OSHA for Behavioral Health Professionals

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Carol Shenold, RN, ICP, graduated from St. Paul's Nursing School, Dallas, Texas, achieving her diploma in nursing. Over the past thirty years she has worked in hospital nursing in various states in the areas of obstetrics, orthopedics, intensive care, surgery and general medicine.

Mrs. Shenold served as the Continuum of Care Manager for Vencor Oklahoma City, coordinating quality review, utilization review, Case Management, Infection Control, and Quality Management. During that time, the hospital achieved Accreditation with Commendation with the Joint Commission, with a score of 100.

Mrs. Shenold was previously the Infection Control Nurse for Deaconess Hospital, a 300-bed acute care facility in Oklahoma City. She is an active member of the Association for Professionals in Infection Control and Epidemiology (APIC). She worked for the Oklahoma Foundation for Medical Quality for six years.

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Contributing faculty, Carol Shenold, RN, ICP, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner

Margaret Donohue, PhD

Senior Director of Development and Academic Affairs

Sarah Campbell

Division Planner/Director Disclosure

The division planner and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all persons working in mental or behavioral health fields.

A complete Works Cited list begins on page 15.

Mention of commercial products does not indicate endorsement.

Accreditations & Approvals

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0021.

This course is considered self-study by the New York State Board of Mental Health Counseling.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed marriage and family therapists. #MFT-0015.

This course is considered self-study by the New York State Board of Marriage and Family Therapy.

Designations of Credit

Social workers completing this intermediate-to-advanced course receive 3 Non-Clinical continuing education credits.

NetCE designates this continuing education activity for 1 NBCC clock hour.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to provide information that will allow those working in mental and behavioral health fields to more easily comply with the broad spectrum of rules covered by the OSHA regulations.

Learning Objectives

Upon completion of this course, you should be able to:

1. Explain the OSHA regulations related to employee health and reporting injuries.
2. Discuss safety issues in behavioral health settings, including workplace violence and employee mental health concerns.
3. Describe the purpose of the Bloodborne Pathogens Standard as it applies to the healthcare setting.
4. Outline the impact of fire safety on patients and employees in the healthcare facility.
5. Review legal issues related to OSHA compliance and employee health.

INTRODUCTION

Death and disability due to unsafe or unhealthy workplaces remain ongoing issues in the United States. In 2021, there were 2.6 million job-related nonfatal injuries and illnesses in the private sector alone [1]. The U.S. Bureau of Labor Statistics reported a total of 4,764 employee deaths in 2021, slightly down from the number of fatal injuries reported in 2017. This figure may not include the deaths of workers due to occupationally acquired diseases [2]. The continuous efforts of the Occupational Safety and Health Administration (OSHA) to promote employee safety are part of what makes it such an important regulatory entity.

OSHA AND EMPLOYEE HEALTH

The Employee Health Department of the healthcare facility has a critical role in the interpretation and implementation of OSHA guidelines. Depending on the facility's policies and structure, its Employee Health Department may be responsible for the oversight (in conjunction with the Infection Control Department) of many OSHA-related issues.

Because the Employee Health Department is usually the keeper of records related to employee injuries, it becomes responsible for tracking bloodborne pathogen exposures and ensuring that employees are treated appropriately, that laboratory testing follows the appropriate guidelines, and that prophylaxis, if needed, is available. These records should be retained and recorded on the *OSHA 300 Log*.

One of the most confusing parts of recordkeeping is determining whether an injury or illness is recordable based on first aid or medical treatment. The revised standard sets new definitions of medical treatment and first aid to simplify recording decisions. An injury or illness is considered work-related if an event or exposure in the work environment either caused or contributed to the condition or significantly aggravated a pre-existing condition [3].

Work-related injuries and illnesses should be recorded if they result in [3; 4]:

- Death
- Hearing loss
- Loss of consciousness
- Days away from work
- Restricted work activity or job transfer
- Medical treatment beyond first aid

Work-related fatalities should be reported within eight hours. Work-related injuries and illnesses that are significant or meet any of the additional criteria listed below should also be recorded. Any significant work-related injury or illness that is diagnosed by a physician or other licensed healthcare professional or that involves cancer, chronic irreversible disease, a fractured or cracked bone, or a punctured eardrum should be recorded as well [3].

The following conditions should be recorded when they are work-related [3; 5]:

- Any needlestick injury or cut from a sharp object that is contaminated with another person's blood or other potentially infectious material
- Any case requiring an employee to be medically removed under the requirements of an OSHA health standard
- Tuberculosis infection as evidenced by a positive skin test or diagnosis by a physician or other licensed healthcare professional after exposure to a known case of active tuberculosis
- Hearing loss as evidenced by a hearing test (audiogram)

The following interventions are considered medical treatment and are almost always recordable on the *OSHA 300 Log* [3; 4]:

- Administration of immunizations, such as Hepatitis B or rabies (does not include tetanus)
- Use of wound-closing devices, such as sutures and staples
- Use of rigid means of support to immobilize parts of the body
- Physical therapy or chiropractic treatment

Medical treatment does not include [3]:

- Visits to a physician or other licensed healthcare professional solely for observation or counseling
- The conduct of diagnostic procedures (e.g., x-rays and blood tests), including the administration of prescription medications used solely for diagnostic purposes
- Any procedure that may be labeled first aid

If the incident required only the following types of treatment, it is considered first aid and is not reportable [3; 4]:

- Use of a nonprescription medication at nonprescription strength
- Administration of tetanus immunizations
- Cleaning, flushing, or soaking of wounds on the surface of the skin
- Use of wound coverings (e.g., bandages or gauze pads)
- Application of hot or cold therapy
- Use of any nonrigid means of support (e.g., elastic bandages, wraps, and nonrigid back belts)
- Use of temporary immobilization devices while transporting an accident victim (e.g., splints, slings, neck collars, or back boards)
- Drilling of a fingernail or toenail to relieve pressure, or draining fluid from a blister
- Use of eye patches
- Removal of foreign bodies from the eye using only irrigation or a cotton swab
- Removal of splinters or foreign material from areas other than the eye by irrigation, tweezers, cotton swabs, or other simple means
- Use of finger guards
- Administration of massage
- Drinking of fluids to relieve heat stress

If an injury is considered reportable, and therefore recordable, it should be recorded on the *OSHA 300 Log*. In addition, the injury or illness should be recorded on either the *OSHA Form 301* or an equivalent. The *OSHA Form 301* provides more information about the case and the individual involved. Information such as the events leading up to the injury or illness, affected body parts, and objects or substances involved should be included [4]. Any form, such as a workers' compensation report or accident report, may be used as long as it contains the same information. Other items that should be covered following an employee injury include:

- Prompt reporting of the injury
- Thorough documentation and investigation
- Timely treatment if the injury requires medical attention
- Consistent follow-up of an accident without injury or lost time to ensure that time is not lost at a later date
- Immediate notification of any insurance carriers
- Fast repair of any involved equipment
- Prompt recovery of a physician statement
- Retention of a physician's release to return to work before the employee returns to duty
- Methods of returning employees to work as early as possible through prompt rehabilitation or temporary job description alteration
- Accurate reporting on the *OSHA 300 Log*

An annual summary of injuries and illnesses that occurred during the calendar year should be reported. The annual summary (*OSHA Form 300A*) is a total of all the columns to the right of the dotted line on the *OSHA 300 Log* [4]. A company executive should certify that the summary is correct and complete, and it should be posted for three months in areas where other employee notices are normally posted. The *OSHA 300 Log*, privacy case list (if one exists), annual summary, and *OSHA 301 Incident Report Form*, or other suitable form (e.g., state workers' compensation report, insurance claim report, employer's accident report form) should be retained for 5 years following the calendar year to which they relate [3; 4].

The employer should verify that employees have been provided with all the necessary training. A written form of documentation with the name of the employee and date of training is required, as well as documentation of retraining [3].

SAFETY/RISK MANAGEMENT

The mission of OSHA is to provide a safe workplace for all employees. A well-organized employee health risk management program can help a facility meet OSHA requirements.

WORKERS' COMPENSATION

One of the factors that will complicate any employee injury is workers' compensation. Each state has its own set of laws; however, prompt reporting of treated injuries and an accurate OSHA accident log will help to lessen any conflicts.

Hundreds of thousands of dollars are spent every year on workers' compensation claims, including money for medical/surgical costs, rehabilitation, and legal fees. Back injuries top the list of employee injuries; in a healthcare facility, these are frequently due to a combination of improper patient lifting and failure to ask for assistance when lifting patients. Slips and falls on wet floors account for many employee injuries as well. The physical building, outside surroundings, patient population, equipment in use, and staffing plan all play a part in the assessment of employee risk.

Workers' compensation court usually requires an initial accident report and a first injury report to be filed within ten days of the injury, even if the injury leads to no lost time. The documentation of the injury should be complete and kept at the facility. OSHA requires employee health records to be kept confidential [3].

A record of an employee injury is also provided to any third-party payer (i.e., insurance carrier). Some facilities are self-insured. Others have one insurance company that specializes in employee injuries and a second company that handles liability claims, such as physician malpractice or patient/visitor injuries. Prompt reporting to the facility's various carriers will put the facility in the best position to keep costs down. In addition, a good relationship with the insurance carriers will often result in the receipt of educational material that may lighten the risk manager's education responsibilities.

Employees should understand that prompt reporting will lead to effective treatment and lower overall costs to the facility. Risk managers should be familiar with the workers' compensation laws in their own states. It is wise to have the handbook available for reference.

VIOLENCE IN THE WORKPLACE

Violence in the workplace is an issue that is increasingly receiving public attention. An estimated 2.6 million workers are injured each in the workplace, of which more than 37,000 injuries are intentionally caused by another person. While a majority of these injuries are nonfatal, the U.S. Bureau of Labor Statistics (BLS) reported that of the 5,190 fatalities in the workplace in 2021, 761 workers were fatally injured by assault and/or violent attack [6; 7; 8].

The BLS also has reported that in 2020, the majority (61%) of nonfatal workplace assaults occurred in service settings, most commonly affecting healthcare support, followed by healthcare practitioner and technical occupations (24%) [9]. This increased risk may be attributed to several factors, such as the prevalence of weapons (e.g., firearms) among patients, their families, or friends; the use of hospitals by the criminal justice system as places to hold disturbed and/or violent individuals; the unrestricted movement of the public in healthcare facilities; and isolated work with patients [8; 9]. Workplace assaults result in lost workdays and millions of dollars in lost wages each year [8]. For healthcare workers, these assaults comprise 10% to 11% of workplace injuries involving days away from work, compared with 3% for private sector employees [8; 9].

