PA 11-175

SB0970

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| House | 9506-9552 | 47 |
| Public Health | 354-356, 462-501, 565-604 | 83 |
| Senate | 5010-5014, 5122-5123 | 7 |
| | | **137** |

**H – 1119**

# CONNECTICUT
# GENERAL ASSEMBLY
# HOUSE

## PROCEEDINGS
## 2011

**VOL.54**
**PART 28**
**9295 – 9634**

THE CLERK:

On Page 31, Calendar 615, Substitute for Senate Bill Number 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESOPNSE IN HEALTH CARE SETTINGS. Favorable Report of the Committee on Judiciary.

DEPUTY SPEAKER ORANGE:

Representative Ritter, you have the floor, madam.

REP. RITTER (38th):

Thank you, Madam Speaker. I move for acceptance of the Joint Committee's Favorable Report and passage of the Bill in concurrence with the Senate.

DEPUTY SPEAKER ORANGE:

The question is acceptance of the Joint Committee's Favorable Report and passage of the Bill in concurrence with the Senate. Will you remark? Representative Ritter.

REP. RITTER (38th):

Yes I will, Madam Speaker. Madam Speaker, this Bill requires certain healthcare employers to develop and implement plans concerning workplace violence prevention and response.

It requires those healthcare employers to report incidents of such violence to local law enforcement

and establishes a criminal penalty for assault of a healthcare employee.

Madam Speaker, the Clerk is in possession of an Amendment, LCO 8099, and I would request that the Clerk please call the Amendment and I have permission to summarize.

DEPUTY SPEAKER ORANGE:

Will the Clerk please call LCO Number 8099 designated Senate "A".

THE CLERK:

LCO Number 8099, Senate "A", offered by Senator Gerratana and Representative E. Ritter.

DEPUTY SPEAKER ORANGE:

The Representative seeks leave of the Chamber to summarize. Objection? Objection? Seeing none, Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Chairman. This Amendment simply expands on the definition of healthcare employee, giving a little more specificity from it, from the underlying Bill.

I urge adoption.

DEPUTY SPEAKER ORANGE:

The question before the Chamber is on adoption. Will you remark? Representative Ritter. Will you remark further?

REP. RITTER (38th):

I urge adoption on the Amendment, and I will then be happy to entertain questions on the Bill as amended.

DEPUTY SPEAKER ORANGE:

Okay. Will you care to remark further on Senate "A"? Representative Perrillo.

REP. PERRILLO (113th):

Madam Speaker, thank you very much. This issue had much discussion before the Public Health Committee, and I'm just trying to get a handle on exactly who else we have included, excluded for that matter, in the definition of healthcare employee.

The original language referred very specifically to individuals employed by a healthcare facility.

This changes over to individuals directly or indirectly employed by. I am wondering what the word indirectly refers to? If the Chair could answer that, through you.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. That could happen through a contract with the employer.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker. So this would be situations whereby you know, perhaps there was a nurse staffing agency, travel nurses, things of that sort. I would imagine perhaps physicians who are not employed necessarily by the hospital but who have privileges there. That is a little bit of a different relationship and they're not, there's no direct contract with the hospital, but physicians do provide care in hospitals even though they may be in private practice, they are attending for patients within.

And I'm wondering if this language would include those physicians who don't necessarily have a contractual arrangement with a facility, but who do provide care within it. Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. The short answer to that is yes, and I would direct the Representative's attention on the Amendment to lines 5 through 9 where there is more specificity indicating that there must be an involvement with direct patient care or with the family.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Excellent. I had read that section and I appreciate the answer. I just wanted to clarify that indeed, because physicians don't necessarily have a contract, that they are providers and that they are included, and I think, I'm assuming that that does answer my question as to legislative, so I appreciate that.

That is my only question, I think. That clears up a lot of issues I had regarding the Amendment, though I will have questions on the underlying Bill, and I do urge support for the Amendment. Thank you.

DEPUTY SPEAKER ORANGE:

Okay. Thank you, Representative Perillo. Will you care to remark further on Senate "A"? Care to remark further on Senate "A"?

If not, let me try your minds. All those in favor please signify by saying Aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ORANGE:

All those opposed, Nay. The Ayes have it. The Amendment is adopted. Will you care to remark further on the Bill as amended? Representative Ritter.

REP. RITTER (38th):

Thank you very much, Madam Speaker. As Representative Perrillo indicated, this is the final product of a great deal of work involving the Hospital Association, representatives of workers as well as the patient and disability community around the state, Madam Speaker.

I would point out a few key points before we get to questions. First of all, we saw the definition of the healthcare employer, but I would like to point out this only applies to employers with 50 or more full or part-time employees, and that was a key point in the discussion, Madam Speaker.

Essentially it asks that these institutions establish a committee regarding, an ongoing committee regarding workplace safety. It specifies the

composition of the committee. A key point is that up to at least 50 percent must be composed of employees. That would be non-management employees.

It specifies the committee must meet and undertake a risk assessment. In many cases, Madam Speaker, these institutions already have ongoing workplace safety committees. The Bill clearly specifies that those committees may, indeed, meet the qualifications under this Bill.

In addition, a regular assessment of risk and recommendations are required.

The Bill goes on, Madam Speaker, to ask that the Labor Commissioner may choose to adopt regulations as necessary to carry out the purposes of this statute.

It does on to discuss records that must be maintained. I would point out there are no required reports to the Department of Public Health unless requested.

And finally, it requires that the employer report assaults to the appropriate law enforcement officials and that those assaults are qualified as a Class C felony and must be handled accordingly.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Care to remark further on the Bill as amended? Representative Perrillo.

