Question III.1:

CDC/NIOSH defines

2002). Is this the most appropriate definition for OSHA to use if the Agency proceeds with a regulation?

Question III.3:

Though OSHA has no intention of including violence that is solely verbal in a potential regulation, what approach might the Agency take regarding those threats, which may include

Question III.4:

record each fatality, injury or

sufficiently similar to those appropriate to healthcare for a single standard addressing both to make sense?

RESPONSE to QIV.1 and QIV.2:
We recommend that the Standard be more inclusive rather than exclusive with respect to including all healthcare workers inside and outside the Healthcare and Social Assistance Sector including home health workers. Our recommendation is based on the limited epidemiological data indicating the WPV prevalence and risk factors among these workers. The absence of research evidence should not infer an absence of risk. For example, studies have examined WPV incurred by school teachers, yet little is known about type II violence (perpetrated by students and/or parents) towards school nurses. These healthcare workers provide direct patient care outside the healthcare sector and should be provided with the same benefits and protection of this proposed standard as other healthcare workers within the Healthcare and Social Assistance sector. Similarly, occupational health nurses (OHNs) work in numerous industries and settings providing health care and should be covered, as well. With respect to home healthcare workers, we also recommend that these workers be included. With the formation of the Affordable Care Act, and the formation of Accountable Care Organizations (ACOs), home healthcare has increased significantly. Hospitals are broadening their reach to their surrounding communities through outpatient clinics and home health services. Workers in home health most likely face unique challenges with respect to WPV risk factors, and their coverage with this standard is recommended. Broader inclusion will insure that all healthcare workers facing the risk of WPV on the job are protected.

Question IV.4:
OSHA requests information on which occupations are at a higher risk of workplace violence at your facility and what about these occupations cause them to be at higher risk. Please provide the job titles and duties of these occupations. Please provide estimates on how many of your workers are providing direct patient care and the proportion of your workforce this represents.

Question V.27:
What do you know or perceive to be risk factors for violence in the facilities you are familiar with?

RESPONSE QIV.4 and QV.27: There is consistency across numerous studies regarding occupations at risk for WPV and factors that place them at risk. Below is a summary of these findings. However, we have also included information about occupations not typically identified as being at risk, and associated risk factors with respect to their job responsibilities. The salient issue of this summary is that there is no single profile of potentially violent patient/visitor. Similarly, a large number of workgroups can be at risk. This

Often, sitters were not given the appropriate information needed at the outset of the work

Nurse Managers: In this same study, Pompeii et al.[26] observed that nurse managers had a higher than expected prevalence of type II violence. Type II violent events among nurse managers (Prevalence Ratio (PR):1.5; 95% CI: 1.3, 1.8) similar to nurses (PR: 1.8; 95% CI: 1.6, 2.1). This was unexpected finding given that nurse managers typically have a lower risk of other occupational injuries (e.g., musculoskeletal injury) relative to nurses due to differences in job responsibilities. Focus group findings indicated that
policies in which managers instructed workers to contact them first (e.g., by phone, email, in-person) when they needed assistance with a potentially violent patient. Nurse managers
victims of WPV.
Nurse managers play a significant role in the mitigation and management of violent events. They are the go-to person for staff when assistance is needed with a violent patient and/or visitor. This workgroup seems to be shouldering a significant responsibility for managing these events with little training or support from administration. This study observed that nurse managers were frustrated and overwhelmed with managing these events.

Question IV.5:

The GAO Report relied on BLS SOII data, HHS NEISS data and DOJ NCVS data. Are there any other data sets or data sources OSHA should obtain for better estimating the extent of workplace violence?

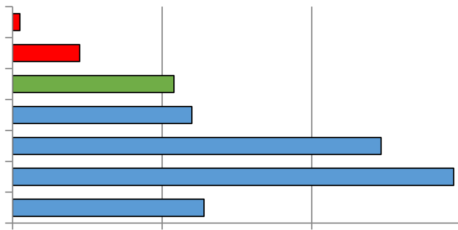
RESPONSE to QIV.5: The GAO report also relied on NIOSH/NIH funded epidemiologic studies

Question V.60:

Are you aware of any issues with reporting (either underreporting or overreporting) of OSHA

and if so, what types of issues? If you have addressed them, how did you address them?

RESONSE to QV.57 and QV.60: Traditional occupational injury surveillance systems, such as the OSHA Log, are populated by reports made by workers into a first report of injury (FRI) system. The utility of these data are dependent on workers submitting a formal report into this type of system. As early as 1983, Lanza[18] highlighted the problem of under-reporting by nursing staff of type II violence events, which has continued to persist.[1-2,7] However, findings from a recent study



they must also formally report into the stand-alone reporting or the first report of injury system).
The reporting policy should guide the manager and/or security to formally report what workers report to them (or ensure that the worker formally reports).
Train workers on reporting procedures (formally and informally), including training upon hire, and then annually.
As recommended by OSHA,[22] hospitals should have a mechanism in place for pooling all type II violent event data captured outside the main reporting systems (e.g., managers, security, human resources, risk management, occupational health, patient charts).
The reporting system should be easily accessible to all workers. The intake event form should be short, avoiding time consuming reporting (e.g., having a link within the medical record system (e.g., EPIC) in which workers could access while documenting about patient care could save additional time).
A process should be in place to evaluate the effectiveness of the reporting policy and reporting system.
Hospitals cannot develop and evaluate the effectiveness of targeted workplace violence prevention programs without this type of surveillance system in place which must be supported by type II violence reporting policies.

Question III. 2:
Do employers encourage reporting and evaluation of verbal threats? If so, are verbal threats reported and evaluated? If evaluated, how do employers currently evaluate verbal threats (i.e., who conducts the evaluation, how long does such an evaluation take, what criteria are used to evaluate verbal threats, are such investigations/evaluations effective)?

Question V.22:
Who provides post- assessment feedback? Is it shared with other employees and if so, how is it shared with the other employees?

Question V.61:
Do you regularly evaluate your program? If so, how often? Is there an additional assessment after a violent event or a near miss? If so, how do you measure the success of your program? How many hours does the evaluation take to complete?

Question V.62:
Who is involved in a program evaluation at your facility? Is this the same committee that conducted the workplace analysis and hazard identification?

RESPONSE QIII.2, QV.22, W.61 and QV.62: It is expected that post

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