Several experts emphasize the importance of safety training for healthcare and human service professionals [10; 11]. Training must be ongoing, beginning at new employee orientations and continuing at staff meetings and in-service training. By raising staff's awareness of their immediate surroundings, training can increase professionals' sense of competence and control and lessen feelings of helplessness. Some topics that have been recommended as part of safety training are environmental assessment, techniques for de-escalation of violence, and self-awareness.

Environmental Assessment

Environmental assessment entails service providers evaluating the work environment, such as office spaces, cars, and for those professionals who conduct home visits, their clients' residences and neighborhoods, for violence risks and potential opportunities for self-defense [10]. For example, when mental health professionals conduct patient interviews in their offices or interview rooms, several questions regarding the environment should be raised. This includes determining the most effective room layout so the professional can exit quickly if there are visual cues that the patient is getting angry or violent. The office should be scanned for items that can easily be used by a potentially violent patient to cause harm; for example, books, ashtrays, and furniture can potentially be used as weapons [12]. It is also important to determine the extent of which the interviewing or evaluation office is visible to others. This requires a delicate balance, because it is important to promote the privacy and confidentiality of the client, but simultaneously, it is also important for the clinician to be safe [12].

The environment of waiting rooms can be potential breeding grounds for patient violence [13]. Organizations should evaluate the mechanisms in place to manage patients' emotions and safety. For example, what can be done to keep the environment peaceful and calm? What mechanisms are in place to reduce waiting times or to communicate waiting times most effectively [13]? What security measures are in place (e.g., cameras, patrols) [14]?

Workers' vehicles are often taken for granted. However, maintenance issues are important, particularly for staff who work late at night or who conduct home visits in unfamiliar neighborhoods [10]. Staff members should have their keys readily available when they walk to their cars, and they should check the back seats before getting in their vehicles. Items that place a car at risk of being vandalized, such as a supply of psychotropic medication, should be put away or not left in the vehicle.

When going on home visits, knowledge of neighborhoods is a prerequisite to safety. The following questions may be helpful in determining the risk associated with certain neighborhoods [10; 15; 16]:

- Do workers know which neighborhoods or areas are unsafe at night?
- Do workers know where to find secure parking and easy exits?

- Are workers apprised of recent incidents of violence or drug-related activities in the neighborhood?
- Is it possible for a worker to be accompanied by another staff person on home visits or rounds?
- Is there a clear plan for workers who conduct home visits to communicate their whereabouts and a protocol to follow if a worker does not report as expected?
- Is it possible for workers in the field to carry hand-held alarms or noise devices?

Twenty-three social workers participated in a study conducted in rural areas in Australia. The study consisted of a forum to identify safety concerns and for workers to convey their experiences with abuse and violence with clients while working [17]. A prominent theme that emerged was the risk involved in conducting home visits and transporting clients from one location to another. In some cases, agencies did not have the resources for radios, mobile phones, security papers, and duress alarms. Even when the equipment was available, it was unreliable in remote locations. As a result, issues of personal safety were a paramount concern for many of these rural social workers.

Techniques for De-Escalating Violence

De-escalation involves defusing potentially agitated patients and reducing maladaptive behaviors using conflict resolution methods, limit-setting, and calm and empathic verbal strategies [18; 19]. Ultimately, this depends upon the clinician's ability to negotiate and use conflict resolution [18; 20]. One of the goals of de-escalating potentially aggressive patients is to promote autonomy and dignity by providing options [21]. To achieve this goal, clinicians must learn to recognize the warning signs of agitation. Behavioral cues may include increased pacing, increased volume and tempo of voice, flushed face, or agitated body movements [18].

Verbal de-escalation strategies can be effective. The National Association of Therapeutic Schools and Programs recommends that clinicians remain calm and convey an attitude of respect by listening to the patient [20]. Next, it is important to identify what is provoking the individual, and then to assist the individual to use prosocial means to express his/her feelings. Clinicians should approach the client calmly [12]. It is important not to convey any cues that may be perceived as confrontational. For example, clinicians should not maintain unrelenting or persistent eye contact. Permission should be given to express feelings of frustration and anger without interruption.

Verbal strategies to de-escalate tension in cases in which clients have weapons can also be effective. When clinicians talk to clients in a calm and rational manner, both clinicians and the clients suffer less physical injury or property damage than when clinicians opt to use verbal or physical aggression [22]. Active listening skills are helpful and involve appropriate eye contact and body language, empathizing, and paraphrasing to convey understanding [12]. Clinicians should also be aware of their tone, volume, rate, and rhythm of speech, also referred to as paraverbals. If not careful, paraverbals can convey the opposite of what is communicated verbally [23]. Empathetic listening and communication can help to de-escalate violent situations [24]. Instead of trying to suppress emotions, listening and talking through the frustration can help mitigate potentially violent anger.

Redirection is another effective de-escalation strategy [25]. In some cases, this may simply involve changing the topic. Alternately, it can be as concrete as offering a patient a glass of water or cup of coffee. This conveys to patients that the clinician is aware of and sensitive to their needs [25].

The use of de-escalation techniques as early intervention results in more therapeutic gains for patients as opposed to using more restrictive management techniques to deal with aggressive behaviors [18]. Clinicians who successfully use de-escalation techniques report improved relationships with patients and increased feelings of self-efficacy, which can lead to greater job satisfaction [18]. It is vital that the environment supports patient self-management of anxiety [26]. Facilities can promote this by providing access to massages, relaxing sounds, aromatic oils, comforting blankets, guided imagery, and other soothing techniques.