REP. PERRILLO (113th):

Madam Speaker, thank you very much. If I may, through you, a few questions to the proponent of the Bill.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. PERRILLO (113th):

Thank you, Madam Speaker. Just to clarify. In lines 4 through 11 we refer to the definition of a healthcare employer. I do not see the specific word hospitals included in this. I know the intent, I understand the intent is to include hospitals, but just to clarify.

Does this indeed refer to hospitals as we know them in the State of Connecticut? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Madam Speaker, the answer is yes.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and I appreciate the answer from the Chair of the Public Health Committee.

Line, Section b, sub b, 14, on, refers to a workplace safety committee, and I would just like to get a better handle on exactly what that committee is charged to do.

Is it charged with the task of identifying problems that currently exist within a healthcare setting?

Is it charged with the responsibility to come up with solutions to those problems?

Is it supposed to be polling staff members to determine where problems may exist?

It is just a little bit vague as to what is required, and I'd like some clarity if I may obtain that.

Through you.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Yes, the Bill beginning on line 26 requires that this committee first undertake a risk assessment of the factors that

could put a healthcare employee at risk for being a victim of workplace violence.

But based on the findings of this assessment, Madam Speaker, on or before July 1, 2012 and annually thereafter, the committee shall develop and implement a written workplace violence prevention and response plan.

I would like to point out also, Madam Speaker, and you can see beginning in line 34, there is an opportunity for an institution that has a similar existing committee to use the work and structure of that committee, as long as it meets the 50 percent membership requirement.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and again, I thank the Chairman of the Public Health Committee for her answer. She did refer to a risk assessment. I am wondering if that needs to be a formal risk assessment that is generated in writing and then presented to the staff for review, presented to the administration for review, the hospital administration or facility

administration, I mean, or does it need to be presented to the Department of Public Health.

I just want to clarify to what degree of specificity and detail and formality the facility would need to go to in order to satisfy the requirement of the legislation?

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, the Bill is not, in my opinion, overly prescriptive as to structure or required formality.

What I would like to point the Representative to the composition of the committee, beginning in line 17 where it indicates that representatives from administration, physician, nursing and other staff, security personnel and in addition, any other staff deemed to be appropriate, as well as the requirement that 50 percent of the membership come from the employees.

If you examine the composition, I believe that the communication the Representative is concerned about will obviously be effectively performed.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Madam Speaker, thank you. And again, I thank the Chair of the Public Health Committee for her answers to the question.

If I could, just referring briefly to line 22, I understand the Bill does require that at least 50 percent of the workplace safety committee be composed of non-management personnel.

If the Chair could clarify as to who non-management personnel would be. What individuals within the facility would qualify as non-management?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, this Bill was put together with representatives both from the workers as well as hospitals and healthcare institutions and this to be honest, was their choice of wording.

The traditional definition of non-management employee I would expect would apply.

And I'm going to also speak a little bit to legislative intent here. You can see from the 50 percent membership requirement that the emphasis here really is on workplace violence and I would say threats or danger to staff to direct hands on patient care staff.

So I think when looking at non-management employees, it would obviously, that's the intent.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and just to further clarify. Would that include volunteers? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

One moment, Madam Speaker. Madam Speaker, as long as the definition of healthcare employee, which under the Amendment does indeed include volunteers. As long as that definition is met, I believe they would qualify.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker. And to go back to a question I had asked previously. We established that physicians may work at the hospital. They may not necessarily be employed by the hospital, but oftentimes physicians are in a bit of a (inaudible) role in that they oversee the work of nurses and other staff.

Would physicians in this case be considered management or would they not be considered management?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

One moment, Madam Speaker. I want to point the Representative to two places in the Bill, Madam Speaker in answering that question.

First, back under sub b where it is clear that the membership of the committee must include representatives from the physician unity and so that would be an opportunity for that particular representation to be accommodated.

But also, in the Amendment that we have adopted under the definition of employee, of course it's clear

that those individuals must be either involved in direct patient care or have direct contact with the patient or the patient's family, and so those members would have to meet those qualifications.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and I appreciate the fact that the physicians, indeed, would be included in the pool of individuals who could serve.

But again, just to clarify. Physicians do in some cases serve, in many cases serve in a managerial or supervisory role. Would having a physician on the committee come within the 50 percent non-managerial staff, or would they be considered managerial staff?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

One moment, Madam Speaker. Madam Speaker, I do not believe that is specified in the Bill. I would point out that certainly through intent of the discussion the role of the physician is perhaps different, but that does not mean that they are not

actively involved in and concerned with issues of workplace violence in these situations.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and I appreciate that. I'm simply just trying to clarify how a facility would meet the 50 percent threshold for non-management staff. I could see where, I mean, obviously physicians are providing, most physicians in a setting are providing direct patient care, but I'd like to try to give some guidance to any facilities out there that may be listening and interested.

And obviously, you know, just to further clarify, maybe through you there could be some clarification, I believe the Chair may have something that might shed some light. Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you very much, Madam Speaker. I would also like to point the Representative to sub f lines 66 through 68, the Labor Commissioner may adopt regulations necessary to carry out the purposes of

this section, and I think that would be a very appropriate designee to come from the, appropriate distinction to be made in those regulations, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and I agree that would be appropriate place for those decisions to be made. The word there, though, on line 66 in sub f is may. It is not shall. So in the instance of the Department of Labor does not come up, you know, and chooses may rather than shall and chooses not to actually move forward with regulations. I'm just trying to clarify.

