against their respective employees. In one instance, OSHA's citation against BHC Northwest Psychiatric Hospital LLC d/b/a Brooke Glen Behavioral (BHC), a 146-bed inpatient psychiatric/behavioral health hospital in Fort Washington, PA, was upheld. In the other, OSHA's citation against HRI Hospital, Inc. d/b/a Arbour-HRI Hospital (Arbour), a 62-bed facility in Brookline, MA, was not.

Following OSHA's receipt of complaints describing incidents of patient violence[14] against employees at both facilities, inspectors conducted investigations and citations were issued against BHC and Arbour for failing to protect their employees from injuries arising from physical assaults by their patients. Both facilities appealed their citations. After hearing the evidence in the two cases, the same administrative law judge (ALJ) affirmed the OSHA citation against BHC[15] and vacated the citation against Arbour.[16] BHC appealed the ALJ decision, which the D.C. Circuit affirmed on March 3, 2020.[17]

At BHC, the OSHA Compliance Safety and Health Officer concluded that over the course of one year, there were at least 51 incidents where employees were injured by patients, having been punched, kicked, grabbed, spit on, slapped, bitten, scratched, and hit with objects, sometimes also resulting in injuries to hands, knees, and backs.[18] At Arbour, while the number of incidents was not specifically identified, the OSHA Compliance Safety and Health Officer found that nurses and mental health workers were subjected to similar attacks by patients, finding they had been punched, kicked, scratched, bitten, and hit with objects.[19] It was also determined that both facilities and the industry[20] recognized the hazards present in treating those suffering from behavioral health conditions.

The difference in outcomes concerning the OSHA citations resulted from the efforts taken by the facilities to address types of workplace violence through adequate risk assessment, planning, and active employee involvement in seeking solutions. OSHA conceded that the hazard of employee injury in this treatment environment cannot be eliminated.[21] The focus centered on each facility's efforts to abate the situation. The ALJ and the court found that OSHA met its burden in showing that there were feasible methods not advanced by BHC.[22] By contrast, the ALJ found that because of abatement efforts already implemented by Arbour, OSHA failed to meet its burden.[23]

Health care workers and employers are often caught between two conflicting duties—the duty to provide compassionate, quality care in a nondiscriminatory manner and the duty to protect those who provide the care.

These cases reveal the challenges faced by health care employers—especially those in behavioral health—while seeking to deliver compassionate health care, protecting the well-being of their employees, and addressing requirements in the OSHA Guidelines.

The Joint Commission and Its Sentinel Event Policy

The Joint Commission also addresses workplace violence in its accredited health care settings including

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nursing homes, laboratories, home care, behavioral health, office-based surgery practices, ambulatory care, critical access hospitals, and hospitals. It has several broad standards that relate directly or indirectly to workplace violence, including Emergency Management standards that require risk analyses and action plans.

The Standards in the Environment of Care chapter require accredited organizations to manage both safety and security risks.[24] Security risks include workplace violence, theft, infant abduction, and more. Organizations must take action to minimize or eliminate identified safety and security risks in the physical environment.

Under The Joint Commission's Sentinel Event Policy, which applies to all accredited programs, an event of workplace violence could be considered a sentinel event. There is a general definition for sentinel events as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. But there are also more specifically enumerated definitions in the Sentinel Event Policy, which include rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of *a staff member, licensed independent practitioner, visitor, or vendor while on site* at the accredited organization.[25] For several years, criminal events have been among the top ten sentinel events reported to The Joint Commission.

Accredited organizations are expected to prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 45 business days of a sentinel event or of becoming aware of the event. Root cause analysis, which focuses on systems and processes, is the most common form of comprehensive systematic analysis used for identifying the factors that underlie a sentinel event, but an organization may use other tools and methodologies to conduct its comprehensive systematic analysis. The corrective action plan identifies the strategies that the organization intends to implement to reduce the risk of similar events occurring in the future.