Training to Increase Self-Efficacy and Confidence

Workers should be given an arsenal of tools to increase their sense of confidence and self-efficacy. Practitioners who work with patients who can become highly volatile and violent should be aware of the warning signs of potential violence. They should also be taught calming communication approaches and restraining techniques and when to use them [13; 19; 27]. For example, tone of voice and use of eye contact can be employed to calm potentially violent or aggressive patients [27]. Using traditional and simulated trainings, practitioners can also learn how to prepare for violent situations and learn self-defense techniques [28].

Clinician Self-Awareness

Clinicians should also be attuned to their own feelings and reactions. If they sense that a client will be violent, a safety plan should be implemented immediately. Not only should clinicians be aware of their feelings, but they must be aware of how their body language and facial expressions mirror their feelings. For example, if they feel fear and anxiety, these reactions should be masked so as not to communicate the fear to their patients [12]. If patients sense fear, open communication, trust, and rapport can be negatively impacted [12].

When employees are trained to assess their environment, encouraged to listen and be aware of their feelings and reactions toward patients and their environment, and to report potentially violent incidences, their responses will differ dramatically compared with those who have not been trained [29]. According to a 2011 study, employees who have been educated will initially express a startled reaction/response to a violent incident, but they are more likely to prepare themselves and others to address the act appropriately than untrained employees, who are more likely to panic, deny the incident, and feel helpless.

Self-Care for Employees/Staff

For some practitioners who witness workplace violence, compassion fatigue, secondary traumatization, and burnout are typical consequences. Compassion fatigue is a relatively new term, coined in 1992, and is meant to convey a nonpathologic concept [30]. It is a natural consequence of the emotions that stem from either witnessing or knowing about a traumatic event or daily continual contact with those who are suffering [30]. Secondary, or vicarious, traumatization is defined as "transformation of the inner experience of the therapist that comes about as a result of empathic engagement with clients' trauma material" [31]. Vicarious traumatization can cause emotional and cognitive arousal symptoms, such as increased emotional sensitivity, lack of well-being, intrusive thoughts, and difficulty concentrating [32]. Finally, burnout has been defined as physical and emotional symptoms that are linked to the workplace experience, ranging from working with clients to environmental components of the workplace [32]. The practitioner experiencing burnout feels exhausted and, at times, emotionally detached from clients [32]. In one study, Levine, Hewitt, and Misner found that nurses withdrew from their patients after an incident of workplace violence [33].

Self-care is integral to the prevention of negative symptoms such as burnout, secondary traumatization, and compassion fatigue. Twemlow suggests a self-care plan for persons at risk for these effects that includes cognitive and stress management techniques, such as biofeedback or hypnosis [25]. In addition, nutrition and regular physical exercise are vital. Maintaining social and familial relationships is also crucial.

Self-care may be conceptualized along a continuum, with proactive planning and reactive intervention on either ends of the continuum [32]. Self-care includes an array of activities that touch on the following domains [32]:

- Physical (e.g., exercise, nutrition, sleep)
- Recreational (e.g., play activities, vacation time, hobbies)
- Social support (e.g., interaction with friends, family members)
- Spiritual/religious (e.g., prayer, meditation)

On the organizational level, administrators can create a culture of promoting self-care in organizations. Practitioners should be discouraged from skipping breaks and lunches in order to catch up on work. Built-in supervision and support can also reduce burnout [34].

Practitioners should not merely consider these activities in passing but spend time asking themselves about the self-care activities they are currently undertaking [32]. Practitioners must view self-care as proactive rather than reactive [32].

Practitioners who have experienced workplace violence may also consider going to their employee assistance program (EAP) to obtain assistance, if available. Counseling and mental health services are free and confidential through EAPs.

Occupational Policies

It is important to view occupational policies regarding workplace violence in the context of the range of different types of organizational responses to incidents of workplace violence or bullying. Ferris divided organizational responses into three categories: "See no evil, hear no evil, and speak no evil" [35]. Organizations that fall into the "see no evil" category acknowledge the existence of workplace violence or bullying but normalize the behavior. When affected staff members approach the employer, they are told to toughen up and to learn how to deal with the behaviors [35]. Organizational responses identified as "hear no evil" acknowledge the problem but frame it as an interpersonal conflict. The victim is often blamed for somehow triggering the negative behaviors due to his or her personality [35]. The third and final response is classified as "speak no evil." These organizations acknowledge the problem and its deleterious effects. Consequently, they take allegations seriously, follow up with an investigation, and take action against the bullying or violent individual. Ferris noted that the "speak no evil" organizations had learned from previous encounters of workplace violence that had resulted in lawsuits [35]. Organizations may ask where their current policies would be categorized based on this system.

Mandates for the development of zero-tolerance violence policies have been set for healthcare organizations [15]. This sends a clear message to employees that all types of workplace violence, including harassment, are not tolerated [36]. Such behaviors should be followed up with the appropriate disciplinary action [37]. The main premise of zero-tolerance policies is that workplace violence is reduced by promoting open communication of acceptable behaviors [37]. However, it is crucial for organizations to remember that a zero-tolerance policy itself does not prevent workplace violence [19].

After implementing zero-tolerance policies, mechanisms must be implemented to support the organizational message. First, a reporting, monitoring, and documentation system should be in place. Having a mechanism for reporting and documenting allows the type of aggressive violence and abusive behaviors to be identified and discipline enacted uniformly [14; 38]. This should minimize under-reporting and send a clear message about where and how to report various types of violence. A monitoring system would also allow for collection of data and identification of risk factors to be utilized in training and the development of intervention strategies [36; 38].

