Testimony of
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Hearing on "Safe Care Act"

Maryland House of Delegates
Economic Matters Committee

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Good afternoon Chairman Davis, Vice-Chair Dumais, and members of the Economic Matters Committee.

My name is Jane Lipscomb. Thank you for this opportunity to present my views on the compelling need to better protect frontline workers from workplace violence in State –operated hospitals and residential centers. The proposed amendments to the Safe Care Act do just that.

My training is as a nurse and epidemiologist. I have spent my career-including the past two decades as a Professor of Nursing and Medicine at the University of Maryland - researching and addressing the hazards facing the health care workforce. Among the hazards that I have studied, few have received less attention than workplace violence. This is despite the fact that this workforce experiences a higher number of non-fatal assaults than any other worker group. And let me be clear, I am not talking about the random acts of violence that get much media attention. I am referring to the systemic acts of violence that occur every day in these workplaces, that are

predictable and therefore preventable. The good news is that we know how to prevent much of this type of violence.

Health care workers want to provide the compassionate and professional care that patients deserve, but such care is compromised when steps to prevent workplace violence, as described in the amended legislation, are not taken.

In the course of my work I have conducted federally-funded research into how to prevent workplace violence in hospitals and other high-risk settings. In addition, I have consulted with numerous state and federal agencies, including the State of Maryland, on how to advance workplace violence prevention. The risk of workplace violence that I am most concerned about arises from exposure to individual patients, their family members and visitors, who sometimes are violent, in combination with a lack of sufficiently strong violence prevention programs. Patients, especially those in hospital and residential settings are often in treatment because they are a danger to themselves or others; and once in a residential setting, exhibit violent behaviors related to their illness or treatment. They may not “intend” to assault their caregiver, but regardless of intent, an employee is still injured (often both physically and emotionally).

While I believe that patient rights and confidentiality are important and must be respected, health care and social service institutions also need to recognize that workers in these facilities have a legal and moral right to come home safely at the end of the day. My experience

and research show that both concerns can be reconciled by the proposed amendments to the Safe Care Act.

The proposed legislation requires that covered workplaces develop, implement and evaluate a Workplace Safety Plan that is established and administered by a Workplace Safety Committee, made up of an equal number of management and non-management employees. This is vitally important because front-line workers know their patients and their behaviors best, and as such, are critically important to developing plans to prevent violent behaviors.

My first encounter with a victim of workplace violence occurred while I was working at UCSF in Northern California. Two physicians from a State Psychiatric Hospital in Napa, CA (one who lost his sight in one eye and another who suffered a punctured lung) requested to meet with me after reading a journal article I had published in 1992, describing workplace violence as an occupational hazard amendable to public health interventions. At the time, workplace violence was considered a criminal justice issue and handled as such. Since meeting with the Napa State Hospital physicians, I have heard personal testimony from hundreds of workers who have dedicated their lives to caring for the health of the public, yet suffered serious and even career-ending assaults.

Today, workplace violence is one of the most dangerous occupational hazards facing health care workers. This is in part because of the lack of attention to the prevalence and severity of workers' injuries,

but also because of the failure to recognize workplace violence as a public health problem amenable to an occupational health approach to prevention, as well as the view that working with individuals with cognitive impairment, mental illness or a tendency towards violent acts "is part of the job" [1] [2].

I am here to testify that workplace violence prevention plans, tailored to the specific risk, workplace and employee population work. Deep employee involvement in the form of the proposed Workplace Safety Committees are in my opinion and experience, the only way to successful address the risk.

Evidence that workplace violence prevention plans are feasible and work includes research from Wayne State University, the Veteran Health Administration and others, as well as my own.

My research focused on the feasibility and impact of OSHA's Guidelines using a non-experimental intervention design focused on three state-run in-patient psychiatric hospitals in New York State. This research provided evidence for the feasibility and positive impact

[1] Lipscomb, J.A., Rosenstock, L. (1997). Healthcare workers: Protecting those who protect our health. *Infection Control Hospital Epidemiology,* 18: 397-399.

[2] Lipscomb, J.A., London, M. (2015). Not Part of the Job: How to Take a Stand Against Violence in the Work Setting. American Nurses Association. Silver Spring Maryland.

of comprehensive violence prevention program in the in-patient mental health workplace[3] (Lipscomb, 2006).

Evidence from a randomized, controlled intervention study (the "gold standard" in research methods), published in 2017 by researchers at Wayne State University, demonstrates that a data-driven, worksite-based intervention based on the OSHA Guidelines was effective in decreasing the risk of patient-to-worker violence-related injuries by 60%, 24 months following the intervention[4] (Arnetz, 2017).

House Bill 1568 focuses on employees, but a well-recognized benefit of such a regulation will be enhanced patient safety. This is especially true in State hospitals and residential centers where patients frequent experience assaults perpetrated by other patients. For example, when there is an insufficient number of qualified staff to meet patient needs, they act out not only towards caregivers, but also other patients. Ask anyone who has a family member or friend who required in-patient mental health services.

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[3] Lipscomb, J., McPhaul, K., Rosen, J., Geiger Brown, J., Choi, M., Soeken, K., Vignola, V., Wagoner, D., Foley, J., Porter, P. (2006). Violence prevention in the mental health setting: the New York state experience. *Canadian Journal of Nursing Research,* 38(4).

[4] Arnetz, J.E., Hamblin, L., Russell, J., Upfal, M.J., Luborsky, M., Janisse, J., Essenmacher, L. (2017). Preventing patient-to-worker violence in hospitals: Outcome of a randomized controlled intervention. *J Occup Environ Med*. 59(1) 18-27.

House Bill 1568 is a clearly written, straightforward piece of legislation that would do much to stem workplace violence. I urge this committee to act on this important bill.

Thank you and I would be happy to respond to any questions.