But if they are, indeed, to move forward, we could perhaps offer some legislative intent to the Commissioner of Labor.

And it is worthy also to mention that not every physician, a is not b is not c. There is a difference between an attending physician, a resident, even an intern, a student may be different, and in some instances a physician may be management. In some instances a physician may not and if regulations are indeed adopted, I would hope that the Commissioner

would take those variations and subtle differences into consideration.

If I could move to line 39, this refers to the development of a plan that the employer would put into place, and I'll just read very, very briefly.

In developing the plan the healthcare employer may consider any guidance on workplace violence issued by any government agency including the federal OSHA, et cetera.

Oftentimes we see including but not limited to. In this case we just include, we just see the word including. So does that mean that only those federal agencies listed here would qualify, or are there others that might qualify, and just briefly it lists OSHA< CMS, DPH, Labor Department and any hospital accrediting organizations.

There are, indeed, other organizations that may have some sort of model guidance, but because we used the word including, I'm uncertain as to whether or not they would be included or not. Through you, Madam Speaker, if the Chair could clarify.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Chair. Madam Chair, it's my understanding that when you look at, back up a little bit to starting on line 36 it's clear that they may consider guidance from those agencies, and it's more than simply OSHA. It goes on to ask, to specifically mention both the federal centers for Medicare and Medicaid studies, the Department of Public Health. In addition, the Labor Department as well as hospital accrediting organizations.

But again, that is permissive and there is nothing in the Bill that would not prevent consideration from other sources.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and I appreciate that. I'm just wondering in certain instances the American Hospital Association may not necessarily be an accrediting organization.

If a hospital were to utilize model language from the AHA, you know, because it does say may, would that mean that DPH would rule that the plan that was put together was not the appropriate, because an

organization not listed in the legislation was utilized.

And my understanding is that indeed, no, DPH would be supportive, likely be supportive provided the plan met the guidelines contained within. And just to clarify, is that correct?

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

That is also my understanding.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and again, I thank the Chair of the Public Health Committee for her clarification.

If we can move on to sub e, which begins at line 50, this refers very specifically to patient care assignments.

One of the concerns that we heard in Committee from the hospitals was that giving employees the option of not providing care to potentially violent patients who had in certain instances perhaps threatened harm to the employee, may compromise the

hospital's responsibility to provide care to all patients.

So in this instance it says that a healthcare employer shall, to the extent practical, adjust patient care assignments so that no healthcare employee who requests an adjustment to his or her patient care assignment is required to treat or provide services to a patient who the employer knows to have intentionally physically abused or threatened the employee.

Again, as I said, some of the concern was that patients could be left without the proper care that is required, and that is actually demanded by law.

What is the intent of this? Is the intent to, I just want to clarify that there is no intent to leave patients in a situation whereby they are not provided the care that they require. Is that correct?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Through you, Madam Speaker, that is correct.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker. If we can move to Section 2, which begins at line 69, it states a healthcare employer shall maintain records, which detail incidents of workplace violence, and the words workplace violence occur, appear in a number of sections within the Bill.

So just a very quick question. There is no definition of workplace violence within the Bill. So if for legislative intent the Chair of the Public Health Committee could give us some examples, perhaps not, including but maybe not limited to, what would classify as workplace violence. Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Yes, I would point the Representative to the discussion that begins a little further along in discussing assaults, beginning in Section 4 line 90, and it's clear from the structure of the Bill that workplace violence certainly would include all and anything that would fall under that definition of assault.

In fact, there very well may be, and are ongoing acts that perhaps don't quite fit that definition that would qualify as workplace violence.

Workplace violence is sadly, very sadly, a growing concern, growing frequency in healthcare settings. We've had some regrettable incidents in the last few years that really have served as the impetus for this Bill.

I would point out to the Representative that he may be aware as well, that these institutions regularly maintain incident reports of a variety of nature and detail that provide the information essentially that is required in Section 2. They may go by different names and different institutions, depending on the structure of their ongoing employee rules and procedures, as well as any existing workplace safety efforts they've already initiated, and those would also be the basis for the compilation of this information. Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and I think that does provide some clarity and some guideline as to what workplace violence would be.

Section 4 sub a is very, very clear as to what is included, so that is some very good guidance and I appreciate that.

If very briefly, we could stay, you know, go to Section 3, specifically line 83. The Bill refers to a timeline by which the employer needs to notify, or needs to generate a report.

Just to clarify. It says 24 hours after the occurrence of the act. I can envision there might be circumstances whereby the facility is not even notified within 24 hours of the occurrence.

Is the intent to penalize, the intent of the legislation to penalize the employer in those instances where they have not been notified in a timely manner, or is it expected that DPH would make some sort of allowance for those situations whereby notification did not happen within a 24-hour period, or quite frankly, happen within 22 hours.

I imagine the facility would not need to do what they need to do within two hours. They would be given

24 hours ample and appropriate and practical time by which to get the work done. Is that the intent?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Perrillo.

REP. RITTER (38th):

Thank you, Madam Speaker. The Bill does not mention the opportunity for any such penalty.

DEPUTY SPEAKER ORANGE:

Thank you, Representative Ritter. Representative Perrillo.

REP. PERRILLO (113th):

Thank you, Madam Speaker, and again, I thank the Chair for answering the question.

I understand, and we heard very compelling testimony in Committee during the public hearing. You know, this does arise from a few instances, but one very, very specifically at Danbury Hospital, a very, very tragic and unfortunate one.