It is recommended that an interview be conducted with the victim and witness(es) as soon as possible after the event. The American Federation of State, County, and Municipal Employees recommends questions covering [39]:

- Location, date, and time of the incident
- Description of the perpetrator and relationship to victim (e.g., stranger, client/patient, colleague)
- Type of aggressive behavior (e.g., physical assault, use of weapon, verbal threat)
- Was the worker alone when the incident occurred?
- Prior incidences (e.g., threats prior to the incident)
- Other witnesses (e.g., security guard)
- Factors or circumstances leading up to the incident
- Any reports to the employer about previous incidents

Ultimately, post-incident debriefing helps to increase staff awareness and future reporting of workplace violence events [19].

Another recommendation is for employee assistance programs to take a more active role in helping to prevent workplace violence. EAPs can address certain stressors, whether they originate in the individual, the home, or work, that may precipitate workplace violence. Voelker found that when the U.S. Postal Service worked to improve their employee assistance programs' counseling services, their incidence of workplace violence was reduced [37].

Security measures should also be a key priority. Certain sectors, such as in-patient facilities, operate on a 24-hour-per-day basis, with a constant flow of clients, family members, and staff. Many healthcare organizations have implemented more stringent and secure entry identification mechanisms; some facilities require staff to wear badges with photos or require the swipe of an electronic identification card to enter certain areas [40].

OSHA has established the following recommendations for organizational policies for decreasing workplace violence and promoting the safety of employees [15; 41]:

- Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats, and related actions. Ensure that managers, supervisors, coworkers, patients, and visitors know about this policy.
- Ensure that no employee who reports or experiences workplace violence faces reprisals.
- Encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and measure progress.
- Outline a comprehensive plan for maintaining security in the workplace. This includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.

- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. Ensure that adequate resources are available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.
- Affirm management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.
- Set up a company briefing as part of the initial effort to address issues such as preserving safety, supporting affected employees and facilitating recovery.

It is also recommended that organizations implement grievance mechanisms that allow employees a forum or venue to voice their concerns. Some studies have found that perceived injustices are related to precipitations of workplace violence [42; 43]. The opportunity for an employee to voice his/her opinions and to be heard by an unbiased third party might mitigate the frustration level, which could then reduce the likelihood of a violent incident [37]. Some states mandate that certain facilities (e.g., hospitals, home health agencies, emergency medical services, correctional facilities) have a written prevention plan outlining how they will protect employees from workplace violence [44]. Good workplace violence reporting policies and prevention plans are key in sustaining an environment that is productive and safe [45].

EMPLOYEE MENTAL HEALTH

Nearly one in five adults in the United States live with a mental illness [46]. Stress can increase these and other mental health challenges and can be harmful to our health. The amount and type of stress experienced varies from person to person due to many factors, including those experienced at work. Approximately 65% of U.S. workers surveyed have characterized work as being a very significant or somewhat significant source of stress in each year from 2019 to 2021. An estimated 83% of U.S. workers suffer from work-related stress, and 54% of workers report that work stress affects their home life [46]. In addition, workplace stress has been reported to cause 120,000 deaths in the United States each year [46].

While there are many things in life that induce stress, work can be one of those factors. Workplace stress and poor mental health can negatively affect workers through their job performance and productivity, as well as with their engagement with others at work. It can also impact worker physical health, given that stress can be a risk factor for various cardiovascular diseases. However, workplaces can also be a key place for resources, solutions, and activities designed to improve our mental health and well-being [46].

Work has always presented various stress. Workers are constantly dealing with new stressors introduced to the workplace, and in some instances, these stressors have amplified other issues at work. Workplace stressors may include [46]:

- Concerns about job security (e.g., potential lay-offs, reductions in assigned hours)
- Lack of access to the tools and equipment needed to perform work safely
- Fear of employer retaliation
- Facing confrontation from customers, patients, coworkers, supervisors, or employers
- Adapting to new or different workspace and schedule or work rules
- Having to learn new or different tasks or take on more responsibilities
- Having to work more frequent or extended shifts or being unable to take adequate breaks
- Physically demanding work

- Learning new communication tools and dealing with technical difficulties
- Blurring of work-life boundaries, making it hard for workers to disconnect from the office
- Finding ways to work while simultaneously caring for children including overseeing online schooling or juggling other caregiving responsibilities while trying to work, such as caring for sick, elderly, or disabled household members
- Concerns about work performance and productivity
- Concerns about the safety of using public transit as a commuting option

These, and many other, work-related stressors can take a toll on a person's sense of well-being and negatively impact their mental health. For some, these stressors can contribute to serious problems, such as the development or exacerbation of mental health challenges (e.g., anxiety disorder, depression disorder or substance use disorders) [46]. Psychologists and psychiatrists are sounding the alarm about a mental health crisis forming, and data supporting their concerns have started to emerge. As one example, survey results from the Centers for Disease Control and Prevention (CDC) suggest that about 40% of U.S. adults were experiencing negative mental or behavioral health effects in June 2020, including symptoms of anxiety disorder or depressive disorder, trauma-related symptoms, new or increased substance use, or suicidal thoughts. An article published by the National Safety Council in August 2020 detailing a spike in opioid overdoses further highlights the need for more mental health resources [46].