While The Joint Commission encourages voluntary reporting, accredited organizations are not required to report sentinel events to The Joint Commission. But, if The Joint Commission becomes aware of a sentinel event because of a news article or a complaint submitted to its Office of Quality and Patient Safety, a member of the Office of Quality and Patient Safety may contact the accredited organization to determine whether the comprehensive systematic analysis and corrective action plan were acceptable. If factual indications demonstrate repeated occurrences of workplace violence at an organization, the Office of Quality and Patient Safety will elevate that information to Joint Commission leadership. Leadership could potentially send surveyors to the organization to conduct a for-cause survey centering on risk analysis and mitigation plans.

While reporting is encouraged but not required, reporting a sentinel event to The Joint Commission enables "lessons learned" from the event to be added to The Joint Commission's Sentinel Event Database, thereby contributing to the general knowledge of sentinel events and to the reduction of risk for such events in other organizations. In April 2018, The Joint Commission issued a *Sentinel Event Alert* on workplace violence.[26] Though no new accreditation standards were created to specifically address workplace violence, the Sentinel Event Alert article contained suggested actions to address the growing problem.

Challenges for Hospitals and Other Health Care Settings

The Dilemma: Balancing Access to Care and the Safety of Health Care Workers

While preventing workplace violence seems simple, in practice it is not. Part of the problem is a culture of accepting violence in health care due to a perception that it is part of the job and that patients who commit acts of violence are not responsible for their actions because of dementia, being disoriented, or experiencing a mental health crisis. This is not altogether surprising because health care workers are caregivers by nature; however, such an approach to care can often result in violent incidents going unreported while health care workers put their own health and safety at risk.

Preventing workplace violence can be challenging depending on the health care setting. As noted, violence is particularly prevalent in the ED, likely due, at least in part, to each hospital's obligation to comply with the Emergency Medical Treatment and Labor Act, which requires a medical screening examination and stabilizing treatment for anyone who enters the ED, including any patient who presents a danger to self or others. Other factors such as a lack of de-escalation training, violence prevention programs, adequate staffing, and properly trained security guards may also trigger violence, not to mention the ED environment, which

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is inherently stressful. Lack of mental health resources also creates a challenge to the overall system due to the shortage of psychiatric beds and of long-term placements. Shortages of resources can lead to overcrowding in the ED and increased incidents of violence, particularly when patients require restraint or seclusion.

These challenges illustrate why workplace violence remains such a complex issue. Health care workers and employers are often caught between two conflicting duties—the duty to provide compassionate, quality care in a nondiscriminatory manner and the duty to protect those who provide the care.

Finding a Solution to Curb Workplace Violence in Health Care

While workplace violence in the health care industry has become an epidemic, how to fix the problem is not clear. One option, which has been heavily debated, is whether to impose harsher criminal penalties on patients. However, particularly with behavioral health patients, such an approach raises ethical concerns, including whether patients should be punished for behavior they cannot control and whether punishment serves any deterrent function.

Those opposing harsher criminal penalties argue that, in many cases, a behavioral health patient may assault a health care worker unintentionally due to a cognitive impairment, psychiatric diagnosis, or belief they are protecting themselves. In those situations, the patient may not appreciate what happened because they lack capacity. As a result, attempting to prosecute patients may have no impact on reducing violence and if anything, may result in impediments to housing or employment for patients who are convicted.

On the other hand, those advocating for greater criminal accountability argue that such an approach is necessary to protect health care workers and will, through the deterrence created by harsher penalties, send the message that violence will not be tolerated.

