

VIOLENCE AGAINST HEALTH CARE EMPLOYEES

House Bill 2022 (2007)

DCBS

4/30/2009



**Prepared By Oregon Occupational Safety & Health
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EXECUTIVE SUMMARY

House Bill 2022 (2007)

In 2007, the Legislative Assembly passed House Bill 2022 (2007 Or. Laws ch. 397) requiring hospitals, ambulatory surgical centers, and home health care services operated by hospitals to implement strategies to protect health care employees from acts of violence in the workplace.

House Bill 2022 requires health care employers to:

- (a) Conduct periodic security and safety assessments to identify existing or potential hazards for assaults committed against employees;
- (b) Develop and implement an assault prevention and protection program for employees based on the assessments; and
- (c) Provide assault prevention and protection training on a regular and ongoing basis for employees.

In addition, health care employers were required to maintain a record of assaults committed against employees on the premises of the health care employer or in the home of a patient receiving home health care services.

For the 2008 calendar year, facilities were required to send data to the Department of Consumer and Business Services/Oregon OSHA for review. The response rate for this requirement was 100 percent. House Bill 2022 directs DCBS to analyze this data and report the findings to the legislature by April 30, 2009.

Overview of Data

Of the 1061 assaults recorded during the 2008 calendar year, 99 percent of those occurred in a hospital, and 50 percent were in the behavioral health/psychiatric unit. The medical/surgical unit followed with 13 percent, and the emergency room with 11 percent.

In almost all cases, the assailant was a patient. More specifically, 57 percent were behavioral health patients and 39 percent were general patients. The most commonly listed reason for the assault was that the person was a behavioral health patient (32 percent), had a history of violence (26 percent), or had emotional issues (19 percent).

The majority of victims were identified either as certified nursing assistants, orderlies, or aides (42 percent), or as registered nurses or licensed practical nurses (32 percent). Most assaults resulted in a minor injury, including mild soreness, small bruising, and scratches (80 percent), which would not be likely to be reported under other general injury recordkeeping requirements. Of the remainder, the vast majority involved major soreness, lacerations, and large bruises (18 percent). In 2 percent of all cases reported, the resulting injury was severe, defined as a bone fracture or head injury.

Discussion of Data and Data Limitations

The House Bill 2022 requirement to track violence against health care employees expands the current Oregon OSHA recordkeeping and reporting requirements by including all incidents regardless of whether they required treatment. Currently employers are required only to record incidents of employee injury that require medical treatment beyond first aid. By requiring employers to record and track all incidents of employee injury caused by physical assault, the existing law allows employers and their workers to more effectively identify relatively high-risk areas and completing security assessments, and more proficient in developing assault prevention training programs. The value of such expanded recordkeeping as a risk identification measure is highlighted by the number or relatively minor incidents that were recorded in 2008.

The House Bill 2022 tracking requirement is limited in several respects. The statute ties the recordkeeping to the definition of assault, meaning that there must be assailant intent to harm, and an injury must occur for it to be tracked. Attempted violence that does not result in injury is not tracked. In addition, verbal threats are often a precursor to physical violence, and the current recording requirement does not include those types of incidents.

Although facilities are required to continue tracking incidents, annual reporting of the data appears unnecessary. It may be useful however, to take another “snapshot” of the data in three to five years to see if there have been any meaningful shifts. The law does not require future submissions. However, based on conversations with employers and the 100 percent compliance with this year’s required reporting, the department believes that employer cooperation with a request to submit data at some point in the future would be high.

Background

In 2006, DCBS reported that in 41 percent of compensable assault claims the assailant was a health care or residential care patient. So, although the health care sector continues to lead all other industry sectors in incidence of nonfatal workplace assaults it remains difficult to assess the extent of the problem.

In Oregon, employers must report workplace injuries and illnesses to their workers' compensation insurance carrier. However, most such claims are not reported to the Workers' Compensation Division of DCBS. Only those claims that result in three or more days away from work are reported, allowing DCBS to assess the incidence of what is referred to as "disabling claims." But many injuries – including broken bones, sprains, lacerations, and many other problems – will not necessarily result in more than three days away from work and therefore will not result in a time-loss claim.

Although discussions of criminal intent are largely irrelevant to the question of whether the workplace hazard is a genuine one, it's important to understand the type of motivation involved in assaults against health care employees.

In order to assist policy makers in effectively targeting interventions the University of Iowa Injury Prevention Research Center developed a system that classifies most workplace violence into one of four categories.

Box 1. Types of Workplace Violence

- **Type I (Criminal Intent):** Results while a criminal activity (e.g., robbery) is being committed and the perpetrator has no legitimate relationship to the workplace.
- **Type II (Customer/client):** The perpetrator is a customer or client at the workplace (e.g., health care patient) and becomes violent while being served by the worker.
- **Type III (Worker-on-Worker):** Employees or past employees of the workplace are the perpetrators.
- **Type IV (Personal Relationship):** The perpetrator usually has a personal relationship with an employee (e.g., domestic violence in the workplace).

Even though health care workers may be exposed to all four types in the course of their work, the overwhelming majority of threats and assaults against caregivers come from patients, patients' families, and visitors (Lipscomb et al., 2002). In addition, there is wide-spread agreement that nonfatal assaults without lost work time and verbal threats of assaults are widely underreported, resulting in an incomplete picture of the extent of Type II workplace violence (Bensley et al., 1993; Hesketh et al., 2003; Lion, Snyder, & Merrill, 1981) and an inability to examine the relationship between verbal threats, low-level physical assault, and more serious forms of assaults and violence.