Because of the many potential stressor's workers may be experiencing, a comprehensive approach is needed to address stressors throughout the community, and employers can be part of the solution. More than 85% of employees surveyed in 2021 by the American Psychological Association reported that actions from their employer would help their mental health. The goal is to find ways to alleviate or remove stressors in the workplace to the greatest extent possible, build coping and resiliency supports, and ensure that people who need help know where to turn. Time and financial constraints are often notes as reasons employers have not fully addressed employee mental health. However, for every $1 spent on ordinary mental health concerns, employers see a $4 return in productivity gains [46].

There's no one-size-fits-all strategy when it comes to alleviating workplace stress. The most effective approach is to identify the specific stressors associated with a particular job or industry and take concrete and practical steps to remove or lessen those stressors. Much can be learned by exploring what others are already doing and tips experts in the field have identified to address workplace stress.

BLOODBORNE PATHOGENS

The purpose of the Bloodborne Pathogens Standard, which was published by OSHA in final form in 1991, is to limit occupational exposure to blood, bodily fluids, and other potentially infectious materials, because any exposure could result in bloodborne pathogen transmission. This standard applies to all reasonably anticipated occupational exposures to blood or other potentially infectious materials that may result from the performance of an employee's duties [51]. "Good Samaritan" acts, such as resuscitating a co-worker, might not be considered occupational exposure [47; 48; 49].

The standard requires employers to implement an exposure control plan that mandates Universal Precautions (i.e., treating all body fluids as if they are potentially infectious). The standard also stresses hand hygiene, recommends the use of Personal Protective Equipment (PPE), sets forth processes to minimize needle sticks and blood splashing, ensures appropriate packaging of specimens, and regulates waste by employing biohazardous labeling before shipping [50; 51].

Employers must require the use of, and provide at no cost, barrier items or PPE for employee protection. This includes gowns, masks, mouthpieces, goggles, resuscitation bags, and the proper gloves for the job being performed. Also included in the standard are methods for disposing of contaminated sharps and other regulated waste in OSHA-compliant containers [50].

Another aspect of the Bloodborne Pathogens Standard is the requirement that Hepatitis B vaccination be made available at no cost and within 10 working days of assignment to all employees who have occupational exposure to blood. Postexposure evaluation and follow-up must be made available to all employees who have had an exposure incident. Included in the evaluation and follow-up are laboratory testing, counseling, evaluation, and prophylaxis, if deemed necessary and if the employee consents [3; 51].

Some of the most common bloodborne pathogens include hepatitis C, HIV, and hepatitis B [50].

TUBERCULOSIS CONTROL

In 2019, the CDC updated their guideline for the prevention of TB transmission in healthcare settings [52; 53]. The updated guideline recommends baseline (preplacement) TB testing and screening for all U.S. healthcare personnel. Although routine follow-up screening is not recommended, healthcare facilities should aim to identify latent tuberculosis infection among personnel and to encourage treatment. Postexposure screening and testing should be conducted for any healthcare personnel with known exposure to a person with potentially infectious TB disease. Healthcare personnel with a newly positive test result should undergo a symptom evaluation and chest radiograph to assess for TB disease. Personnel with latent TB infection and no prior treatment should be offered, and strongly encouraged to complete, treatment with a recommenced regimen, unless a contraindication exits. Finally, the CDC also recommends that healthcare facilities should provide annual education on TB, including risk factors, signs, and symptoms [52; 53].

FIRE SAFETY

Workplaces that house patients should be concerned with the risk of fire. Fire safety should be part of any hazard communication training program. Smoke alarms, sprinklers, and/or fire extinguishers should be present. All employees should know about the fire risks associated with chemicals, gases, or equipment used. They should also know how to respond to a fire, which includes how to rescue patients and other employees, and how to locate and properly use fire extinguishers.

Fire safety plans should include fire emergency preparation, including alarm systems, marked exits, and written emergency plans. Many hospitals use acronyms such as RACE (Rescue, Alert, Confine, Extinguish) to help employees remember the proper steps for fire emergency response.

Annual inspections by the fire marshal, quarterly fire drills, annual fire safety in-services, and monthly fire extinguisher documentation are all elements of a successful fire safety program. Staff education and documentation of the education are integral parts of the fire safety plan.

OSHA requires that employers develop and maintain on site a written fire prevention plan. The plan must be available for employee review; employers with 10 or less employees may orally communicate the plan. The plan should include a list of all major fire hazards, proper handling and storage procedures for hazardous materials, potential ignition sources and how to control them, and the type of protective equipment needed to control each type of hazard [3].

LEGAL ISSUES

In today's litigious society, any facility is at risk for lawsuits. If an employee is injured on the job and able to show that a lack of safety equipment or training or unsafe conditions caused the injury, the facility is at risk for litigation. Lack of proper treatment of the injury and continuing unsafe conditions might also contribute to an employer's risk for litigation.

Attorneys who investigate incidents of employee injury will expect to be able to examine available documentation, including incident reports, medical records that include treatment of the employee, and training and education records. Safety conditions that might have caused the injury, any perceived unsafe conditions that exist, the safety committee minutes that show how the facility has addressed the condition, and further actions to correct the condition may also be reviewed.

Knowing what the standards prescribe for a particular facility and properly documenting all programs (e.g., written plans, the education program, or follow-up of existing conditions) will provide the employer with the best protection possible. Employers should carefully read the standards and provide training seminars and other relevant employee resources to ensure that their facilities are in compliance.

