Cal/OSHA Advisory Meeting
Workplace Violence Prevention in Healthcare
Thursday, February 5, 2015
Los Angeles, CA

Meeting Chairs: Bob Nakamura, Kevin Graulich
Notes: Grace Delizo

NAME	AFFILIATION
Jerry Abraham, MD, MPH	CIR/SEIU
Monica Aleman	UNAC/UHCP
Lisa Alverson	UNAC/UHCP
Virginia Anders-Ellmore	Harbor UCLA Medical Center
Kawana Anderson	SEIU/USWW
Ewiro Arellar	SEIU/USWW
Jennai Arrias	SEIU Local 721
Gerado Bajamundi	UNAC/UHCP
Aimee Baror	SEIU 121RN
Jason Barry	University of California
Gayle Batiste	SEIU 121RN
Jonathan Besnick	UNAC
Elizabeth Billberry	UC San Diego Health System
Christian Bobadilla	College Hospital Cerritos, SEIU 121RN
Michael Boccio	UNAC/UHCP
Peter Bowen	Willis Group
Michael Brown	SEIU/USWW
Scott Byington	UNAC HCP
Jorge Cabrera	SoCalCOSH
Linda Calderon	UNAC/UHCP
Max Carbuccin	UNAC/UHCP
Rosa Carcamo	
Marilen Castanon	UNAC
Cesar Castrejon	Los Angeles Alliance for a New Economy (LAANE)
Michelle Chambers	Senior Field Deputy for Assemblyman Mike Gipson
Genevieve Clayreal	
Lt. Cindy Conner	LA County Sheriff's Dept.
John Consoli	Atascadero State Hospital
Samantha Contreras	SEIU-ULTCW
Cory Cordova	SEIU 121RN
Grace Corse	SEIU Nurse Alliance
Elissa Brown	ANA/California
Ingela Dahlgren	SEIU Nurse Alliance of California
Maxine Davidson	SEIU 121RN
Suzanne Delaney	UNAC/UHCP
Denise Duncan	UNAC/UHCP
Erik Eggins	UCLA Health
Joel Emerson	
Chi Fong	LA County Dept. of Health Services
Juan Flores	SEIU/USWW

Jennifer Gabales	California Association for Health Services at Home (CAHSAH)
Tiashira Gadlin	UNAC
Edwin Giarrano	UNAC
Albert Grimus	SEIU/USWW
Donah Gue	UNAC/UHCP KPRNA
Lisa Hall	California Association of Health Facilities
Marley Hart	Occupational Safety and Health Standards Board
Elizabeth Hawkins	UNAC
Kim Hawkins	UNAC/UHCP
Katherine Hughes	SEIU121RN
Fred Huicochea	Union Steward Local 721, UCLA Medical Center
Napoleon Imperio	CDPH
Kristin Jenkins	UNAC/UHCP
Felix Jimenez	SEIU Local 721
Yorlina Jimenez	
Vanessa Johnson	SEIU Local 721
Carol Jones	UNAC/UHCP
David Kernazitskas	Occupational Safety and Health Standards Board
Deirdre Kirkwood	UNAC/UHCP
Mary Kochie	Cal/OSHA
Risha Kraal	SEIU 121RN
Connie Lackey	
Dorlah Lawrence	SEIU Local 721
Jollene Levid	SEIU Local 721
Pamela Lew	Disability Rights California
Rita Lewis	
David Markir	SEIU ULTCW
Sandi Marques	UNAC/UHCP
Arthereane McLaughlin	UNAC/UHCP
Peter Melton	CA Dept. Industrial Relations
Linda Meyer	UNAC
Lynn Michels	Kaiser Permanente
Elsa Monroe	SEIU 1000
Charmaine Morales	
Darren Morgan	
Michael Musser	California Teachers Association
Richard Negri	SEIU 121RN
Cheryl Obasih-Williams	UNAC UHCP
Tami Olenik	SEIU Nurse Alliance
Steve Pitocchi	SEIU 1021
Pam Pressy	UNAC UHCP
Hortensia Quiaga	UNAC UHCP
Ivy Quicho	SEIU Local 721
Jorge Ramirez	Ronald Reagan UCLA Medical Center
Jennifer Rios	SEIU
Mala Rivera	SEIU/USWW
Jeff Rogers	UNAC
Colleen Scanlon	St. Joseph Health
Brandon Shelton	Dignity Health
Carmen Sierra	SEIU 121RN

Ruby Sloan	Alameda Health System, John George Psych Hosp
Kim Smith	UNAC/UHCP
Matthew Smith	CIR/SEIU
Pattie Soltero	Harbor UCLA Medical Center
Sarah Springer	SEIU 121RN
December Stroble	
Kevin Thompson	Cal/OSHA Reporter
Gordon Tokamatsu	NBC-4
Michael Tutko	Kaiser Permanente
June Valem	
Brad Vandersall	UC San Diego
Rosaria Vergara	UNAC/UHCP
Eva Vikew	UNAC/HCP KWLA
Brendan White	California Nurses Association
Sandra Williams	Alameda Health System
Wally Wold	Kaiser Permanente
Ed Wright	
Tamara Yildiz	UNAC/UHCP
Albert	SEIU/USWW
Dolores	SEIU/USWW
Idris	SEIU/USWW
Jenet	SEIU/USWW
Lovely	SEIU/USWW
Michael	SEIU/USWW

Bob Nakamura welcomed the attendees. He stated that this is the 4th meeting to discuss some of the issues that are involved with preventing workplace violence in different healthcare facilities and types of settings. The Division wants input on what would make an effective regulation and on the proposal the Division drafted.

Bob summarized previous meetings. In September, we went over basic issues that people confront in healthcare, heard people tell their own experiences and problems. What we did at the next meeting was try to deal with non-hospital settings and try to get their experience and point of view on what's needed and what the problem would be like. And at the third meeting we focused on law enforcement and security personnel involvement and how that plays into controlling problems in different settings. From that, the Division composed a draft regulation. It's not a formal proposal yet.

Bob explained that the Division writes the proposal, but does not pass or adopt the regulation. That function is left to the Occupational Safety and Health Standards Board, which is an appointed body that votes on whether a regulation should be adopted or changed. The Division sends the Board a proposal that comes out of the advisory meetings, which is referred to pre-rulemaking. Once it goes to the Board for formal rulemaking it is a different process. The Division wants to get as much input from stakeholders before it does the actual proposal that is sent to the Board so that problems are ironed out beforehand and that it is an effective regulation.

Bob then went over housekeeping issues, reminded attendees to sign in, and asked for comments to be submitted before the end of February. The plan is to make any necessary changes to the draft to send out before April.