Summary of data

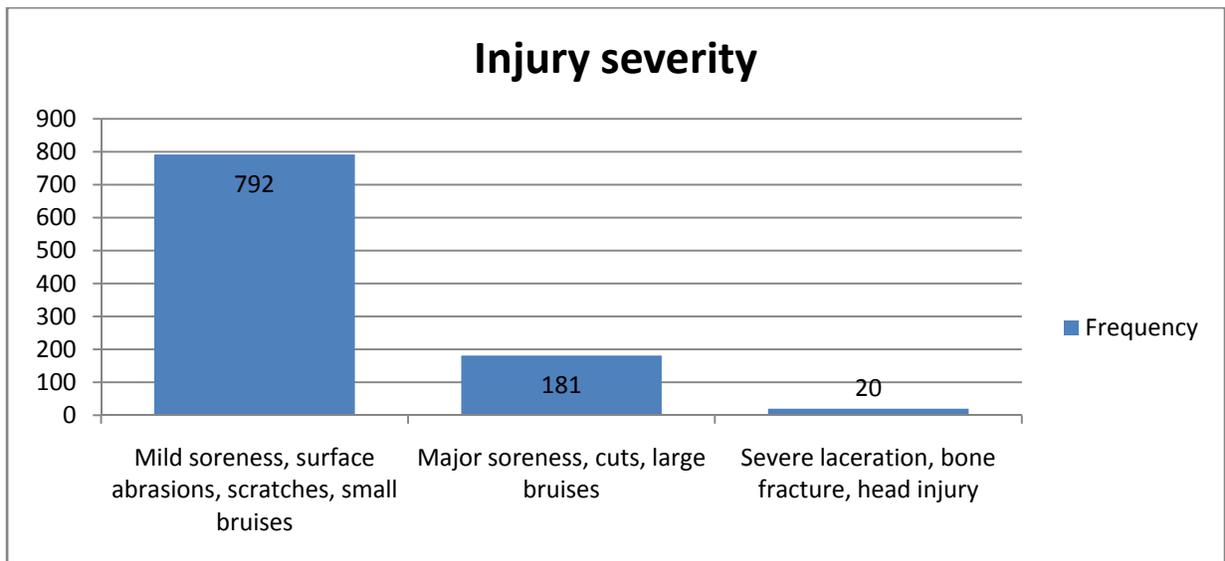
Injury type was broken into three categories: mild, major, or severe. In the event of multiple injuries, the facility was asked to report the most severe. Mild injury included mild soreness, surface abrasions, scratches, or small bruises; it accounted for the majority of reported assaults (80 percent). Major injury is defined as major soreness, cuts, or large bruises and accounted for 18 percent of all assaults. A severe injury is described as a severe laceration, bone fracture, or head injury, and occurred in 2 percent of assaults.

FACILITY TYPE

Nearly all (99.5 percent) of the recorded assaults against health care employees occurred within a hospital setting. This isn't surprising considering the acuity level and volume of patients.

RESULTING INJURY

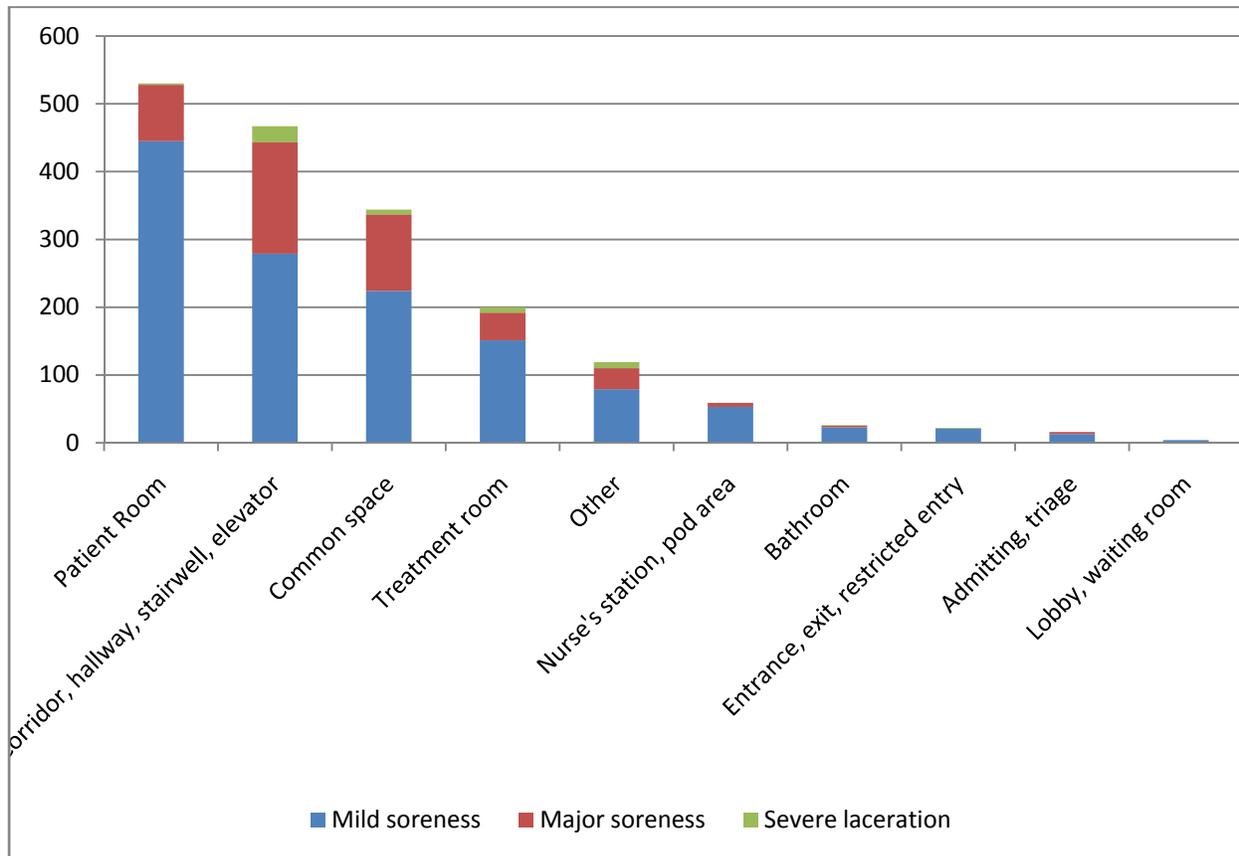
Of the 1061 attacks, 993 provided data on the resulting injury. Of those, nearly 80 percent resulted in mild injury, which included mild soreness, surface abrasions, scratches, and small bruises. In another 18 percent, major soreness, cuts, and large bruises resulted, and in 2 percent of attacks, the result was a severe laceration, bone fracture, or head injury.