RESOURCES

The most important resource is the *Code of Federal Regulations*, title 29, sec. 1910. Additional resources include:

National Institute for Occupational Safety and Health (NIOSH)
https://www.cdc.gov/niosh

National Institute of Environmental Health Sciences (NIEHS)
https://tools.niehs.nih.gov/wetp

National Safety Council
https://www.nsc.org

U.S. Department of Labor, Bureau of Labor Statistics
https://www.bls.gov

U.S. Department of Labor, Occupational Safety and Health Administration
https://www.osha.gov

Works Cited

1. Bureau of Labor Statistics. Employer-Reported Workplace Injuries and Illnesses, 2022. Available at https://www.bls.gov/news.release/osh.nr0.htm. Last accessed December 14, 2023.
2. Bureau of Labor Statistics. Census of Fatal Occupational Injuries Summary, 2022. Available at https://www.bls.gov/news.release/cfoi.nr0.htm. Last accessed December 14, 2023.
3. U.S. National Archives and Records Administration. *Code of Federal Regulations*. Washington, DC: Occupational Safety and Health Administration, U.S. Department of Labor; 2004.
4. Grainger. OSHA Recordkeeping Requirements (Updated for 2015 and 2016). Available at https://www.grainger.com/know-how/safety/safety-management/safety-compliance/kh-osha-recordkeeping-requirements. Last accessed December 14, 2023.
5. Occupational Safety and Health Administration. OSHA Forms for Recording Work-Related Injuries and Illnesses. Available at https://www.osha.gov/recordkeeping/forms. Last accessed December 14, 2023.
6. U.S. Bureau of Labor Statistics. Injuries, Illnesses, and Fatalities. Available at https://www.bls.gov/iif/home.htm. Last accessed December 14, 2023.
7. U.S. Bureau of Labor Statistics. Economic News Release: Census of Fatal Occupational Injuries Summary, 2021. Available at https://www.bls.gov/news.release/cfoi.nr0.htm. Last accessed December 14, 2023.
8. U.S. Bureau of Labor Statistics. Employer-Reported Workplace Injuries and Illnesses – 2021. Available at https://www.bls.gov/news.release/pdf/osh.pdf. Last accessed December 14, 2023.
9. U.S. Bureau of Labor Statistics. Workplace Violence: Homicides and Nonfatal Intentional Injuries by Another Person in 2020. Available at https://www.bls.gov/opub/ted/2022/workplace-violence-homicides-and-nonfatal-intentional-injuries-by-another-person-in-2020.htm. Last accessed December 14, 2023.
10. Spencer PC, Munch S. Client violence toward social workers: the role of management in community mental health programs. *Soc Work*. 2003;48(4):532-544.
11. Harris B, Leather P. Levels and consequences of exposure to service user violence: evidence from a sample of UK social care staff. *Br J Soc Work*. 2012;42(5):851-869.
12. Tishler CL, Gordon LB, Landry-Meyer L. Managing the violent patient: a guide for psychologists and other mental health professionals. *Prof Psychol Res Pr*. 2000;31(1):34-41.
13. Vellani KH. Reducing violence in healthcare facilities. *J Healthc Prot Manage*. 2014;30(1):21-29.
14. Zhoa S, Lui H, Ma H, et al. Coping with workplace violence in healthcare settings: social support and strategies. *Int J Environ Res Public Health*. 2015;12(11):14429-14444.
15. Occupational Safety and Health Administration. Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. Available at https://www.osha.gov/Publications/osha3148.pdf. Last accessed December 14, 2023.
16. American Federation of State, County, and Municipal Employees. Controlling and Preventing Workplace Violence. Available at https://afscmestaff.org/wp-content/uploads/2020/03/Preventing_Workplace_Violence.pdf. Last accessed December 14, 2023.
17. Green R, Gregory R, Mason R. It's no picnic: personal and family safety for rural social workers. *Aust Soc Work*. 2003;56(2):94-106.
18. Cowin L, Davies R, Estall G, Berlin T, Fitzgerald M, Hoot S. De-escalating aggression and violence in the mental health setting. *Int J Ment Health Nurs*. 2003:12(1):64-73.
19. Morphet J, Griffiths D, Beattie J, Reyes Velasquez D, Innes K. Prevention and management of occupational violence and aggression in healthcare: a scoping review. *Collegian*. 2018;25(6):621-632.
20. National Association of Therapeutic Schools and Programs. Behavior Support Management in Therapeutic Schools, Therapeutic Programs, and Outdoor Behavioral Health Programs. Available at https://natsap.org/page/BehaviorSupportManagement. Last accessed December 14, 2023.
21. Kontio R, Joffe G, Putkonen H, et al. Seclusion and restraint in psychiatry: patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspect Psychiatr Care*. 2012;48(1):16-24.
22. Richmond JS, Berlin JS, Fishkind AB, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med*. 2012;13(1):17-25.
23. Nau J, Halfens R, Needham I, Dassen T. Student nurses' de-escalation of patient aggression: a pretest-posttest intervention study. *Int J Nurs Stud*. 2010;47(6):699-708.
24. Sturrock A. Assessing the risk of aggression and violence among service users. *Ment Health Pract*. 2012;15(5):26-29.
25. Twemlow SW. Interviewing violent patients. *Bull Menninger Clin*. 2001;65(4):503-521.
26. Sutton D, Wilson M, Van Kessel K, Vanderpyl J. Optimizing arousal to manage aggression: a pilot study of sensory modulation. *Int J Ment Health Nurs*. 2013;22(6):500-511.
27. Child RJ, Mentes JC. Violence against women: the phenomenon of workplace violence against nurses. *Issues Ment Health Nurs*. 2010;31(2):89-95.