SB 1299 went into effect and was adopted into the Labor Code and directed the Standards Board to adopt a regulation by 2016. This means we have to get a proposal and formal rulemaking started by July 2015. There is a certain structure required by SB 1299 that can either be incorporated into an employer's existing Injury and Illness Prevention Program or have a separate program directed at controlling workplace violence aspects, establishing different control methods and training. SB 1299 requires that hospitals report to the Division incidents of workplace violence. It's unusual because although the Division gets notices within 8 hours of serious injuries, illnesses or deaths on the job, it typically does not get notices of any type of injury so that it can deal with the workload. We have to shape the regulation to incorporate those two requirements. Bob then explained the formal rulemaking process and referenced the OAL rulemaking chart.

Bob gave an overview of the petitions filed by the Service Employees International Union Nurse Alliance and the California Nurses Association. They both wanted to have healthcare employers establish an effective plan to control workplace violence in their specific facilities. The structure of the petitions is similar to that of SB 1299, so in some ways they are very consistent. The basis for that is the healthcare industry has had a long history of recognized violent incidents against healthcare personnel – nurses and others, and we want to do something about that today.

Bob Nakamura, **Kevin Graulich** and **Grace Delizo** introduced themselves as Senior Safety Engineers from the Division's Research and Standards Health Unit working on this rulemaking project. Bob polled the attendees to see how many were nurses, other healthcare workers, administrators, law enforcement and security personnel.

Bob began the review of the discussion draft, beginning with the scope. He explained that the two petitions differed in that one was directed primarily at hospitals and the other was directed at all types of healthcare. The Division found from its work on the Aerosol Transmissible Diseases (ATD) Standard that trying to define all health facilities is difficult, so he reviewed the list in (a)(1) – health facilities, such as general acute care hospitals; outpatient medical offices and clinics; home health care and home-based hospice; EMT and paramedic services; mobile clinics; drug treatment programs; and ancillary health care operations.

Elsa Monroe wanted to know whether correctional facilities are included in the scope. Bob confirmed that they are covered under health facilities.

Erik Eggins wanted to know if psychiatric hospitals and facilities are included in the scope. Bob stated they were included in the definitions.

Katherine Hughes suggested the following changes:

1. (a)(1) – applies to work in "all" health care facilities, service categories, or operations, "including"… to emphasize that all HC facilities, service categories and operations are included along with examples cited below.
2. (a)(1)(A) – health facilities, as defined "in subsection (b)"
3. (a)(1)(E) – "Field operations, such as" mobile clinics… to recognize that these are field operations and these may just be some of the examples of what a field operation in healthcare is.

Richard Negri stated that field operations is defined in the regulation but wasn't used so they felt it would be good to insert the term in (a)(1)(E) so that it lists some of the examples of field operations.

Frederick Huicocha felt that employer to employee violence should be covered under the definition of "reportable workplace violence incident."

Bob Nakamura explained that the definition is required by SB 1299 and is limited to what's stated there and limited to hospitals.

Jonathan Besnick stated that it's not just about individual patients, visitors, or employees. It is all encompassing – anybody acting violent against any healthcare worker.

A Securitas representative stated concern that they are often third party in hospital settings and want their officers to be able to have information about any communicable diseases that patients may have so that they can protect themselves. Bob mentioned that the ATD standard requires that different employers at a health facility communicate about patients without naming them, and that there should be a program in place and if there's not you can file a complaint with the Division. But that issue is a prime consideration of what we want to talk about today too.

Elissa Brown said she is retired from the VA after 38 ½ years where she chaired a mental health safety committee. Regarding psychiatric facilities or areas, the draft only addresses acute psychiatric facilities and wants that to be broadened.

Tami Olenik stated that she is a victim of workplace violence. She wants bullying to be addressed and primarily among employee-employer relations. The Joint Commission in 2008 addressed behaviors that undermine a culture of safety where employees are so intimidated that often sentinel events related to patients go unrecorded. She referenced this study and a State of Washington, Dept. of Labor and Industries document. Often the employers will have a written policy on dignity and professionalism, but are often not enforced. Some of the avenues are broken and enforcement needs to happen in order to have claims heard and any conflict resolution.

Richard Negri suggested adding typologies to the list of definitions because typologies are referred to in the regulation and were addressed at previous advisory meetings and accepted by stakeholders:

"Typologies" are defined as follows:

- "Type 1" violence means violence with criminal intent, and includes violent acts by people who enter the workplace to commit robbery or other crime – or a current or former employee who enters the workplace with the intent to commit a crime.
- "Type 2" violence means violence directed at employees by patients, clients, customers, students, inmates, or others to whom the employer provides a service.
- "Type 3" violence means violence against co-workers, supervisors, or managers by a current or former employee, supervisor, or manager.
- "Type 4" violence means violence in the workplace by someone who does not work there, but who is known to, or has a personal relationship with, an employee.

John Consoli wanted acute psychiatric facilities in the definition of health facility and correctional facilities should be spelled out in the regulation. He also wanted to address threats such as "I'm going to kill you later" which can also traumatize people.

Bob Nakamura moved the discussion on to the definitions section and spoke of retail clinics listed in the ancillary health care operation definition and how there is not much information about workplace violence incidents that occur there.

Gail Blanchard-Saiger expressed concerns about the need for a clearer definition of dangerous weapon for hospitals and other facilities that would have to report so as to have consistency as well as to not have the Division inundated with reports. Bob asked for suggestions in writing and mentioned a story in network news about a patient that took apart his bed and attacked nurses in their station room with the rails, so we would have to deal with the issue of whether we'd want to call that a weapon.

Richard Negri agreed that the definition of a dangerous weapon would capture whether it's a bed or a chair or any other instrument that any violent individual could use to harm a worker. On the next line, suggested adding the definition, "Division" means the Division of Occupational Safety and Health of the Department of Industrial Relations, since the term is used within the regulation.

Dierdre Kirkwood recommended keeping the definition broad because a patient used a device with metal hooks that's used to hang an IV and swung it at her. She called the code for security and was admonished by security and management because they said it was not a weapon. She contends that it definitely was a weapon that could have caused her harm.

Elissa Brown proposed not putting the word "dangerous" before weapon because she doesn't know of any weapons that aren't dangerous. The policies that are used at the VA just say weapon. She also suggested adding a definition for "threat."

Jennai Arrias stated that it's not the device, it's how it's used whether it's a pencil, or IV tubing. No one thinks of IV tubing as a weapon, but if it's wrapped around your neck and you're being choked by it, it's a dangerous weapon.