68 REPORTS DID NOT INCLUDE A DESCRIPTION OF RESULTING INJURY

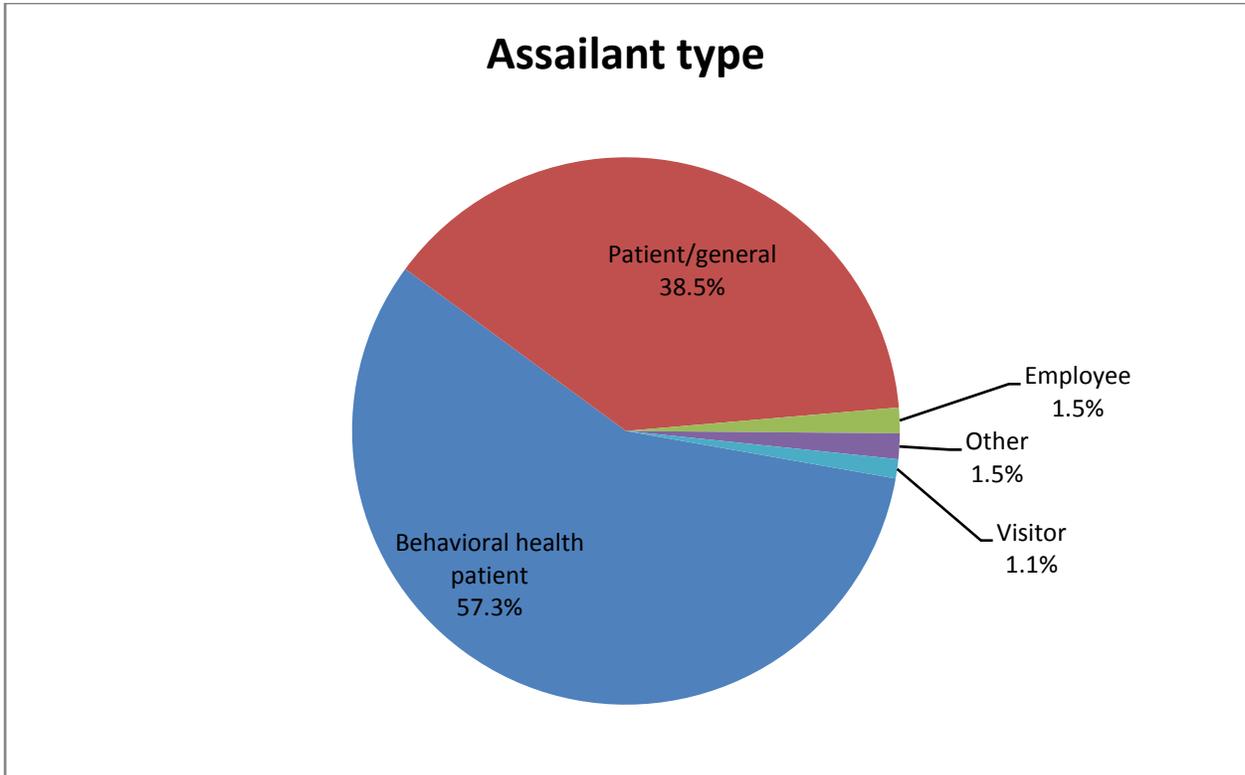
LOCATION OF ASSAULT AND INJURY SEVERITY

Assaults that occurred in the patient’s room (38 percent) resulted in mild injury in 84 percent of the cases and major injury in 15 percent. Attacks that occurred in the corridor (19 percent), or common space (13 percent), resulted in mild injury 59 percent of the time and major injury 35 percent of the time, more than twice that of attacks in the patient’s room. This could be attributed to behavioral health facilities where patients often gather in a communal area.