It is very clear that healthcare providers are going to put in harm's way, they are frequently put in harm's way. This is one way to address that risk, which is ever present, and the fact that this was a very collaborative effort not only within the employee

community and healthcare settings, but also within the Connecticut Hospital Association and those other associations that represent these facilities.

This, in my opinion, is a very practical approach to solving a problem that definitely needs attention, so I would urge support among colleagues for the legislation placed before us. I think it is very prudent, and I thank the Chamber and the Chair of the Public Health Committee for their time, and especially the Chair and Vice-Chair for their leadership in making this happen.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Thank you, sir. Will you care to remark further on the Bill as amended? Will you care to remark further on the Bill as amended? Representative Carter, your light's on.

REP. CARTER (2nd):

Thank you, Madam Chairman, I appreciate that. Just a few questions, through you to the proponent of the Bill.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. CARTER (2nd):

Thank you, Madam Chairman. In lines 52 through 65 where they were talking about some of the situations where a healthcare employer can determine an adjustment can be made and let more than one person interact with that patient.

I was curious if the esteemed Chair could give me an example of a situation where that might happen.

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. I can give a fictional example. Most hospital emergency departments have patients that perhaps come in on a regular basis and in some instances those patients have perhaps an ongoing relationship with a previous healthcare employee there.

Due to perhaps a disagreement, it might not be perhaps as comfortable or friendly an experience for either that patient or that employee. In a case like that, it may indeed be practical for that emergency department to simply assign a different employee to see that patient.

I would like to point out for Representative Carter that the Bill, I believe, is very clear that this only is to the extent practical, and in no case is the patient's treatment, health or safety to be put at risk.

DEPUTY SPEAKER ORANGE:

Representative Carter.

REP. CARTER (2nd):

Thank you, Madam Chairman. And I do appreciate that answer. Obviously, sitting on Public Health it was a huge concern for us on the Committee to make sure that number one, patients receive their care first, and I think this Bill does that.

What's interesting about this is, the other part of it, we wanted to make sure we protected patients who were those frequent flyers, if you will, who come to the emergency room or folks who may be in a psychiatric unit of the hospital.

And I think this Bill was very thoughtfully created to make sure that we protect those individuals.

Through you, Madam Speaker, one other quick question for the Chair. In Section 2, lines 69 through 76, we're talking about the healthcare

employer has to record all incidents of workplace violence to include all the details.

Now, my question through you, Madam Speaker, does this also apply to those who would otherwise be excluded from having criminal reporting, meaning those with some sort of disability? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, my reading of the Bill indicates that those situations would, indeed, be included in those records.

DEPUTY SPEAKER ORANGE:

Representative Carter.

REP. CARTER (2nd):

Madam Speaker, I would like to point out that I think this is another point in the Bill that was very thoughtfully done, because at one point here in Section 2 we're making sure that we take a record of all those instances that happen, and I think it's very important to record those.

Yet in the next section, Section 3, we're making it very clear that only those that are reported to the

police are the ones who don't involved somebody with a disability.

So I'd like to speak in favor of this Bill and I urge my colleagues to accept it and vote for it.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Thank you, sir. Will you care to remark further on the Bill as amended? Representative Noujaim.

REP. NOUJAIM (74th):

Good afternoon, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Good afternoon.

REP. NOUJAIM (74th):

How are you this fine day? Last day of Session.

DEPUTY SPEAKER ORANGE:

Eight hours, sir.

REP. NOUJAIM (74th):

Correct, Madam Speaker, thank you.

Madam Speaker, through you, I would like if I may to make a comment and then ask a question of Representative Ritter.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. NOUJAIM (74th):

And please understand, Madam Speaker, I am not trying to be facetious in any way because I have the highest respect to Representative Ritter and she knows that I love her dearly.

But here is my dilemma. Madam Speaker, I've been in business for 35 years. I worked for large companies. I worked for small companies. I have visited numerous corporations. Some of them are nonprofit. Some are for profit. I have had the ability, and thank God I say this in a very humble fashion, I have taught seminars not only in this country but throughout the world, being with top management of companies, looking at their procedures, looking at their practices.

And in addition to that, I had the honor of being a member of the board of numerous organizations, some of them are healthcare, hospitals, entertainment and educational association.

And I am looking at this Bill and the printing is so little small, so I just want to put my glasses on just to read the first two lines of it.

It says, require healthcare employers to develop and implement plans and training programs related to workplace violence prevention and response.

And through you, Madam Speaker, all of those companies that I have visited, all of those companies that I either have worked for, worked with, consulted for, taught, all of those companies I have seen every single one of them having those kind of programs, and they are very much current law.

Whenever there is a problem it is reported. I see plans. I see safety committee meetings all the time. I see them done on a regular basis and again, I am not trying to be facetious or anything. I'm just asking through you, Madam Speaker to Representative Ritter, if all of those are already being enforced, why do we need to put a new law?

If I may, through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. And I will respond to the Representative's question in a couple different points. First of all, I would like to make sure that the Representative does understand that in many cases there may be an existing committee, and most commonly you see this in hospitals and indeed, as the Bill states in line, starting on line 34, that any existing

committee already established to do this, may indeed, do this work as long as it meets the appropriate membership committee description. That's the first thing.

The second thing, Madam Speaker is, that while the Representative I know has experienced all over the State of Connecticut, we did hear testimony from instances where this is not regularly perhaps occurring or occurring at all in certain institutions.

This Bill makes that more uniform and assures the employees of a more uniform level of protection.

Finally, Madam Speaker, at the end of the Bill starting on line 144, the Bill adds assault of healthcare personnel as assault that would constitute a Class C felony in these instances.