Frederick Huicocha stated that if he has a pocket knife to peel an orange, it's not a weapon it's a tool. He suggested the language read that any instrument "used as a weapon" rather than naming a specific weapon would be considered a weapon at that point and time.

Jonathan Besnick stated that a weapon is a tool. It's how you use the tool. His finger can be a weapon. It depends on how he uses it. It's any item, body part, any physical manifestation of aggression toward somebody. The term dangerous weapon is a pigeon hole that is another area that can be open to interpretation.

Gail Blanchard-Saiger clarified her earlier comment was not to suggest that a pencil or an IV pole cannot be used as a dangerous weapon. Her concern is that in the regulation there are things that must be done (reporting, preventive, etc.) with regard to dangerous weapon. It might make more sense to have a definition of dangerous weapon or weapon that are things that are commonly considered (knife, gun, etc.) versus items found in the hospital that can be used as a weapon.

Jenet B said she represents security guards and wants security measures to address outside of a hospital setting. They work in commercial buildings and other facilities where they are the first responders, such as a 5150 situation. They are responsible for moving the homeless from

buildings and have concerns about HIV, so they need to be covered and have protective measures as first responders.

Richard Negri pointed out that in correctional facilities dental floss is not allowed in some environments because it has been used as a weapon. He called attention to the definition of workplace violence and concerns made about what would be covered and feels adding the typologies definition would help explain what the violence is.

Donah Gue, ER nurse, UNAC HCP, strongly agrees with keeping the definition broad because she was choked with her own scarf by a disoriented patient. She asked that the definition not be pigeon holed.

Katherine Hughes referred to the definition of patient related risk factors and stated that patients that are disoriented and become combative do it under numerous reasons (under influence of drugs or alcohol, negative response to medication such as sleeping pills or anti-anxiety medications, coming out of anesthesia, sundowners). SEIU proposes to broaden the definition of Patient-related risk factors to mean factors specific to a patient, such as "a condition or disease process that would cause confusion and/or disorientation." They also recommend removing the word "workplace" from history of workplace violence because someone may have a history of violence, but not workplace violence. Several definitions are not used anywhere else in the regulations (medical specialty practice, physician or other licensed health care professional, patient contact). Bob pointed out those definitions are there as placeholders because they are expected to be used as we go through the process.

Erik Eggins wanted to add a definition for employee to clarify between a paid employee, third party person, contractor, or vendor because employers have reporting requirements for workplace violence and they need to know whether or not they have to report workplace violence incident involving a contract employee, a vendor. He stated that the definition of employee should also point out what that excludes. Bob explained that there are no definitions for employee in other Cal/OSHA regulations because the definition has changed over time and it's difficult to put something that broad in the regulation.

Elizabeth Billberry commented that they have many licensed facilities, such as a pharmacy managed by Vons. They have third party companies operating out of their facility and she wants to know if those employees would be included. Bob stated that the approach the Division takes is that when there are employers of different employees, such as contractors, there needs to be interaction between the facility and that employer to work out how those different programs will be covered.

Elsa Monroe said she used to be a traveling nurse and feels that for employers to consider her as a contractor if something happens to her in the workplace is disrespectful.

Katherine Hughes expects that as the scope states this section applies to any kind of work that would cover work done by an employee, contracted employee, travel employee or outside vendor in any of the covered facilities, service categories or operations.

Jorge Cabrera recommended keeping the definition broad to cover not only traditional employees, but there are trends to subcontract out to other companies and there is a litany of thousands of temporary workers. AB 1987 was passed and equal protections are given to temporary workers. It's important to protect all types of workers and recognize that it's the

employer that is responsible for the working conditions of any type of worker, whether subcontracted, temporary, etc.

Gail Blanchard-Saiger questioned who is in the hospitals' universe of reporting. If they contract out dietary, those are not hospital employees. She sees the language similar to safe patient handling where if you've got a third party working on your site you have to integrate them, but there is the separate question of reporting. It gets more complicated as hospitals move their services out into the community, such as the example of hospital pharmacists working at Von's. The coverage could also fall under ancillary health care operations. Bob responded that the reporting issue is new so we have to look at how to handle that. The basic thing is that whoever employs the person that gets hurt or might get hurt has to train that person so whether that's through an overall agreement with the hospital or on their own, somebody's responsible for doing that. Gail also brought up the issue of when hospitals lease space in some other area, they don't own that facility so they don't have the ability to put in security XYZ.

Virginia Anders-Ellmore questioned whether volunteers and students are covered because they are not necessarily employees. Bob replied that there are conditions that determine whether students are considered employees under the Labor Code. The basic thing is to have a program that tries to address how to prevent injuries to anybody working in the facility, but how we do that is the question.

Jonathan Besnick commented on the CHA not having areas covered such as ancillary health care operations and field operations like setting up in a Von's. The responsibility falls basically to the person in charge in enacting that action. They chose to step out of the bounds of their campus to create an extension of their zone. He disagrees with the administrator and strongly suggests that anything associated with a hospital, healthcare or employees actions related to it should be covered by this.

John Consoli discussed the issue of contract employees at their occupational health nurse meeting. Several sites are doing contracts, but they also put in the contracts where they say you will train them on this and they provide the documentation to the employer. He stated that someone got injured at a Kaiser in southern California and there was a question of who was responsible and was the person trained. That's why they put it in their contracts and a couple of other facilities wound up doing the same thing. There are also volunteers at Atascadero State Hospital and they are trained not to respond to red lights and combative situations. There have been volunteers injured and they were taken care of under occupational health.

Gail Blanchard-Saiger stated that hospitals are not asking for any type of exemption but simply asking for clarity when you've got third party employers, leased space, or other complicated situations.

Richard Negri stated that 3203 requires that the employer provide a safe and healthful workplace. Bob further explained that an employer is required to have a program for preventing injuries and illnesses in their workplace. The issue has been over the years how to apply that to different employees, employees of other employers like temps or contractors. Under the basic plan that an employer has, there has to be some acknowledgment that the other employees that are on their site are provided some way to interact with their plan so that those employees are not left out on safety issues.

Michelle Chambers, Senior Field Deputy for Assemblyman Mike Gipson, stated that they house Martin Luther King Hospital and Saint Francis Hospital within the 64th district. They have

called for a meeting with Ms. Luana Murphy, Exodus Foundation, as well as the King Hospital on this security issue. It is something he is addressing and will be updating the community. His main focus is on the safety of the patients, the safety of staff and the facility as a whole. They are looking at security measures as well as legislation.