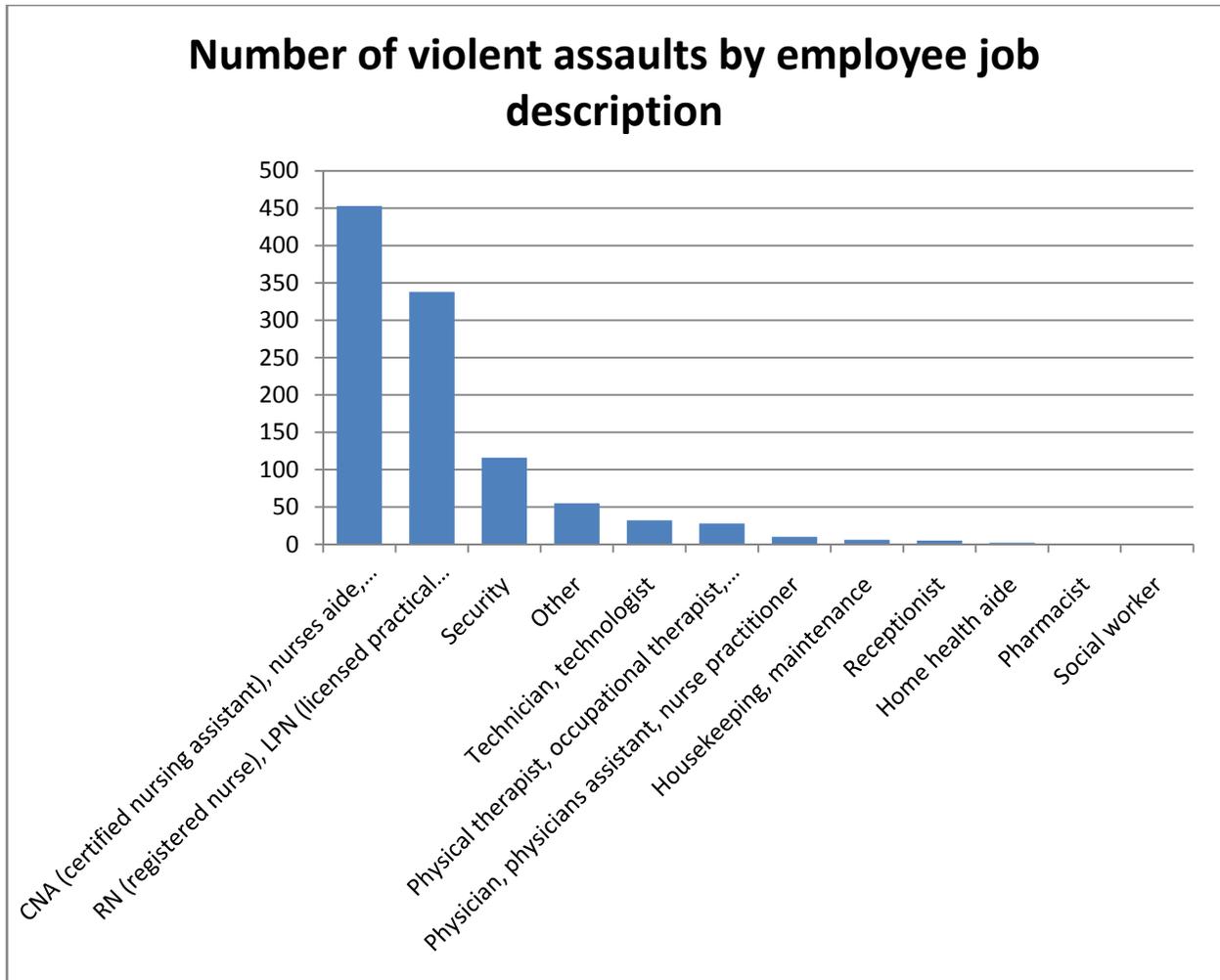
ASSAILANT

In 57 percent of the cases, the assailant was a behavior health patient, and in 38 percent it was a general patient. Employee, visitor, or “other” was each listed in less than 2 percent of all cases.



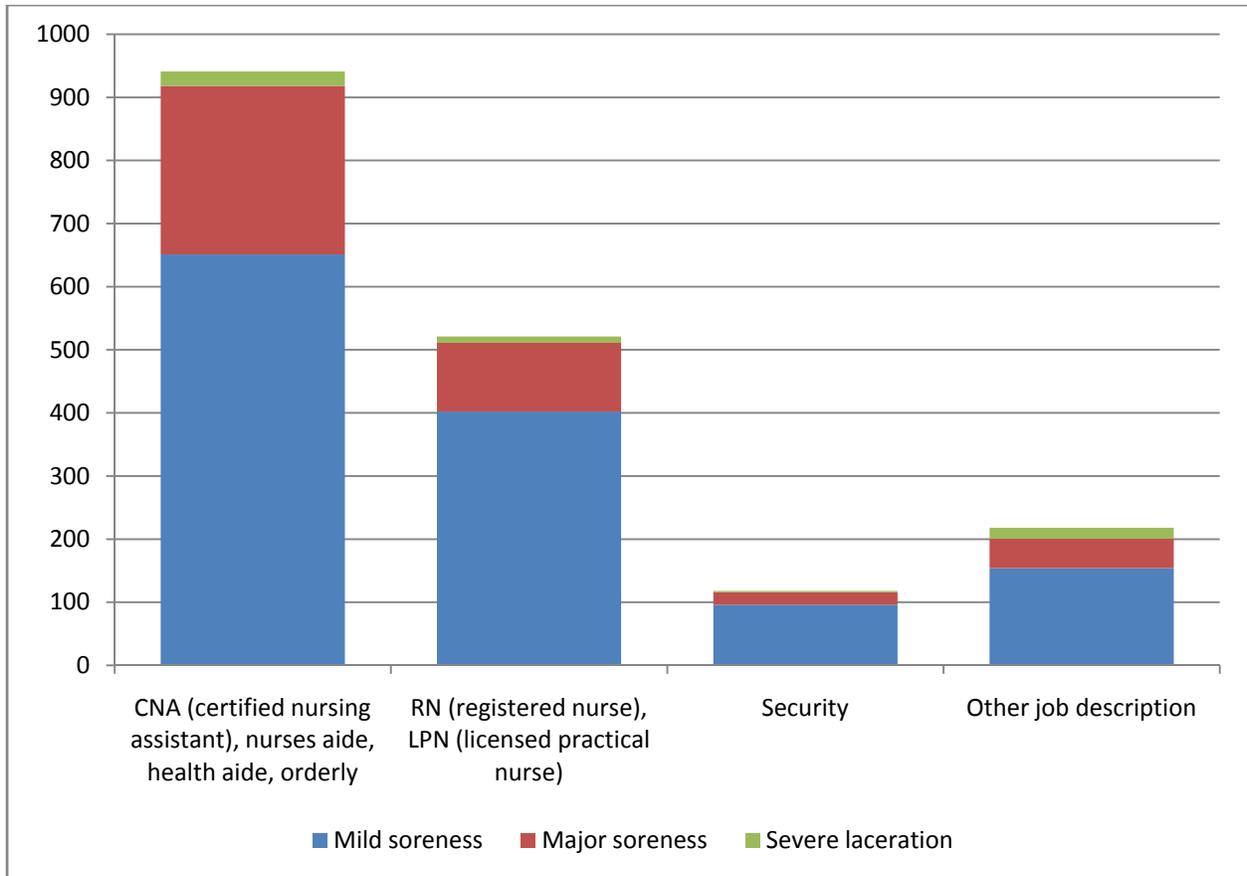
EMPLOYEE JOB DESCRIPTION

In 43 percent of the cases, the victim was a certified nursing assistant, nursing aide, health aide, or orderly. Thirty-two percent of reported victims were registered nurses or licensed practical nurses, 11 percent were security personnel, and 5 percent were reported as other, which included mental health therapists, unit clerks, unit directors, and interpreters. Another 3 percent were technicians, 2 percent were physical therapists, occupational therapists, or speech therapists and less than 1 percent were physicians, housekeeping staff, receptionists, home health aides, pharmacists, and social workers.