Apart from the Guidelines, there is no federal law or regulation requiring protection against workplace violence in the health care setting, so states have sought legislative solutions. Thirty-eight states have made it a felony to assault a health care worker.[27] Some states, such as Oklahoma, have enacted new laws to increase prison time for assaulting a health care worker.[28] Other states have focused more on prevention to reduce violence. For example, California, Connecticut, Illinois, Maryland, Minnesota, New Jersey, Oregon, and Washington all require employers to have workplace violence prevention programs (New York requires this for public employers).[29]

In practice, hospitals and other health care facilities have implemented a variety of safety measures to curb workplace violence, including sitters, panic buttons, limited badge access, security cameras, metal detec-

tors, security dogs, de-escalation training, increased security and police presence, and rapid response teams to alleviate potentially violent situations and identify potentially violent patients. Additionally, efforts have been made to reduce incidents of violence by seeking to increase safety and reporting through technology that allows staff to more easily (and anonymously) report violent incidents, by creating facility safety assessments, by offering enhanced training on how to identify/defuse potentially violent situations, and by conducting post-incident debriefing sessions.

At the same time, hospitals and other health care facilities sometimes implement safety strategies that may go too far. One example is when mentally ill individuals seek help, and after exhibiting disruptive behavior, are sent, instead, to jail. While some argue that such an approach is appropriate for safety reasons, others contend that it criminalizes mental illness and discriminates against behavioral health patients. Advocates recommend a proactive approach that devotes more resources to preventing workplace violence before it occurs.

In the end, no one will deny that health care workers need to be protected and feel safe at work. The key, however, is finding the right balance between ensuring a safe workplace and providing an accessible location for the public to receive care. There is no one-size-fits-all approach. In developing a plan, health care employers should engage front-line nurses and clinicians who deal with workplace violence regularly to create and establish a comprehensive approach that works well for that facility.

Conclusion

During the current unprecedented public health emergency, it is more important than ever to protect health care workers from incidents of violence. Health care workers cannot provide quality patient care if they do not feel safe. As the pandemic continues, anxiety and stress levels will undoubtedly grow, increasing risks of violence against health care workers. Hospitals and health care systems will need to be prepared in how to manage workplace violence.

In addition to the Guidelines, numerous resources are available for developing a comprehensive workplace violence prevention program. The Joint Commission offers a portal that provides resources and toolkits for preventing workplace violence.[30] The National Institute for Occupational Safety and Health offers a free online training entitled, "Workplace Violence Prevention for Nurses."[31] The Joint Commission, OSHA, and the World Health Organization also have published extensive articles that address workplace violence prevention.[32] Additionally, professional organizations, such as the Emergency Nurses Association, American College of Emergency Physicians, and American Hospital Association, also offer resources on workplace violence prevention.

Workplace violence remains a significant threat to the health care system, but steps can be taken to reduce incidents of violence. The OSHA Guidelines, The Joint Commission standards, and other resources discussed above offer a framework to create and maintain a culture of safety. While implementing systemwide changes cannot happen overnight, these resources provide practical solutions and innovative approaches to address workplace violence in a way that balances access to patient care and the safety of health care workers.

Endnotes

1. *See* Marcelina Behnam, et al., *Violence in the Emergency Department: A National Survey of Emergency Medicine Residents and Attending Physicians*, J. Emergency Med., 565–579 (2011), https://www.medscape.com/viewarticle/742883_print; Laura Iozzino, et al., *Prevalence and Risk Factors of Violence by Psychiatric Acute Inpatients: A Systematic Review and Meta-Analysis*, PLoS One, 10(6) (June 10, 2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4464653/.
2. *See* Am. Nurses Ass'n, Issue Brief: Reporting Incidents of Workplace Violence 1 (2019), https://www.nursingworld.org/~495349/globalassets/docs/ana/ethics/endabuse-issue-brief-final.pdf.
3. *See* The Joint Commission, *Physical and verbal violence against healthcare workers*, 59 Sentinel Event Alert 2 (Apr. 17, 2018), www.jointcommission.org/sea_issue_59/ (last accessed May 31, 2020).
4. Ongoing efforts by others at both the state and federal level include Centers for Medicare & Medicaid Services Emergency Preparedness Requirements (which require a yearly all-hazards risk assessment), California's efforts to pass workplace violence prevention regulations, and the *Workplace Violence Prevention for Health Care and Social Service Workers Act* (H.R. 1309, which passed the House of Representatives in November 2019).
5. OSHA, *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, https://www.osha.gov/Publications/osha3148.pdf.