So those are the three reasons, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Madam Speaker. And through you, Madam Speaker, I truly, truly appreciate Representative Ritter's response.

And not being a Member of the Committee that she presides over, I am more appreciative of those answers

because obv000iously we cannot belong to every Committee and we don't know every single public hearing that takes place in this wonderful, wonderful Chamber.

But the one thing that I like to ask about if Representative Ritter will be kind enough to explain to actually, to all of us and to our audience and to the constituents of the State of Connecticut, to explain to us, what type of people, not to name names, but what kind of organization or professions came before her Committee to testify in the public hearing in support or requesting this legislation? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, we heard from employees. We heard from hospitals. We heard from a variety of different sizes and shapes of healthcare institutions, either personally at the public hearing or in testimony that was submitted either in writing or through their Representatives here at the Capitol.

I would like to point out, Madam Speaker, it's perhaps not that common in a Public Health Committee when you receive essentially the same requests from legislation from both the hospital institution community as well as Representatives of employees in those settings. That's a bit unusual to us and that is what happened in this case, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Noujaim.

REP. NOUJAIM (74th):

Thank you, Madam Speaker. I would like to extend the gratitude to Representative Ritter for her answers. Thank you.

DEPUTY SPEAKER ORANGE:

Thank you, sir. Will you care to remark further on the Bill as amended? Representative Srinivasan, you have the floor, sir.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker. Through you, Madam Speaker, if I can ask a few questions.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker. When we talk about the notification of the violence, I know Representative Perillo did touch upon that. This is Section 3, line 83 about the 24-hour time period for notification.

In the event this were to happen over a weekend, and you know, Saturday, Sunday, are we still bound by the 24-hours, through you, Madam Speaker, or is it you know, from Monday on we are given the 24-hour time period?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, the terms of the Bill are that this be reported to the local law enforcement agency and that this expectation is that it be not later than 24 hours after the occurrence of the act.

As we indicated earlier, I think the intent of this legislation is simply that it be done in a very timely manner. In many, if not all instances, there is no reason why that local law enforcement agency would not be able to receive a report 24/7 so to

speak, and so I think the expectation is reasonable, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker. Through you, Madam Speaker, what happens in real life is many a times in a private office setting, the covering physician or the physicians are not the primary owners of that particular practice. We have what we call as lucum physicians who come in who are covering the practice like you can imagine my practice is covered now by local physicians when I'm here.

In that situation, through you, Madam Speaker, is it the responsibility a) of the physician or the healthcare who is the owner or the proprietor of that particular practice or of the physician or the healthcare provider who is working at that particular time when unfortunately this violence occurs. Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you< Madam Speaker. Madam Speaker, the Bill states it is the responsibility of the employer, and so the extent to which that employer relationship is clearly defined would indicate that that is where the responsibility falls.

DEPUTY SPEAKER ORANGE:

Representative Srinivasan.

REP. SRINIVASAN (31st):

Thank you, Madam Speaker, I do appreciate very much those answers by the esteemed Chair of the Public Health Department, Public Health Committee. Thank you.

DEPUTY SPEAKER ORANGE:

Thank you, sir. Will you care to remark further? Representative Clark Chapin.

REP. CHAPIN (67th):

Thank you, Madam Speaker. Madam Speaker, some questions to the proponent, through you, please.

DEPUTY SPEAKER ORANGE:

Please proceed.

REP. CHAPIN (67th):

Thank you, Madam Speaker. I'm trying to reconcile a couple of things in the Bill here. Under the definition of healthcare employer, it refers back

to institution as defined in statute, and institution as defined in statute does include home healthcare agencies.

As I read Section 1b, the healthcare employer would be required to establish an ongoing workplace safety committee and I guess my first question is, if they're a home healthcare agency and they really don't have a central workplace, would they be required to fulfill that obligation? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER: (38th):

Thank you, Madam Speaker, that's a great question from Representative Chapin.

Some of these employers, and home health is a primary example, have varied locations where the work is performed. There is nothing in the Bill that does not grant some flexibility in that occurring.

As the Representative has suggested, there may indeed be a need for an individualization as this process evolves, and again, there's nothing in the Bill that does not keep that from happening.

We also already discussed in lines 66 to 68 the need or the potential if taken by the Labor

Commissioner, to adopt regulations and that also eventually, if not immediately, could be a subject for those regulations as well, perhaps more specifically in the incidents of the home care taker.

DEPUTY SPEAKER ORANGE:

Representative Chapin.

REP. CHAPIN (67th):

Thank you, Madam Speaker. And again, through you, I certainly appreciate the recognition that those regulations could address, both, any issues regarding quite honestly maybe the inappropriateness of establishing an ongoing workplace safety committee in 1b as well as taking a risk assessment in 1c.

However, Section 2 does also require that these healthcare employers maintain records of workplace violence and that seems to be outside of the requirement to adopt regulations.

Could the proponent tell me how that may be addressed? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Thank you, Madam Speaker. Madam Speaker, I referred earlier to things that are often referred to

as incidents reporting or an incident reporting system, as well as a variety of care records or care delivery records, and in the particular case of the homecare delivery people, all of those records are an integral part of their work, and the opportunity is there to provide that record-keeping function, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Chapin.

REP. CHAPIN (67th):

Thank you, Madam Speaker. And again, through you, so the owner/operator of a home healthcare agency where there's really no central place other than an office, so all of the work is being done in people's homes would be under the same requirements as perhaps a hospital administrator if this Bill were to pass?

Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Madam Speaker, if they qualified with the number of employees, there would be a requirement simply that they maintain records that detail these incidences of workplace violence. That is correct.

DEPUTY SPEAKER ORANGE:

Representative Chapin.

REP. CHAPIN (67th):

Thank you, Madam Speaker. And again, through you, so in this case, in the case I outlined it would be, it would have the potential for being many different workplaces, I assume, since it would be many different homes that these workers would be going into? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

That is my understanding.

DEPUTY SPEAKER ORANGE:

Representative Chapin.

REP. CHAPIN (67th):

Thank you, Madam Speaker. And also under Section 2 if this reporting does not occur, is there any sort of penalty under existing law or in the proposed legislation in the case of home healthcare agency failing to provide that report? Through you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Representative Ritter.

REP. RITTER (38th):

Madam Speaker, this Bill does not assess any additional penalties.

DEPUTY SPEAKER ORANGE:

Representative Chapin.

REP. CHAPIN (67th):

Thank you, Madam Speaker, and I thank the Chairlady of the Public Health Committee for her answers.

DEPUTY SPEAKER ORANGE:

Thank you, sir. Will you care to remark further on the Bill as amended? The esteemed Deputy Speaker from Danbury, Robert Godfrey. You have the floor, sir.

REP. GODFREY (110th):

Thank you, Madam Speaker. I want to start out by saying I did my own homework so I have no questions, Representative Ritter.

I have a few shout outs, though, certainly to Representative Ritter and her Vice-Chairman, Representative Lyddy. This, as we know, we don't vote on concepts here. We vote on specific language, and the amount of work that they, along with their colleagues and their Committee have put in in crafting

this and hammering out the language to make sure it does cover those situations where, in particular, healthcare providers are covered, are so important and you have my gratitude for that.

A couple of other shout outs, though, I wanted a big one for Mary Consoli. She's a longtime friend of mine. She's a nurse at Danbury Hospital. There have been several allusions to the March of 2010 incident at Danbury Hospital where a patient who comes, as we come to have learned is not mentally competent, did have a gun and did fire it off in the cardiac unit.

So Mary Consoli is president of the nurses' union at Danbury Hospital at one of the AFT branches, and she has been a tireless advocate over especially the last few days. I seem to be getting a phone call from her almost every day, and I want to appreciate that. She's going to love the news that we're doing this Bill.

But in particular I want to say a very special thank you to one particular nurse at Danbury Hospital. His name is Andrew Hall and he's the man who took the bullet that day. He threw himself in front of his co-workers when the gentleman was firing off his gun, took a bullet. He's fine now. Maybe it was the fact

that he was a former Marine. That has something to do with it, but I certainly have the highest respect for his military training and obviously his very quick action and quick thinking in a very, very difficult situation back in March of 2010.

So, with those shout outs, with those thank yous, I do urge all of my colleagues to support Andrew Hall and the nurses at Danbury Hospital and healthcare providers across the State of Connecticut and vote for this Bill.

Thank you, Madam Speaker.

DEPUTY SPEAKER ORANGE:

Thank you very much, sir. Will you care to remark further on the Bill as amended? Representative Taborsak.

REP. TABORSAK (129th):

Thank you, Madam Speaker. I will be very brief. I can't put it any better than my colleague, Representative Godfrey did.

It's a very sad day when a Marine comes home from Iraq and is shot while trying to help people, trying to treat people as a nurse in one of our very great hospitals, and I just want to thank the leadership of the Danbury nurses that have been nurses, the

leadership of the Public Health Committee, Chairman Ritter and the remainder of the leadership of that Committee for taking a step in the right direction here, to make sure that sad events like that don't happen again in our hospitals.

And I urge all my colleagues to support this very good piece of legislation. Thank you.

DEPUTY SPEAKER ORANGE:

Thank you, sir. Will you care to remark further on the Bill as amended? Will you care to remark further on the Bill as amended?

If not, staff and guests please come to the Well of the House. Members take your seats. The machine will be opened.

THE CLERK:

The House of Representatives is voting by Roll Call. Members to the Chamber.

The House is voting by Roll Call. Members to the Chamber, please.

DEPUTY SPEAKER ORANGE:

Have all Members voted? Have all Members voted? If all the Members have voted, please check the Board to determine if your vote has been properly cast.

If so, the machine will be locked and the Clerk will take a tally. Will the Clerk please announce the tally.

THE CLERK:

Senate Bill 970 as amended by Senate "A" in concurrence with the Senate.

| | | |
|---|---|---|
| Total Number Voting | 147 | |
| Necessary for Passage | | 74 |
| Those voting Yea | 147 | |
| Those voting Nay | 0 | |
| Those absent and not voting | | 4 |

DEPUTY SPEAKER ORANGE:

The Bill passes in concurrence with the Senate.

Are there any announcements or points of personal privilege? Representative Coutu.

REP. COUTU (47th):

Thank you, Madam Speaker, a request for a point of personal privilege.

DEPUTY SPEAKER ORANGE:

REP. COUTU (47th):

In remembrance of one of our several colleagues who passed on recently.

DEPUTY SPEAKER ORANGE:

Please proceed, sir.

# JOINT
# STANDING
# COMMITTEE
# HEARINGS

# PUBLIC
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**2011**

cut you off in the middle. And then open it up to questions if anyone has any.

So the first speaker is Dr. Mike Summerer. Would you kindly approach the hot seat. We will welcome you. If you would just state your name for the record, we'd appreciate it. Thank you, sir.