Grace Corse said there is no mention of employee on employee, or employer against an employee included in the definition of workplace violence. It's all behavior that's bad from a patient or somebody that's accompanying a patient. It limits the bad behavior addressed because it occurs frequently by agents of the employer will harass, intimidate, bully employees mercilessly. She'd like to see that included in the definition so it's defined there.

Richard Negri again recommended inserting the typologies into the definitions section.

Gail Blanchard-Saiger commented on the need for a clearer definition of reportable workplace violence incident so that everyone knows what they're supposed to be reporting and that they're reporting similar circumstances. She feels it is ambiguous and needs more parameters. She asked if there's a difference in a situation that happens in a behavioral health unit versus an ambulatory surgery center.

Jennai Arrias aked why AHA is having trouble comprehending that it's basically harm to another human being so why do you really need this defined in detail so they can figure out what they need to report. A human being is harmed – you need to report it.

Frederick Huicocha stated that it doesn't matter where you work. If you're an employee working somewhere, dead is dead.

Richard Negri clarified that the reporting language is taken out of SB 1299 which was signed by the Governor.

Gail Blanchard-Saiger gave an example of a manager evaluating a situation to determine whether psychological trauma or stress occurred and asked if it is an objective standard or a subjective standard. If it's subjective, she's going to have to ask employees whether they were stressed and to report that. Similar circumstances that do not cause a colleague stress will not be reported. Someone sustaining a physical injury is obvious. Threats or stress is where it gets ambiguous. There will be a lot of reports to the Division if stress is included in reporting.

Bob Nakamura explained the reporting definition and criteria are required by the legislation. Those are different from the typical Cal/OSHA reports that we receive. We're obligated to receive and try to do something about the 342 type, where there's an accident and someone is seriously injured, has a serious illness or dies. Those have to be reported to our local district offices within 8 hours. That's something we've had for years and will continue to have. What the legislation did was to expand upon this in a way that is frankly difficult for us to figure out how to use because we anticipate, based upon statistical reports and analyses that we've received so far about the types and number of injuries that happen in hospitals, that we're going to get a flood of information. Somebody has to sort through that and decide whether any reports will require us to do an investigation or complaint inspection. That's going to be an issue as well as how to deal with the non-physical types of incidents.

Christian Bobadilla said he works at a behavioral health care unit. To separate reporting injuries coming from the behavioral health care unit and other types like ICUs wouldn't seem fair because they're not expecting to get hurt all the time and there are things that hospitals can do

to prevent employees from getting hurt and ease the tension in the units concerning the patients.

Jonathan Besnick expressed concern about the hospital association saying this is subjective or objective. It is what it is. If people are having stress or are being attacked or harassed consistently, whether they're in the triage area, specific patient care area, they're being put under pressure and stress. He feels it takes the onus and responsibility off the hospital administration and wants this regulation passed so when they file complaints, they're followed through and there's strength behind it. One of the problems is that if I can't say if it's subjective or objective, that way I don't have to be responsible for it. It puts employees in the position that they won't want to make those reports. All the nurses, ancillary staff and security take care of people and the administration should be just as responsible for taking care of its employees.

Elissa Brown stated that the individual who is in the mental health setting might be the same individual coming into the ED for an ingrown toe nail. So it's the individual and what's going on, not necessarily the setting. So that shouldn't be different in terms of reporting. She suggested adding to the definition of workplace violence in (A) "threat to use." She's very passionate about reporting and feels that threats and any incident of violence, whether one gets hurt or not, if a person throws an ashtray at you and it misses, it's still violence. What you get out that, if you're really tracking, is you see patterns of behavior and that's very important. After years of debriefing situations, most of the problems happened when people did not report early, did not report threats. There needs to be a system for reporting to the Division, somehow consolidating the information to make it easier and we don't lose it.

Cindy Conner suggested the wording "force used against any hospital employee by anyone" in the definition of reportable workplace violence incident (A) to keep it simple. She suggested in (B) that non-aggravated assaults – a battery, a slap, a smack, a spit, an attempt to injure somebody – not be reported because they happen frequently many times without any intent. They look at intent of whoever uses force against another.

Elsa Monroe stated that nurses died in California because of mentally ill patients that didn't intend to murder anyone. She referred to SB 1299 that requires general acute care hospitals, acute psychiatric hospitals and special hospitals to report reportable violent incidents to the Division within 24 hours under defined circumstances and all other incidents within 72 hours.

Dierdre Kirkwood said she appreciates the distinction between aggravated and non-aggravated assaults from a law enforcement perspective, but that intent is not applicable when keeping healthcare workers safe. They expect their employers and laws that govern employers to do everything they possibly can do to keep them safe and that's why they're here.

Jorge Cabrera echoed Ms. Kirkwood's comments that intent doesn't matter, it's the result. People die, they're permanently injured, psychologically damaged and that's what we're here to prevent so keep it as broad as possible.

Frederick Huicocha agrees with the distinction made by Ms. Conner, but feels that non-aggravated assaults should remain a reportable incident and whether or not there was intent could be brought out in an investigation.

Felix Jimenez commented on (c)(2)(I)1. – the requirement that corrective measures include procedures to ensure that sufficient staff, trained in appropriate disciplines, is available. He hasn't seen any classes that deal with aggressive patients and their lives are in jeopardy every

day. The nurses brought this to the attention of administration and they suggested using plastic shields that SWAT teams use when dealing with a violent patient. They tried a tracking device that hasn't been working for the last 4-5 months even after addressing this problem to administration. Biomedical staff tried to fix it and couldn't. Administration also came up with the idea that one RN and 2 psych staff should go and deal with aggressive patients, which leaves 3 less staff in the unit. He remembers as a nursing student that law enforcement would deal with aggressive patients, but was told that the sheriffs will not because the patients are not inmates. A few months ago, they presented a list of injured employees to the CEO and administrators and it was disputed by administration. They feel that their employer has failed to protect them.

Richard Negri commented that his concern is prevention instead of looking after an incident occurs. They want to put in a mechanism for prevention regardless of whether there was intent and it's covered in the draft under assessment procedures. He suggested adding "unit" after facility in (c)(2)(F) Assessment Procedures for the identification and evaluation of environmental risk factors for each facility, service or operation. These procedures shall include a review of all workplace violence incidents that occurred in the facility, service or operation…

Cindy Conner took back her suggestion to use intent in reporting. Their biggest obstacle has been nurses failing to report because they didn't believe the patient intended to do it. For reporting purposes, she suggests aggravated assault versus non-aggravated assault. Either way intent is what law enforcement looks at further down the road.