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6. The *Workplace Violence Prevention for Health Care and Social Service Workers Act* (which has not yet been acted on by the Senate) directs the Department of Labor to promulgate an occupational safety and health standard addressing this issue.
7. 29 U.S.C. § 654.
8. *Id.*
9. OSHA, *Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents* https://www.osha.gov/sites/default/files/enforcement/directives/CPL_02-01-058.pdf.
10. *See* OSHA, News Release, Region 4 (June 10, 2013), https://www.osha.gov/news/newsreleases/region4/06102013.
11. *See OSHA, Citation and Notification of Penalty* (Oct. 3, 2018), https://www.osha.gov/ooc/citations/KidsPeaceNationalCenters_1306530.pdf.
12. OSHA, News Release, Region 4 (May 2, 2018), https://www.osha.gov/news/newsreleases/region4/05022018.
13. Aimee Green, *State fines Unity mental health $1,650 after workers suffer hundreds of assaults*, Oregonian/OregonLive, Mar. 19, 2018, https://www.oregonlive.com/portland/2018/03/state_fines_unity_mental_healt.html.
14. Arbour treats patients with psychiatric disorders and illnesses who, in many instances, have a history of violence or aggression and are unable to be treated in a less restrictive setting. BHC, a larger facility, treats a wider variety of patients, including patients who pose a risk of harm to themselves or others.
15. *See Secretary of Labor v. BHC Northwest Psychiatric Hosp. LLC*, OSHRC Docket No. 17-0063, 2019 OSAHRC LEXIS 6* (Jan. 22, 2019) (BHC ALJ Decision).
16. *See Secretary of Labor v. HRI Hosp., Inc., d/b/a Arbour-HRI Hosp.*, OSHRC Docket No. 17-0303, 2019 OSAHRC LEXIS 27*; 2019 OSHD (CCH) P33, 711 (Jan. 22, 2019) (Arbour ALJ Decision).
17. *See BHC Northwest Psychiatric Hosp., LLC v. Sec'y of Labor*, 2020 U.S. App. LEXIS 6645, *1 (D.C. Cir. Mar. 3, 2020) (BHC Appellate Decision).
18. BHC ALJ Decision at 3-4.
19. Arbour ALJ Decision at 2.
20. An OSHA expert involved with both cases cited a 2015 study of 614 psychiatric care units where nearly 15,000 patient assaults occurred over a four-year period, 75% of which resulted in employee injury. BHC ALJ Decision at 7; Arbour ALJ Decision at 3-4.
21. Arbour ALJ Decision at 5.
22. OSHA contended that BHC's workplace violence prevention plan was inadequate, noting a number of deficiencies, including the fact that while patient aggression information was obtained at intake, employees were not required to review it and those providing care were not informed of such risks. The plan also focused upon "employee-against-employee violence" versus "patient-against-employee" violence. Further, while BHC had a policy addressing how staff should approach an aggressive patient, the policy, developed in 2003, had never been updated and its existence was widely unknown. The plan also limited the reporting of incidents to only those requiring first aid. Lastly, OSHA found that when the staff made suggestions for addressing these incidents, there was a lack of organizational follow-up. OSHA showed, by contrast, that there were available and feasible means for materially reducing the hazard. These included a comprehensive hazard evaluation, appropriate staffing (having determined that BHC lacked the necessary staffing to address the patient needs and known hazards), an effective method for securing assistance as a preventative measure, a more robust incident documentation and review process, and the involvement of direct care employees on a safety committee that would review workplace violence incidents and assist in the development of better systems and communication with employees. Given the noted deficiencies and these recommended measures, OSHA was found to have met its burden. BHC ALJ Decision at 18, 21, 33-35, 38, 49, 55, 61 and 65.