MICHAEL H. SUMMERER: Good morning. I'm Dr. Mike Summerer, Director of John Dempsey Hospital at the UConn Health Center.

Senator Stillman and Representative Ritter and the members of the Public Health Committee, thank you for the opportunity to speak with you today in support of Senate Bill 970 entitled AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTHCARE SETTINGS.

You have my written testimony already, so I will not read that verbatim, but I would attempt to summarize a few key points.

At the University of Connecticut Health Center and at John Dempsey, we strive to maintain a safe and secure environment for our staff, our students, our patients and our visitors. We are following national best practices in our committee structures, risk assessments and our training programs for staff to address behavior issues with patients and visitors before they rise to the level of prank violence.

We have also created a response team, similar to those we have for cardiac arrest to bring the proper resources to the site of a disturbance before it escalates to the level of violent behavior. This response team has been in place for the past one and a half years and has been very effective in keeping everyone safe.

Although we are in general support of the bill as proposed, we do feel that the language of Section 1(f) is too restrictive and may impair our ability to provide care for our patients. We do not believe that ongoing verbal abuse should be tolerated but we also recognize the need to stabilize the medical situation for our patients as a primary responsibility while keeping our staff safe.

We would hope that in working with interested parties and proponents of the bill we could redraft this section. We request your support of Senate Bill 970 with the modification of Section 1(f).

Thank you for your time and attention, and I would be happy to answer any questions.

SENATOR STILLMAN: Thank you, sir. And we do have your testimony. Appreciate it. Do you have any suggestions as to, first of all, we do appreciate your support of the bill, and obviously we will probably have broad support for this bill by hospitals.

But in reference to 1(f), that section, is there anything you would like to suggest in terms of how to amend the language?

MICHAEL H. SUMMERER: I think the exact language would require some care and some careful thought. I think the absolute nature of the language as proposed precludes the ability to address the needs of a patient in the acute first encounter.

We treat patients with psychiatric conditions. We treat patients who are very anxious or in pain, and at times the initial verbal interaction could be perceived as inappropriate, but that's part of providing care.

We train our staff to handle those situations, and as I said, to de-escalate those.

On the other hand, we do not condone repeated inappropriate verbal interactions, and we attempt to remove our staff from those when we can identify them. It's that initial interaction and our need to provide care for the patient that's of concern to us.

SENATOR STILLMAN: I appreciate that. But if you, you have indicated you'd like to work this out, so if you do have anything you'd like to suggest you can please forward it to the Committee chairs.

MICHAEL H. SUMMERER: We will.

SENATOR STILLMAN: Thank you. Anyone else have any questions for the gentleman? Thank you very much.

Next is Senator Duff. Senator Looney. We'll go back to those two. Representative Cafero. Representative Fleischmann. Okay. You're in luck. If they come we'll come back to them. So we'll go right on to the public list as soon as I have a copy of it. Okay. It's on its way. If you'd just wait a moment, we'll get started shortly.

If you'd like to talk amongst yourselves, it's perfectly allowable. Okay. Anybody know a joke you can share? Okay. You don't have to sit in silence. Certainly, if you need to chat with someone sitting next to you or even across the room, go right ahead.

Okay. We're ready. We're back in business. Thank you for your patience. We truly appreciate it. So as I said, we're moving on to the public speaking portion of the public hearing and on House Bill 5289, which is the first one on our

REP. RITTER: Go ahead.

ALICE CENNAMO: -- that will be inserting the lines are properly trained and certified nurses are already appropriate to do these procedures.

REP. RITTER: Thank you very much. I appreciate hearing that emphasized again. Are there questions from the Committee? Representative Carter.

REP. CARTER: Thank you, Madam Chair. I did have one question I wish I'd asked earlier, and maybe I'll have you come back.

Does a physician still control whether or not the PICC line is going to be inserted or taken out, and if there's going to be anti-coagulant therapy added later? Does a physician still control all that?

ALICE CENNAMO: Yes. A physician has to give the order, a physician or advanced practitioner that's authorized.

REP. CARTER: Thank you. Thank you, Madam Chair.

REP. RITTER: Thank you. Any other questions from the Committee? Thank you for your testimony.

We're going to move to our next bill, which is Senate Bill Number 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTHCARE SETTINGS. And our first speaker will be Mary Consoli, to be followed by Kirk Lowry.

MARY CONSOLI: Good afternoon, Senator Stillman and Representative Ritter and the Committee for Public Health. Thank you for raising this bill and giving me the opportunity, along with my colleague Helene Andrews to address you.

My name is Mary Consoli and I am President of the Danbury Nurses Union. I represent a labor union representing 600 members at Danbury Hospital.

I'm speaking on behalf of all our members in support of Senate Bill 970. We are asking you to require each healthcare employer to establish and convene an ongoing safety committee to address issues of worker health and safety.

You have my testimony, but I want to highlight it. This bill is needed because the federal requirement for health and security and CMS and for JCAHO are not enough. A mandate is needed because OSHA does not regulate workplace violence, and in Connecticut there's no specific law to help prevent it.

In our healthcare facilities consider associated with providing a safe work environment, but at what cost is the life of a healthcare worker? This is why we need Senate Bill 970.

And we are also not seeking voluntary programs. Nurses at Danbury Hospital shared their concern for safety at staffing meetings and administration for many years.

Over the last ten years I've communicated these concerns to senior management in correspondence and during monthly labor/management meetings with no changes implemented to improve our security.

In 2008, union and non-union members petitioned, circulated a petition that stated their lack of security and requested a meeting with the then Frank Kelly, the CEO, to express their concerns and refused a meeting.