28. Brown RG, Anderson S, Brunt B, Enos T, Blough K, Kropp D. Workplace violence training using simulation. *Am J Nurs*. 2018;118(10):56-68.
29. Romano SJ, Levi-Minzi ME, Rugala EA, Hasselt VB. Workplace violence prevention readiness and response. *FBI Law Enforcement Bulletin*. 2011;80(1):1-10.
30. Sabo BM. Compassion fatigue and nursing work: can we accurately capture the consequences of caring work? *Int J Nurs Prac*. 2006;12(3):136-142.
31. McCann IL, Pearlman LA. Vicarious traumatization: a framework for understanding the psychological effects of working with trauma. *J Trauma Stress*. 1990;3:131-149.
32. Patrick PKS. Stress-induced challenges to the counselor role: burnout, compassion fatigue, and vicarious traumatization. In: *Contemporary Issues in Counseling*. Boston, MA: Allyn and Bacon; 2006: 210-250.
33. Levin PF, Hewitt JB, Misner ST. Insights of nurses about assault in hospital-based emergency departments. *Image J Nurs Sch*. 1998;30(3):249-254.
34. Newell JM, Nelson-Gardell D. A competency-based approach to teaching professional self-care: an ethical consideration for social work educators. *J Soc Work Educ*. 2014;50(3):427-439.
35. Ferris P. A preliminary typology of organisational response to allegations of workplace bullying: see no evil, hear no evil, speak no evil. *Br J Guid Couns*. 2004;32(3):389-395.
36. Clements PT, DeRanieri JT, Clark K, Manno MS, Kuhn DW. Workplace violence and corporate policy for health care settings. *Nurs Econ*. 2005;23(3):119-124.
37. oward JL. Workplace violence in organizations: an exploratory study of organizational prevention techniques. *Employee Responsibilities and Rights Journal*. 2001;13(2):57-75.
38. Roche M, Diers D, Duffield C, Catling-Paull C. Violence toward nurses, the work environment, and patient outcomes. *J Nurs Scholarsh*. 2010;42(1):13-22.
39. American Federation of State, County, and Municipal Employees. Reacting to Violence After it Occurs. Available at https://afscmestaff.org/wp-content/uploads/2020/03/Preventing_Workplace_Violence.pdf. Last accessed December 14, 2023.
40. Keely BR. Recognition and prevention of hospital violence. *Dimens Crit Care Nurs*. 2002;21(6)236-241.
41. Pestka EL, Hatteberg DA, Larson LA, et al. Enhancing safety in behavioral emergency situations. *Medsurg Nurs*. 2012;21(6):335-341.
42. Greenberg L, Barling J. Predicting employee aggression against coworkers, subordinates and supervisors: the roles of person behaviors and perceived workplace factors. *J Organ Behav*. 1999;20(6):897-913.
43. Dupré KE, Barling J. Predicting and preventing supervisory workplace aggression. *J Occup Health Psychol*. 2006;11(1):13-26.
44. Gooch P. Hospital workplace violence prevention in California: new regulations. *Workplace Health Saf*. 2018;66(3):115-119.
45. Chang YP, Lee DC, Wang HH. Violence-prevention climate in the turnover intention of nurses experiencing workplace violence and work frustration. *J Nurs Manag*. 2018;26(8):961-971.
46. Occupational Safety and Health Administration. Workplace Stress. Available at https://www.osha.gov/workplace-stress. Last accessed December 14, 2023.
47. Occupational Safety and Health Administration. Standard Interpretations: 1910.1030. Applicability of Bloodborne Pathogens Standard to Emergency Responders, Decontamination, Housekeeping, and Good Samaritan Acts. Available at https://www.osha.gov/laws-regs/standardinterpretations/1992-12-04. Last accessed December 14, 2023.
48. Occupational Safety and Health Administration. Standard Interpretations: 1910.1030. Bloodborne Pathogen Standard's Applicability to Non-Health Care Industries. Available at https://www.osha.gov/laws-regs/standardinterpretations/1992-08-28-0. Last accessed December 14, 2023.
49. Occupational Safety and Health Administration. Standard Interpretations: 1910.1030(a). Coverage of the BBP Standard for Good Samaritan Acts and Personal Medical Conditions. Available at https://www.osha.gov/laws-regs/standardinterpretations/2001-03-23-1. Last accessed December 14, 2023.
50. Occupational Safety and Health Administration. Occupational exposure to bloodborne pathogens; needlesticks and other sharps injuries; final rule. *Fed Regist*. 2001;66(12):5318-5325.
51. Occupational Safety and Health Administration. Bloodborne Pathogens and Needlestick Prevention. Available athttps://www.osha.gov/SLTC/bloodbornepathogens/index.html. Last accessed December 14, 2023.
52. Sosa LE, Njie GJ, Lobato MN, et al. Tuberculosis screening, testing, and treatment of U.S. health care personnel: recommendations from the National Tuberculosis Controllers Association and CDC, 2019.*MMWR*. 2019;68(19):439-443.
53. Centers for Disease Control and Prevention. Tuberculosis: Data and Statistics. Available at https://www.cdc.gov/tb/statistics/default.htm. Last accessed December 14, 2023.