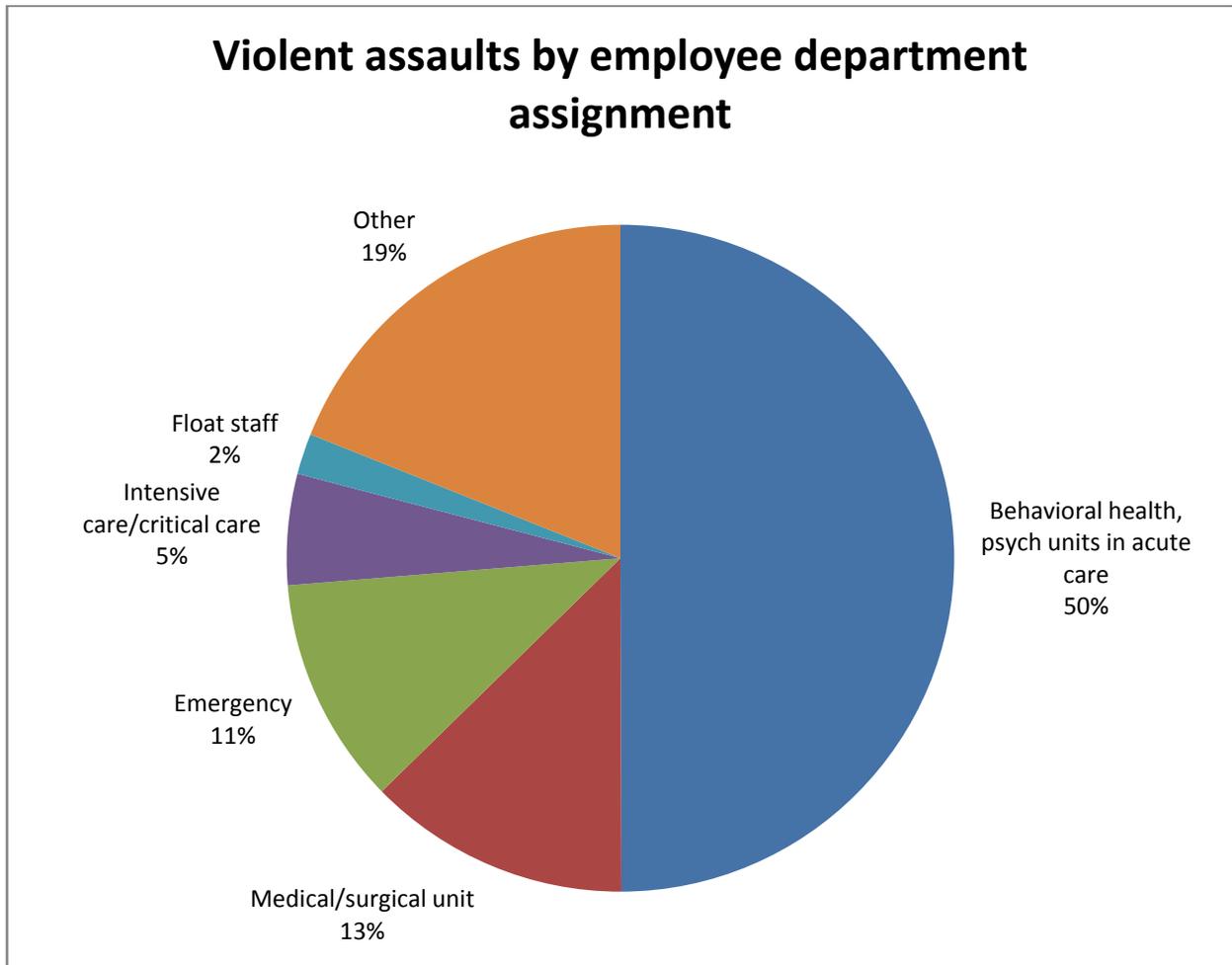
INJURY TYPE AND EMPLOYEE JOB DESCRIPTION

Nursing aides and certified nursing assistants, along with nurses (both registered and licensed practical), were assaulted most frequently. Nursing aides/certified nursing assistants described their injuries as mild 69 percent of the time, major 28 percent of the time, and severe 2 percent of the time. Registered nurses and licensed practical nurses were second most likely to be assaulted, and they described their injuries as mild in 77 percent of the cases, major in 20 percent of the cases, and severe in 1 percent of the cases.



EMPLOYEE DEPARTMENT ASSIGNMENT

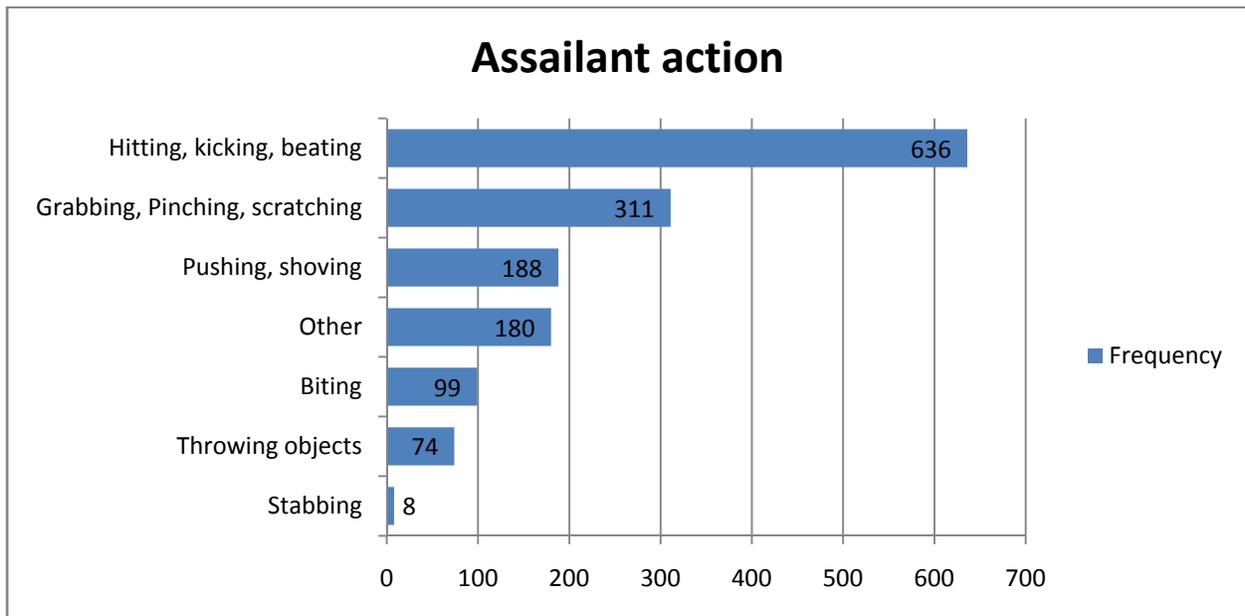
Staff assigned to a behavioral health or psychiatric unit reported half of all assaults. Nearly 13 percent of reported victims were assigned to the medical/surgical unit, 11 percent to the emergency room, 5 percent to the intensive care unit, and nearly 2 percent to the float staff (where they are temporarily assigned to departments that are short staffed).