Gail Blanchard-Saiger wants to clarify what is reportable to Cal/OSHA, which is above and beyond the rest of the regulation to have a workplace violence prevention plan. They are trying to clarify and make reasonable what actually has to be reported to Cal/OSHA. That does not mitigate their general obligation under the rest of the regulation.

Gayle Batiste said she is President of SEIU Local 121RN and works in the operating room at an acute care hospital and spoke of understaffing. A month ago as she was finishing her shift, another nurse called for help with a patient who had injuries inflicted upon him from others and who had a history with the police. He threatened to kill her and shoot her in the face. They deal with this on a daily basis and don't get to pick who they take care of. They have to treat patients with respect and dignity, but they don't want to put their lives in danger because the hospital is not doing their job by providing the staffing and providing security. They need to make sure their workplaces are secure and that employees are safe. Patients are not safe if they're not.

Elizabeth Hawkins told her story where a patient punched her in the head, knocked her against a wall and she was temporarily blinded. She would've probably been dead if she hadn't brought her coworker into the room with her and the patient's father tackled the patient to the floor. Security that was on standby didn't even come into the room until after the father and coworker wrestled the patient to the floor. Short staffing was an issue on that day as well. She demanded the police be called and when the police showed up they tried to talk her out of filing a report. She didn't blame the patient because there was a psychotic component, but she does blame the hospital for not having policies and a plan in place to protect her. This has happened to two additional nurses in the same unit with the same type of patient, so the plan hasn't even been rolled out. She was dramatically affected and out for months on workers' comp and light duty because she had neck injuries and a concussion.

Cory Cordova said he worked as an ER nurse for 12 years, because of his stature and because he is a male, he is the go-to person when there is a situation like doctor strong or code gray. Regardless of how great the regulation is on paper, if the workers don't feel safe and

empowered to use it, it's meaningless. He represents RNs at a mental health facility that are stabbed, beaten because they don't have enough staff. He feels the regulation is getting close to if someone gets a black eye and doesn't need more than an ice pack, it's not reportable to OSHA. Using terms like aggravated and non-aggravated, healthcare workers don't see the result because in reviewing, identifying, assessing and other terms used in the regulation, the final say doesn't seem to be given to the person it happens to. Employers downplay what happens on paper. He would like to see a quality assurance where employees determine what goes on the paper. He's been injured and what he felt happened wasn't reflected on the paperwork. With regards to subjective and objective, that gives the employer the opportunity to downplay the incident. He doesn't care what it's called, if it happens it needs to go on a log. Keeping psychiatric reporting from other facility reporting is also risky in that they're told every day that they should expect this to happen to them. If the litmus test is different for them, the risk is that it will happen again. He feels that the regulation would enable him to report a dangerous situation and remove himself without his employer can't say he's abandoning his patient.

Maxine Davidson said a retired nurse told her stories about working short staffed as a nurse in the OR, where a psych nurse she relieved was bludgeoned with a telephone, having to work with rival gangs in multiple rooms, dealing with gang members interfering with a patient's care, coming to work in the middle of the night in dark parking lots, empty corridors and stairways.

Katherine Hughes suggested in (c)(2)(F) including community based risk factors because for a lot of healthcare workers, the parking is offsite when they have to go to work. And there are home health care workers, community workers that have to work out in the community so part of what needs to be considered is where they're providing healthcare. She also suggested in (c)(2)(F)1.a. adding the language "Working in a condition isolated" from other areas, due to factors such as "working alone." An employee might be working in one room where another may be working two doors down and the employer might not consider that as isolated. She also pointed out (c)(2)(f)1.d. that although use of outside areas during darkness is probably higher risk than other times of the day, they would recommend deleting "during darkness" so as not to exclude incidents that occur during the day. In AB 1083, grounds and parking areas were listed and there was a really good description of places outside the facilities so we should look at that to give us a good idea of what outside area means such as grounds, parking lots, or even somewhat remote like remote parking.

Michael Bossio said he has worked in different types of acute care settings and in the prison system with inmates, psychotic inmates. There were times working in the prison where he felt 10X more secure than in private sector and community hospitals. He felt that the language should hold the employer to a standard that is higher than what we have now in order to protect nurses from violence. He felt more secure in a prison setting because the goal of the staff and administration was his security and the care of the patient. We should make the security of the nurse more of a priority as well as the security of all healthcare workers.

Ingela Dahlgren spoke about the death of Donna Gross, who was strangled by a client at Napa State Hospital mentally insane and dangerous individuals. Alarms didn't work when going from one building to another. She was going to take a break and the client was hiding behind bushes and she pressed her alarm which indicated mistakenly that she was in dietary. They are told that when Donna was laid to rest, management told her husband that "you know what she was getting into." That goes back to the comment that it's not in my job description to get dead. She stated that we need to protect all our patients, and all our healthcare workers, our visitors on the grounds, in the clinics or wherever we are. There needs to be accountability for people that spit

on workers, pull their hair, kick and basically abuse workers. There can also not be abuse tolerated on already weak and sensitive patients.

Richard Negri said hearing these stories show there is a need for something to be established. There are mechanisms of prevention. When they reviewed Donna's case, they felt that every moment that lead to her death was preventable. Who failed, was it Donna, the place she worked, the patient? Who cares who failed? Who's responsible for putting in the mechanisms of prevention? That's why we're here. It's for Donna and the lady in the hospital that's been in a coma for one year after being beaten so brutally on the job in Brooklyn. Richard suggested additional wording in (c)(2)(I)1. Procedures to ensure that sufficient staff "for each shift, including managers or supervisors," trained in appropriate disciplines, is "assigned and" available to prevent and respond to workplace violence incidents. He also suggested adding in (c)(2)(J) "effective" before Procedures for post-incident response. SEIU also has extensive comments about (c)(2)(J)8. The information collected… shall be recorded in a Violent Incident Log. They have suggestions on what information should go on a log and will provide that in writing to the Division.

Tami Olenik said she accompanied a male colleague to the administrative office to report a threat of physical violence which took place in the men's room and he went in to report it. They got no help there so they decided to go to the Sheriff's Dept so administration called the Sheriff. Her administrator detained the Sheriff for 45 minutes keeping him from coming and addressing what they felt was an urgent situation since the offender was still on campus. They're not getting cooperation from administration and there was discussion that they would remove the metal detectors from the entrance to the facility because it wasn't friendly. She's also had an administrator block her exit from an office holding her hostage that she had to report because she was horrified. There are a lot of things on campus and administrators have blinders on and they're not listening. It's going to take this legislation and everyone in the room to rattle cages and address these things.