23. In general OSHA's burden is satisfied if it can demonstrate there are feasible actions that can materially reduce a hazard. To meet this burden, however, OSHA must also show that existing measures are inadequate. It was OSHA's position that Arbour's workplace violence training was insufficient and that the hazard could be materially reduced by employing more effective training methods. OSHA also contended that the facility lacked adequate policies and procedures to materially reduce patient-on-staff violence and that its staffing was inadequate to address these issues. In response, Arbour was able to show that its training was extensive, addressing, in particular, how to identify potentially aggressive patients and providing an entire day of training devoted to de-escalation techniques. The training was further shown to include classroom and "hands-on" learning, and after being trained, new employees shadowed a nurse educator before taking on direct patient responsibilities. All employees also were required to go through annual re-certification that, according to Arbour's expert, provided more annual training on managing patient issues than what is typical in the industry. The ALJ found that OSHA failed to show how its proposed training changes would materially reduce the hazard. Likewise, while OSHA contended that Arbour needed a more comprehensive workplace violence prevention program that included a coordinator, better incident reporting/tracking, and more employee involvement, the ALJ, while recognizing the benefits of OSHA's more comprehensive program, found that it failed to show the existing program was deficient. Lastly, while there was no disagreement that appropriate staffing levels are "critical at any behavioral facility," the ALJ found that OSHA's approach did not call for a higher number of employees, instead, advocating for a different approach for addressing staffing levels at different times. As a result, the ALJ determined that OSHA failed to establish that Arbour's staffing/system was inadequate. Arbour ALJ Decision at 7-10.
24. Comprehensive Accreditation Manuals, The Joint Commission, Environment of Care Chapter, Jan. 2020.
25. *Id.*
26. *See* The Joint Commission, *Physical and verbal violence against healthcare workers*, 59 Sentinel Event Alert 2 (Apr. 17, 2018), www.jointcommission.org/sea_issue_59/ (last accessed May 31, 2020).
27. Kristian Foden-Vencil, *Oregon Legislators Try To Reduce Assaults On Medical Staff*, OPB.org (May 3, 2019), https://www.opb.org/news/article/senate-bill-reduce-violence-nurses-oregon-health-workers-advances/.
28. This is a new law for Oklahoma, and part of the Medical Care Provider Protection Act, which goes into effect on November 1, 2020. *See* Ronn Rowland, *Okla. governor signs law to protect EMS, hospital personnel from violence*, EMS1.com (May 20, 2020), https://www.ems1.com/ems-assaults/articles/okla-governor-signs-law-to-protect-ems-hospital-personnel-from-violence-6OB6YzG6rspiLISv/.
29. Sean Kingston, *Prevention Is Key (Er...Required): Will Your State Soon Mandate Workplace Violence Prevention Programs?*, Fisher Phillips Newsletter (Aug. 4, 2017), https://www.fisherphillips.com/resources-newsletters-article-will-your-state-soon-mandate-workplace-violence-prevention-programs.
30. The Joint Commission, Workplace Violence Prevention Resources, https://www.jointcommission.org/en/resources/patient-safety-topics/workplace-violence-prevention/.
31. National Institute for Occupational Safety and Health, Workplace Violence Prevention for Nurses, https://www.cdc.gov/niosh/topics/violence/training_nurses.html.
32. The Joint Commission, Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation, https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/patient-safety/tjc-improvingpatientandworkersafety-monograph.pdf; OSHA Pub. 3826, Workplace Violence in Healthcare: Understanding the Challenge, https://www.osha.gov/Publications/OSHA3826.pdf; World Health Organization, Framework Guidelines for Addressing Workplace Violence in the Health Sector, https://www.who.int/violence_injury_prevention/violence/interpersonal/en/WVguidelinesEN.pdf?ua=1&ua=1.