ASSAILANT ACTION

The facilities reported what type of assault the assailant engaged in. They were allowed to record multiple actions, so the number of actions may be more than the total number of reported assaults. Of the 1,061 assaults reported all but four included a description of the assailant's actions.

More than 600 of the reported assaults involved hitting, kicking, or beating. Grabbing, pinching, or scratching occurred in 311 of the cases, 188 included pushing or shoving, and another 180 included "other" (spitting, thrashing, tripping, pulling hair, choking, etc.). In eight cases, the victim was stabbed.



REASON FOR ATTACK

The facilities were asked to record the one reason most likely responsible for the attack. In 32 percent of the attacks, a behavioral health issue was attributed for causing the attack and in 26 percent a history of violence was listed. In nearly 19 percent of the cases, an emotional issue was believed to have been the cause and in 7 percent of the cases a systemic or neurological disorder was observed. Medication issues was listed in 6 percent of the cases, which included delivering a baby, receiving a blood draw, confusion, intoxication, a medical condition, or shock. In less than 2 percent of the cases, withdrawal symptoms were reported.

WEAPON USED

In 77 percent of the cases reported, the weapon used was the assailant's body. In 14 percent of the cases, the weapon was listed as "other" which included a water bottle, scissors, cane, clip board etc. In nearly 4 percent of the cases the weapon listed was bodily fluid and in less than 2 percent was furniture, food or utensils, a door, window, floor or wall, medical equipment, or a knife.

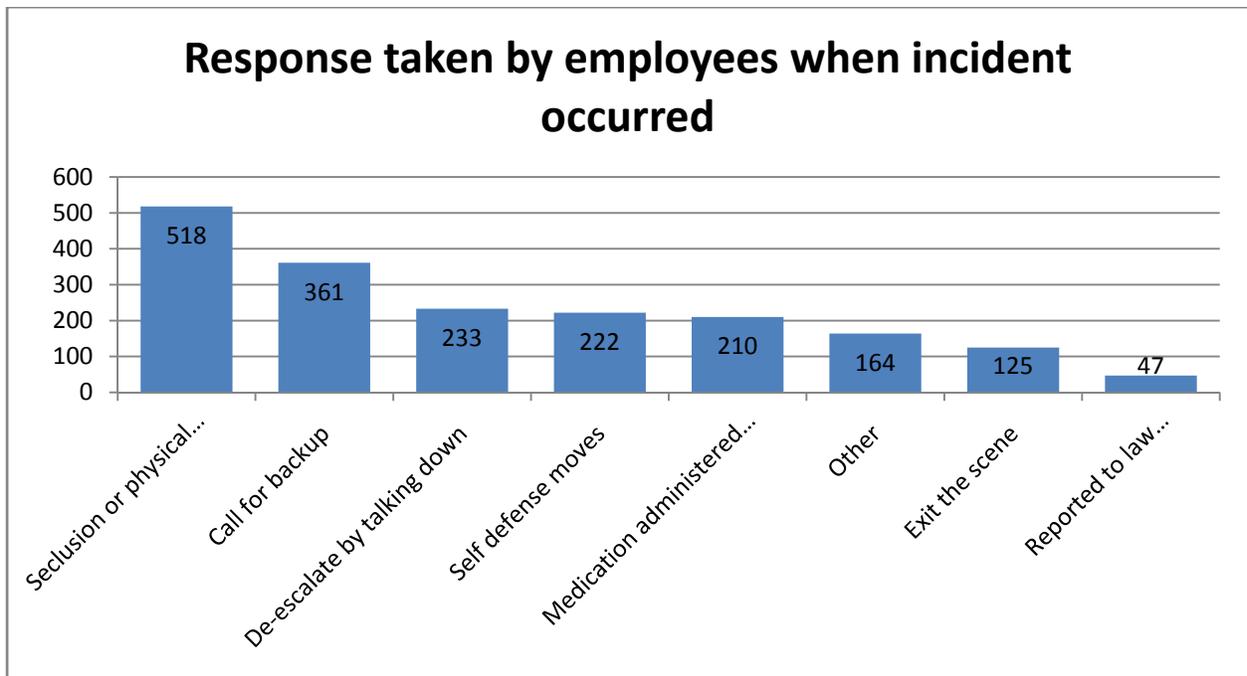
NUMBER OF EMPLOYEES WHO WITNESSED EVENT

The average number of witnesses to all reported attacks was 3.6; however in 10 percent of the cases, there was no witness. Between 16 percent and 17 percent of the cases were witnessed by one to three people and 11 percent of the time four people witnessed the attack. In 22 percent of the cases, there were five to eight witnesses and in less than 1 percent of the assaults there were more than nine.

ACTION TAKEN BY EMPLOYEES WHEN EVENT OCCURRED

The facilities were asked to report what response the employees took when the incident occurred. They were allowed to record multiple actions, so the number of actions may be more than the total number of reported assaults. Of the 1,061 reports, only seven did not include a description of the subsequent action.

In nearly half of the reported assaults (518 cases), seclusion or physical restraint was used. In 361 assaults, a call for backup was the response. De-escalation by talking the assailant down was noted in 233 cases, and in 222 incidents self-defense moves were used. Medication administration occurred in 210 of the assaults and 164 included “other,” such as increased staffing, called security, gave assailant physical space, or reported to supervisor. In 125 of the cases, the victim exited the scene. In only 47 cases was the assailant reported to law enforcement.



LIMITATIONS OF STUDY

COMPLIANCE

A general limitation of the study is compliance in reporting incidents that meet the definition of assault. Practical reporting expectations typically vary between employers, particularly with new programs. Therefore, the possibility exists that both underreporting and overreporting may have skewed the data. In addition, the quality of the data relies on how well administrators communicated the requirement to report and track incidents, in addition to the way the assault was to be recorded. One facility allowed the victim of the assault to enter the report data while most others assigned one specific person to enter data.