Denise Duncan said she is Executive Vice President of United Nurses Association of California/Union of Health Care Professionals, representing over 24,000 nurses and health care workers in Southern California, commended everyone that is here. One thing we've not touched on today is the subject of bullying. When she hears discussions about aggravated and non-aggravated, objective and subjective, these are difficult labels to attach to bullying. Their office brought in 2 years ago one of the nation's leading experts on bullying, Dr. Gary Nami so that they could understand and assess the behaviors around bullying because it's causing a rise in Workers' comp. Five years ago, she represented a gentleman who was being bullied in the workplace who had reported it over and over again. No one could believe that a gentleman close to 300 pounds could be bullied. There's a lack of understanding on the subject of bullying and behaviors of bullying are unique to every setting whether it's home health or the NFL. They've been clearly identified and not catching on in this country to the degree we need to take it on. It causes post-traumatic stress syndrome. It is an act of violence and she does not want this subject to get lost in all the work we do around training, reporting, policies and procedures and all the things we're attempting to design here today to make an effective plan going forward.

Scott Byington stated that some hospitals have a 24-hour visiting policy so they have the same amount of traffic at night as there is during the daytime. His trauma center receives 46% of all the penetrating wounds in the state. They get patients that come in already bullying patients because of where they come from or their lifestyles. They bring in their family, their rival gang members and their gang buddies and scatter throughout the medical center. There are six security officers and if there's one incident, they all go to one place leaving all the exits and

entrances non-controlled. The hospital has had numerous incidents – 3rd floor ICU where windows were busted by a patient who threw a chair out and tried to jump out, but not before he started beating on another patient. Three nurses who tried to help him were injured. There was a patient who came into the ER and brought 3 more gang members with him. They were all shot, they were drop-offs, two went to the OR and one as left in the ER for them to try to revive. When they turned around there were rival gang members standing right behind them in the trauma bay with no security. This is not an uncommon occurrence in medical centers. Administration does everything they can to not provide adequate security. There needs to be legislation and a policy that holds hospitals accountable. Some countries have laws where patients and their families are escorted out of the hospital if they have tried to hurt healthcare providers. In the state of Texas, there's a plaque in each emergency room that says if you threaten a health care provider, you are escorted out and you may get fined or go to jail or both. It's common sense and it needs to stop. Listen to the people who are taking care of the patients.

Jennai Arrias stated that a perpetrator ran past the night guard at Olive View Medical Center and stabbed her friend and colleague over 30 times. She visited her friend in the ICU and each night they still had only one guard at the entrance. They didn't care about the impact it had on her colleagues.

Jonathan Besnick stated that this room is full and overflowing out the door with nurses, security, and ancillary staff. These are the people that are doing the work and that are in harm's way. If the administrators were truly concerned about their safety, they would be here in droves. Health care workers look to the Division for help and support, for legislation, rules and regulations that support their safety. If the Division cannot do that, who do they turn to? Everyone has told stories of violence and intimidation and threats. They have legislation holding them accountable for how they take care of patients. They can't do that in the environment that they have right now so the regulation needs to be as broad and all-encompassing as possible so they can do their jobs.

LUNCH

Bob Nakamura reconvened the meeting, thanked attendees for their morning comments, and stated we will need to move through specific comments about what's drafted. He also requested a friendlier environment and asked that commenters refrain from directing their comments at other commenters so that they don't feel too intimidated to participate.

Bob asked for comments on the (c) Workplace violence prevention plan and stated that the Plan requires involvement of the employees in each specific unit for making the evaluation, assessments etc.

Gail Blanchard-Saiger stated that the challenge in (c)(2)(G) is doing this type of evaluation for every patient and what that would look like. She also referred to procedures for visitors and would that require hospitals to stop them and do an assessment? Bob asked for ideas from stakeholders.

Frederick Huicocha suggested the use of metal detectors and training for security personnel to assess individuals. Bob asked whether it's true that not every hospital has someone stationed at a door – the attendees were in general agreement. So he concluded that metal detectors wouldn't be helpful in those hospitals.

Katherine Hughes commented on (c)(2)(G) and stated that in almost every healthcare setting there is some kind of patient assessment that is done, so part of it can be done while assessing them mentally and for psychological, educational needs. Assessing patients for risk factors can be done while computer or paper charting is done because she charts what they're doing psychologically, if they become confused or disoriented. There are places where we can put that. Regarding procedures for visitors, she commented that when she worked there employees had name badges that they would swipe to access elevators to areas of the hospital. Visitors would have to stop at the front desk and exchange keys or a driver's license for a visitor's pass that would give them access only to the floor they were going to. Now visitors no longer have to check in at the desk, no longer need an access code or card to get on the elevators. The only place that is locked is the maternal child area for child protective reasons. It doesn't have to be a metal detector, but it could have prevented the patient from being brought in with a gun in the shooting that happened a few weeks ago. There are things that can be done and the Division isn't going to dictate what those procedures are. The hospitals, clinics, etc. are going to determine that and they should be the ones doing it. The employees and unions are going to be part of figuring out what the solutions are. But if something happens, and a complaint is filed and the Division investigates, then procedures can be looked at to see if they're effective and if they're best practices based on experience. The patients are not the problem, it's the system and the lack of procedures and a plan.

Lisa Hall said she represents California Association of Health Facilities (CAHF), for long term care, skilled nursing facilities, and intermediate care facilities for the developmentally disabled. Metal detectors would not be practical in their settings which are home-like environments. They also can't restrict who's coming to visit because they have a more open type setting. They would be developing policies and not necessarily have security guards or metal detectors.

Elissa Brown stated that the VA has a flagging system for high-risk patients so that people would know and you don't need a whole lot of information. They also set up a multi-disciplinary safety inspection team to go on rounds, weekly or twice a month, with the staff on that unit to look at all the possible problems and safety. Engineering was also there so they could do something about the problems. When she teaches about safety plans, she talks about having a plan for yourself so that you know how you might respond in a situation and get yourself prepared in the unit so that it's very specific and everyone's on the same page. So the agency knows what kind of support it's going to give if there's an incident.

Jonathan Besnick stated that the idea of not being able to control visitor flow is ridiculous. The administrative offices in his hospital are locked, but everywhere else where nurses are, are accessible.

Steve Pitocchi said SEIU Local 1021 represents employees from environmental services to nurses and classes in between. He stated that the solution is about communication, which includes raining. Huddles for certain classes don't include environmental services. If there is a huddle in environmental services it doesn't include a briefing on violent patients, so employees go on to ER, ICU and other places and they have a potential for being harmed. They want all of their classifications to be part of the solution and not caught in the middle of the problem. If everyone is not included in the conversation regarding workplace violence, then it will continue to get worse. The employer needs to be held accountable to make sure those communications are happening.

Elsa Monroe stated that assessments in home health are done in their environment. There are demographics which indicate areas with increased violence, and they need security when going

to high risk areas. She doesn't understand how that can be so abstract. Without bodily, physical security to protect them, nurses will continue to die and be incapacitated. She told a story about a nurse in a correctional setting that was attacked by an inmate who choked her and banged her head on the courtyard floor while she was on a lunch break, not knowing that there weren't any armed custody officers watching over potentially violent inmates.

Richard Negri said he feels that in (c)(1) the Plan "shall" be maintained as a separate document because it will be site specific, unit specific and facility specific. He also recommended adding "unit" in (c)(2)(F) to be as site specific as possible in identifying and evaluating environmental risk factors and in reviewing workplace violence incidents.

Bob Nakamura asked for additional comments on assessment procedures in (c)(2)(F).

Brendan White stated that nurse and other staff perform patient assessments and that placards are placed on the door if a patient is a fall risk and maybe these can be used in the context of workplace violence. Nurses have strong intuition and if they have fear or concern about a patient or their family members, there has to be a way to indicate that to management and for management to behave appropriately, and not just business as usual that they understand the nurse is afraid of the patient. There has to be a way for the nurse to summon assistance that is contemplated by the regulation and to make sure that the plan actually gets put into effect. Healthcare workers have to be able to rely on management to respond appropriately when a patient or family member has been assessed as a high risk group for violence.

Elsa Monroe stated that when she worked at the old ER in Highland Hospital employees could see each other, and see patients coming in on meth and those having seizures from withdrawals from alcohol. Then they transferred to the new facility. She was discharging a nine-year old patient and the mother was insisting he had asthma after being ruled out and was so angry because she wanted to qualify her son for a disability. The mother had caused a fire by lighting paper towels in the treatment room. Ms. Monroe called for help, but the sheriff was busy in another area of the hospital and when they finally came they couldn't do anything about it. She feels there needs to be more security and more sheriffs available. It's not about alarms, it's about prevention.

Brad Vandersall said he is a nurse educator, UC San Diego Health System, and studied extensively on workplace violence and behavioral health in ERs and there are very good tools for assessing and predicting workplace violence, but not med surge and critical care areas. There is a small study by Dr. Kim in San Diego where she predicts workplace violence from patients and wanted to know as a researcher if there are funds available to expound on that tool specifically in med surge areas. Bob asked Mr. Vandersall to send him and e-mail so that he could explore that in the Department.

Gayle Batiste commented on training (d) and asked about training existing employees that have not yet been trained. In her facility there are employee badges but they don't register outside their immediate department. They have a code gray (violent act) going on in their med surge units every day, so they need to be included on the training and not just behavioral health and emergency. If all employees understood what to do if someone is trying to attack them or how to deescalate a patient, it would be helpful and maybe not get to the point where somebody is injured.

Katherine Hughes suggested the following changes to (d) Training:

The employer shall provide training to all employees in the facility, “unit,” service or operation, including temporary employees. The training shall effectively address the workplace violence hazards identified in the facility, “specific unit, service, or operation,”…
She also suggested in (d)(1)(C) Frequency of training:
(C) Employers shall provide additional training when new equipment or work practices are introduced”, or when a new, or previously unrecognized, hazard has been identified.” The additional training may be limited to addressing the new equipment or work practices” or hazard.”
She gave an example of sending out an e-mail blast to alert employees of areas closed off from construction work that creates a visual block. She gave another example of a county jail that had a practice of lining up inmates to bring them from one place to another, where an inmate stepped out of line and assaulted a nurse walking by. The facility hadn’t anticipated that as a recognized hazard but immediately enacted a policy and trained employees to take inmates around and not through areas occupied by workers.

Richard Negri suggested a walkthrough of an environment where there are known violent incidents that have occurred to identify ways to get between the violence and the worker. When he was interviewing as a visitor at Harbor UCLA, he observed there were no mirrors in a known violent area which made him nervous. It’s simple to do, but if there isn’t a formal plan to assess the environment, it’s a busy facility and easy to overlook.

Elsa Monroe commented on frequency of training requirements in (d)(1)(B) that bullying should be covered and not only while performing patient contact activities and that management should be made aware of how economics are affected by it.

Gail Blanchard-Saiger stated there was a bill passed last year requiring that harassment training be conducted every couple of years including abusive conduct and that there were discussions in previous advisory meetings about whether bullying constitutes workplace violence. She stated that it was Government Code 12940.

Elsa Monroe gave an example of a nurse with auditory dyslexia that experienced a hostile work environment where a supervisor mimicked him and stated this is why we need training every year.

Gail Blanchard-Saiger met with a number of hospital administrators who are present at the meeting and are interested in collaborating on this issue. She commented on (e) reporting requirements and that one administrator mentioned the possibility of a potential inconsistency on reporting obligations for serious injuries and that there may be duplicative reporting obligations.

John Consoli stated that Atascadero Hospital has done workplace violence management for 25 years and in addition to reporting to the Division, they send out an SIR which tells them incidents of violence that’s occurred in units and to supervisors. He’s done sick calls and checks to see which units are hot (has assaults) before he goes there. E-mail works well and the shift leads will notify staff is something is going on a sister unit they’d have to respond to if there’s a violent event.

Erik Eggins asked if the 24 hour reporting requirement in (e)(1) starts from the time of the incident because sometimes incidents happen on the weekend or after hours and the hospital may not be aware of it. Bob stated that the Division’s understanding is that the reporting is from the time of the occurrence and that it is an issue if the hospital doesn’t know if an incident has

happened. That's all part of this regulation, trying to create a system so that you don't have a big lag time in finding out about an incident.

Jonathan Besnick stated that hospitals should be proactive and tell the nurses that they need to know about everything that happens to them that's related to violence. They should have an open door policy so they can make workplaces safer and not have any confusion about the 24 hour reporting requirement.

Steve Pitocchi stated that the entire department of a hospital is responsible for reporting incidents so despite the fact that someone may not have filed a workers' comp claim or filed a complaint with OSHA, anyone on the department floor or visiting the department floor from somewhere else in the hospital should be reporting through an incident report system. That mitigates most of the confusion over what happened. If you hear it or see it, you must report.

Brendan White commented that the definition of reportable workplace violent incident is problematic because it only includes those that involve physical violence or the use of a weapon. There are plenty of incidents of workplace violence that nurses and healthcare workers go through in a day that don't meet this definition such as bullying, which is psychological violence. He feels that many of the concerns that workers are addressing could be solved by the reporting requirement because hospitals don't want to report their mistakes and many incidents of workplace violence involve mistakes. He also stated that this definition is inconsistent with the statute. Bob asked Mr. White to send the Division his comments about being inconsistent.