DEFINITION OF ASSAULT

The definition of assault used for the recording of health care assault data is “*intentionally, knowingly, or recklessly causing physical injury.*” This definition requires a subjective judgment of intent and may have led to variable reporting of assaults. A more thorough risk assessment may have been achieved by including *all* assaults, regardless of intent. Although the law does not require such broader tracking, Oregon OSHA has encouraged employers to err on the side of inclusion, rather than exclusion, in order to accurately reflect risk.

REPORTING LIMITATIONS

According to a 2008 study by Gallant-Roman, underreporting of workplace violence, both physical and non-physical, is high. That, coupled with the potential confusion about what to report, may have contributed to assaults going unreported. In addition, it would have been useful to include total number of employees and hours worked, as reporting criteria, in order to obtain an overall rate of injury.

Health care employees often consider violence part of the job. Without continued encouragement to report issues, many go unreported. A witness reported one example in our study and when hospital administration approached the victim, the victim refused to report, so the witness statement was used instead. In situations like this, the statement may be less complete than victim reporting. This example also speaks to the impact the facility’s culture can have on reporting of assaults. If the policy for reporting is not understood by all employees and enforced by the administration the result may be incomplete data.

Another factor to consider when reviewing the data is that all incidents reported by facilities were included in the report even if the incident appeared to fall outside the definition of “physical assault.” An example that was included but was clearly outside the scope of the study involved a cut to a staff member while trying to open a bio-hazard bag.

EXCLUSION OF NEAR MISSES

One of the challenges in assessing the issue of violence in the workplace is the need to obtain meaningful data. The sources of information readily available at Oregon OSHA are limited.

There is no general requirement for Oregon employers to keep records of “near misses” or “non-injury incidents.” While the practice is recommended as part of workplace safety and health programs, there is typically a wide variation in actual employer practice. Even among employers who attempt such near-miss tracking, there is a wide variation in the consistency of the reports and, therefore, in the reliability of the information available. The most effective of these reporting systems are those that are seen as credible and as presenting no real burden to employees.

Although Oregon OSHA has access to employer records and routinely checks them during enforcement visits, the data is *not* routinely reported to Oregon OSHA or to any other organization other than as part of the Bureau of Labor Statistics’ Survey. While employers have access to data regarding any injury and illness in their workplace, neither Oregon OSHA nor the Department of Consumer and Business Services (DCBS) as a whole has ready access to such data.

SCOPE OF HOME HEALTH

The scope of which facilities were included in this study is one area that may have limited the data. For example, only home health services licensed under a hospital were included in the study. This excluded such agencies as Keiser Permanente’s home health services, which are licensed separately from the hospital.

Another limitation may be the exclusion of long-term care from the study. Although dementia plays a role in some of the attacks on employees in this setting, this is an area of health care that will continue to grow as will the incidence rates of violence against employees in this sector.

INTERPRETATION OF “ACTION TAKEN BY EMPLOYEE”

This particular data element could have benefited from a clearer definition. There was a wide variation in response that seems to suggest uncertainty as to whether this referred to the immediate response by the victim or the long-term response planned by the facility. Data would have been statistically more relevant if the two categories were separated out.

Health Care Assault Log – basic results
Facility type

FACILITY TYPE	Frequency	Percent	Cumulative frequency	Cumulative percent
Hospital	1056	99.53	1056	99.53
Surgical center	3	0.28	1059	99.81
Home setting	2	0.19	1061	100.00

Health Care Assault Log - basic results Assault location

The FREQ Procedure

ASSAULT LOCATION	Frequency	Percent	Cumulative frequency	Cumulative percent
Patient room	405	38.83	405	38.83
Corridor, hallway, stairwell, elevator	207	19.85	612	58.68
Common space	144	13.81	756	72.48
Treatment room	136	13.04	892	85.52
Other	68	6.52	960	92.04
Nurse's station, pod area	32	3.07	992	95.11
Bathroom	21	2.01	1013	97.12
Admitting, triage	17	1.63	1030	98.75
Entrance, exit, restricted entry	9	0.86	1039	99.62
Lobby, waiting room	4	0.38	1043	100.00

Frequency missing = 18

Health Care Assault Log - basic results Employee job description

The FREQ Procedure

JOB DESCRIPTION OF VICTIM	Frequency	Percent	Cumulative frequency	Cumulative percent
CNA (Certified Nursing Assistant), nurses aide, health aide, orderly	453	43.27	453	43.27
RN (Registered Nurse), LPN (Licensed Practical Nurse)	338	32.28	791	75.55
Security	116	11.08	907	86.63
Other	55	5.25	962	91.88
Technician, technologist	32	3.06	994	94.94
Physical therapist, occupational therapist, speech therapist	28	2.67	1022	97.61
Physician, physician's assistant, nurse practitioner	10	0.96	1032	98.57
Housekeeping, maintenance	6	0.57	1038	99.14
Receptionist	5	0.48	1043	99.62
Home health aide	2	0.19	1045	99.81
Pharmacist	1	0.10	1046	99.90
Social worker	1	0.10	1047	100.00

Frequency missing = 14

Health Care Assault Log - basic results Employee department assignment

The FREQ Procedure

DEPARTMENT DESCRIPTION WHERE ASSAULT OCCURRED	Frequency	Percent	Cumulative frequency	Cumulative percent
Behavioral health, Psych units in acute care	530	49.95	530	49.95
Other	147	13.85	677	63.81
Medical/surgical unit	135	12.72	812	76.53
Emergency	117	11.03	929	87.56
Intensive care/critical care	57	5.37	986	92.93
Float staff	21	1.98	1007	94.91
Primary care/medical clinic	8	0.75	1015	95.66
Radiology/diagnostic imaging	7	0.66	1022	96.32
Laboratory	6	0.57	1028	96.89
Recovery	6	0.57	1034	97.46
Rehabilitation medicine	5	0.47	1039	97.93
Surgery/operating room	5	0.47	1044	98.40
Cardiac care	4	0.38	1048	98.77
Neurology	4	0.38	1052	99.15
Oncology	4	0.38	1056	99.53
Pediatrics	3	0.28	1059	99.81
Obstetrics/gynecology	1	0.09	1060	99.91
Pharmacy	1	0.09	1061	100.00

Health Care Assault Log - basic results Assailant

The FREQ Procedure

ASSAILANT DESCRIPTION	Frequency	Percent	Cumulative frequency	Cumulative percent
Behavioral health patient	608	57.30	608	57.30
Patient/general	409	38.55	1017	95.85
Employee	16	1.51	1033	97.36
Other	16	1.51	1049	98.87
Visitor	12	1.13	1061	100.00

Health Care Assault Log - basic results
Assailant action
Multiple responses were allowed, so percents are not meaningful

The FREQ Procedure

ASSAILANT ACTION	Frequency	Cumulative frequency
Hitting, kicking, beating	636	636
Grabbing, pinching, scratching	311	947
Pushing, shoving	188	1135
Other	180	1315
Biting	99	1414
Throwing objects	74	1488
Stabbing	8	1496

Frequency missing = 4

Health Care Assault Log - basic results Reason for attack

The FREQ Procedure

CAUSE OF INCIDENT	Frequency	Percent	Cumulative frequency	Cumulative percent
Behavioral health	344	32.48	344	32.48
History of violent behavior	278	26.25	622	58.73
Emotional issue	201	18.98	823	77.71
Systemic/neurological disorders	77	7.27	900	84.99
Other	72	6.80	972	91.78
Medication issue	64	6.04	1036	97.83
Withdrawal symptoms	18	1.70	1054	99.53
Anesthesia recovery	5	0.47	1059	100.00

Frequency missing = 2

Health Care Assault Log - basic results Resulting injuries

The FREQ Procedure

RESULT DESCRIPTION	Frequency	Percent	Cumulative frequency	Cumulative percent
Mild soreness, surface abrasions, scratches, small bruises	792	79.76	792	79.76
Major soreness, cuts, large bruises	181	18.23	973	97.99
Severe laceration, bone fracture, head injury	20	2.01	993	100.00

Frequency missing = 68

Health Care Assault Log - basic results Number of employees who witnessed the event

The FREQ Procedure

Witnesses				
EMPLOYEES PRESENT DURING ASSAULT	Frequency	Percent	Cumulative frequency	Cumulative percent
0	109	10.50	109	10.50
1	166	15.99	275	26.49
2	178	17.15	453	43.64
3	172	16.57	625	60.21
4	115	11.08	740	71.29
5	88	8.48	828	79.77
6	73	7.03	901	86.80
7	42	4.05	943	90.85
8	27	2.60	970	93.45
9	7	0.67	977	94.12
10	29	2.79	1006	96.92
11	1	0.10	1007	97.01
12	7	0.67	1014	97.69
13	3	0.29	1017	97.98
14	1	0.10	1018	98.07
15	6	0.58	1024	98.65
17	3	0.29	1027	98.94
18	3	0.29	1030	99.23
20	8	0.77	1038	100.00

Frequency missing = 23

Health Care Assault Log - basic results
Response taken by employees when incident occurred
Multiple responses were allowed, so percents are not meaningful

The FREQ Procedure

RESPONSE BY EMPLOYEES	Frequency	Cumulative frequency
Seclusion or physical restraint	518	518
Call for backup	361	879
De-escalate by talking down	233	1112
Self defense moves	222	1334
Medication administered as necessary	210	1544
Other	164	1708
Exit the scene	125	1833
Reported to law enforcement	47	1880

Frequency missing = 7

Health Care Assault Log - basic results Injury type by injured employee job title

JOB TITLE	All injuries		Injury					
			Mild soreness, surface abrasions, scratches, small bruises		Major soreness, cuts, large bruises		Severe laceration, bone fracture, head injury	
	Total	%	Total	%	Total	%	Total	%
Total	1,798	100.0	1,303	72.5	443	24.6	52	2.9
CNA (Certified Nursing Assistant), nurses aide, health aide, orderly	941	100.0	651	69.2	267	28.4	23	2.4
RN (Registered Nurse), LPN (Licensed Practical Nurse)	521	100.0	402	77.2	109	20.9	10	1.9
Security	118	100.0	96	81.4	20	16.9	2	1.7
Other	103	100.0	71	68.9	19	18.4	13	12.6
Technician, technologist	43	100.0	34	79.1	8	18.6	1	2.3
Physical therapist, occupational therapist, speech therapist	35	100.0	26	74.3	9	25.7	-	-
Physician, physician's assistant, nurse practitioner	16	100.0	9	56.3	7	43.8	-	-
Housekeeping, maintenance	10	100.0	9	90.0	1	10.0	-	-
Receptionist	5	100.0	3	60.0	2	40.0	-	-
Home health aide	4	100.0	-	-	1	25.0	3	75.0
Pharmacist	1	100.0	1	100.0	-	-	-	-
Social worker	1	100.0	1	100.0	-	-	-	-

**Health Care Assault Log - basic results
Injury type by incident location**

INCIDENT LOCATION			Injury					
			Mild soreness, surface abrasions, scratches, small bruises		Major soreness, cuts, large bruises		Severe laceration, bone fracture, head injury	
	Total	%	Total	%	Total	%	Total	%
Total	1,787	100.0	1,292	72.3	443	24.8	52	2.9
Patient Room	530	100.0	445	84.0	83	15.7	2	0.4
Corridor, hallway, stairwell, elevator	467	100.0	279	59.7	164	35.1	24	5.1
Common space	344	100.0	224	65.1	113	32.8	7	2.0
Treatment room	200	100.0	151	75.5	41	20.5	8	4.0
Other	119	100.0	79	66.4	31	26.1	9	7.6
Nurse's station, pod area	59	100.0	53	89.8	6	10.2	-	-
Bathroom	26	100.0	23	88.5	2	7.7	1	3.8
Entrance, exit, restricted entry	22	100.0	21	95.5	-	-	1	4.5
Admitting, triage	16	100.0	13	81.3	3	18.8	-	-
Lobby, waiting room	4	100.0	4	100.0	-	-	-	-