Cindy Conner agrees about the 24 hour reporting requirement. She gave an example of an employee that was a victim of sexual assault and didn't report for several days, so the supervisor and administration wasn't aware of it. There will be exceptions such as this where she feels administration shouldn't be held accountable and to consider when it's presented to administration or a supervisor. Bob stated that the Division appreciates when these things happen but the legislation was written the way it was.

Erik Eggins commented that it will be difficult for health facilities to train every 90 days as required in (d)(3)(B) and that the timeframe in (d)(3)(A) and (B) should be looked at.

Richard Negri suggested that reporting be on the agenda for the next advisory meeting so that folks could do additional thinking about the subject and come back with suggestions. Bob stated that is a good idea.

Cory Cordova said on the issue of reporting stated that sometimes employees don't know what their rights are when things happen. He doesn't think we should lessen the 24 hours, and there shouldn't be a caveat where an employee doesn't get to report it if it's beyond the timeframe.

Jonathan Besnick agreed with the idea that sometimes there are going to be extenuating circumstances that may extend the time of reporting like nurses in a coma. It's not reported in 24 hours because the employee is comatose or injured, or scared of what he/she went through, or doesn't know his/her rights. Hospitals should require employees to report as soon as possible if they are aggressively threatened, intimidated, battered, hurt or attacked so they can act appropriately and make reports. When he report incidents, he is questioned or they turn a blind eye, and police discourage reports because a patient is on a 5150 etc. Hospitals need to know they all need to take accountability.

Michael Musser asked if we have to use the reporting requirement in SB 1299. Bob stated that it is and it has to be in the regulation that way.

Elsa Monroe spoke about a nurse who revealed in a meeting of nurses in her local section that she had been violated by an inmate and was ashamed and embarrassed. The facility used a buddy system and there was a glass partition where her buddy told her he was keeping an eye on her. She walked past a room that was dark, heard the commode flushing and was grabbed by an inmate/patient. Her buddy called officers for help and she was wearing a belt so that prevented her from further assault but she still suffered from post-traumatic stress and she had to have psych meds and counseling.

Jennifer Gabales said she is with the California Association for Health Services at Home (CAHSAH) and represents home health and hospice providers. She commented on initial training requirements in (d)(2) and doesn't see training for employees on how to report an incident. She feels if employees are educated on what the process is and how to report, there will be more incidents reported and hospital administration will be able to report them to the Division.

Richard Negri suggested that in (f)(4) records also be made available to "the National Institute for Occupational Safety and Health, the California Department of Public Health, and the local health officer" for examination and copying.

Tami Olenik stated that bullying is acts of aggression that go on forever. They don't stop unless the person removes themselves from the environment or somehow they're set up and terminated. There are unwarranted, invalid criticisms that go on daily, blame without actual justification, being treated differently, being humiliated, and socially isolated. She spoke of her personal experience where she was asked to work in a storage room with the door shut, her colleagues told not to speak with her, and she surgeons she worked with for over 10 years were told that she no longer had the authority to talk to them. There are acts of micromanaging that go on, they're given work with unrealistic deadlines, and work in different physical locations that are impossible to do. She takes pride in her work and cares for indigent people, but this has been the worst horrible attack where she feels like she's in a war with someone and there's no just cause for it. This has happened to some of her colleagues and sometimes they are so anxious they have to use a brown paper bag so they continue to breathe. She's never in her life been subjected to something so horrific and of all places in a healthcare setting where they're supposed to be concentrating and advocating for other people. She hopes that bullying will be put in the regulation.

Elissa Brown agrees that this is a healthy work environment as well as an ethical issue to prevent. It is a kind of violence and she is wondering if there's language that can be put somewhere addressing this as a lateral violence, acknowledging that it exists and it affects the safety of the institution of the individual.

Grace Corse echoed Ms. Brown's comments and feels that the document has very little about the issue of bullying and it needs to be emphasized. It is rampant in every facility in Los Angeles County and probably in the private sector too. She urges the Division to take it into consideration in the reporting, in the training, that there be information and regulations concerning the act of bullying.

Katherine Hughes stated that Ms. Olenik's experience was one of the reasons why SEIU supported the OSHA definition of workplace violence because it talks about harassment,

intimidation, threatening behavior and disruptions in the workplace. That's also why they suggested adding in the typologies and spent a lot of time in the first advisory hashing out the definition and the typologies and these are perfect examples of why that needs to be in there. We can use that definition for the extreme examples of workplace bullying because there's intimidation involved in that. It would be awesome to not only be the first state to do a workplace violence regulation in healthcare, but also has some anti-bullying built into it just by way of using that definition and the typologies.

Dierdre Kirkwood stated the importance of keeping those definitions and making sure it's broad enough to encompass bullying. Employers, hospitals, healthcare providers have been working on this for a while. They all have anti-harassment language and do anti-harassment training, yet the bullying continues. The bullying is often sanctioned or perpetrated by management or administration and the employer is not being held accountable for keeping the work environment safe and harassment-free for the employee. As a union representative, she has been representing an employee for over a year who continues to experience the same things and it shouldn't take a year to solve a problem like this. She wants to make sure this is part of the Plan because bullying is a much larger problem than anyone of us wants to believe.

Jorge Cabrera stated that on behalf of all the workers SoCal COSH represents including health care workers, they support all these pleas and calls for making sure they are protected against bullying not only for the workers' perspective but also for the patients. A lot of patients don't feel safe when they go into facilities where they see a nurse being bullied and it boils down to quality healthcare. It's the employees that are responsible for transferring that quality healthcare to the patients, so if we don't keep them safe from bullying we're not going to feel safe either. A lot of things we do we lead as a state, the rest of the nation looks to us for guidance for a lot of things including worker protection, so he urges everybody in the room to take that under consideration and make sure there is protection against bullying.

Bob Nakamura talked about the next steps and stated that we received an extensive number of comments today. Over the next 3 weeks, we'll be looking at the draft, see what the comments deal with and then try to make adjustments as we can. We also anticipate getting written comments from which we'll also review. It's a fairly intensive process to revise our draft and get it back out stakeholders. The next meeting will probably be at the end of March or early April in Oakland. He thanked the attendees for their participation and help with the rulemaking project and advised them to keep looking at the Division's website for changes, announcements, and minutes to be posted. He stated we will send out another email when we have something concrete and then adjourned the meeting.