We filed a grievance in January of 2009 when one of our nurses on an inpatient psych unit was hit

by a patient who then threatened daily to throw her down a flight of stairs.

Our internal grievance system is limited with the scope and concerns. It cannot provide comprehensive system-wide workplace safety improvements.

In October of 2009 we filed a complaint with OSHA and the Department of Public Health, after Helene Andrews, who's here with me and would be happy to answer questions and comments. Her inpatient psych unit was assaulted by a patient, fell and broke a hip.

It was not until March 2, 2010 when a nurse was shot while disarming a patient that OSHA came and did a citation. It was only after this citation that Danbury Hospital addressed our long-standing safety issues.

We were not involved with the process. The hospital hired a consultant. We were not involved in the consultant's investigation. To this day we still have not received the documentation that we requested about their workplace violence prevention plan.

This is why the bill is needed that would be a collaborative effort to ensure the safety of patients, workers and business.

REP. RITTER: Thank you very much for your testimony. Are there questions from the Committee? Representative Taborsak.

REP. TABORSAK: Thank you, Madam Chair. I'd like to first start off by thanking the nurses, the Danbury nurses for being such good advocates on this issue.

As Mrs. Consoli was stating, we had a real traumatic incident in Danbury where a nurse was shot, thankfully he survived, while on the job focusing on caring for his patients.

I think that this legislation addresses a real need. I think that healthcare workers are particularly vulnerable because they're occupied with taking care of people, it has to be so far from their mind to have to be concerned about protecting themselves from situations like this. And so this is an issue that really hits home in Danbury and I appreciate your advocacy on it.

Looking at the legislation that's proposed before us, I guess my question is to the nurses, the Danbury nurses is, as it is drafted, do you think that this bill will give the nurses a sufficient voice in the process of establishing and designing a workplace safety plan?

MARY CONSOLI: I think, yes. Well, certainly as I stated before, there's no laws and there's no measurement. Voluntary programs work if there's a committed management.

Danbury Hospital has not been committed to this process. We have asked on several occasions and they have not addressed it. After, they hired a consultant after the shooting and he drew up a plan and the hospital formed a task force, a committee to address their concerns.

I was not invited to be part of that committee until the end. I was not, I attended two last meetings. I made some suggestions. I put my suggestions in writing, and I never received an answer to my letter.

The changes that have been made at Danbury are changes that we had asked for over many years, and part of the reason in the past was the cost

of security, and they felt that they had a safe environment.

And the shooting, while such a situation may be embarrassing, it brought to light, because OSHA cited them with a failure to provide a safe working environment and even the consultant that they hired showed the deficiencies that they needed.

We as a union had asked the hospital to be prepared at no cost to the hospital to bring up people from the University of Maryland that are acclaimed experts from the Work and Health Research Center from the University of Maryland to give presentations to all employees, including the management, to develop a comprehensive workplace violence intervention program and the hospital refused our offer.

So that's why we need some kind of a mandate to go forward. The union leadership has no development, as I said with the hospitals. When they did the focus groups for this consultant, individual employees participated in some of these focus groups but they were invited and they were at certain times. It wasn't open.

And you know, nurses shouldn't accept workplace violence, not only nurses but healthcare workers, as part of their job. They should feel safe coming to work.

REP. TABORSAK: If I could just have a follow up question. Thank you, Madam Chair. It's important, I think, to a number of members on this Committee, that healthcare workers have a say in this, so I appreciate your answer.

I think that what I got from you is that this bill would make sure that healthcare workers, nurses included, would have a sufficient say in

this process with this legislation. Is that fair to say?

MARY CONSOLI: Yes.

REP. TABORSAK: Thank you. And I want to thank you again for coming up here and testifying, your advocacy on this issue. I thank the leadership of this Committee for bringing up this important bill, and I look forward to supporting it going forward. Thank you.

REP. RITTER: Thank you. Representative Carter.

REP. CARTER: Thank you, Madam Chair. And I thank you for being here. Obviously, this is a huge issue, not only for the folks in our district of Danbury, but across the State of Connecticut.

Workplace violence is something that's somewhat preventable, and obviously we have to look at the best way to do that.

Now, you had mentioned before that you're seeking programs that aren't voluntary. The voluntary programs that were in place, there were voluntary programs in place that you know of?

MARY CONSOLI: Yes, but they're not effective.

REP. CARTER: Okay.

MARY CONSOLI: We had a lack of security that was brought to the hospital on many occasions.

REP. CARTER: Right.

MARY CONSOLI: I can go back in history of the times that we wrote to the hospital administration.

REP. CARTER: If you were looking for one thing that they did right, did they do anything with those

programs, you know, with a committee, or did they do any workplace training that you know of across the hospital?

MARY CONSOLI: Not until after the shooting. They had minimal, they had training within the inpatient psych unit, but the training was limited and the facility was very open and we had major concerns, especially in the psych unit, the inpatient psych unit and the emergency department.

REP. CARTER: So they tried to have training inside the psych department but security was lacking in the hospital, because in a way, that could be two different things.

MARY CONSOLI: Correct.

REP. CARTER: There's the training for the employees and awareness and things like that, just the same as we get in the Capitol, you know, the intruder training.

But then there also is a general security in the hospital, which you feel that's where, that part failed resulting in the shooting.

MARY CONSOLI: What happened, you know, how the shooting happened, it probably could never be prevented the same way that all these shootings that take place that make the news. Something like that is something that probably could not have been prevented unless you have scanners at every opening to do that.

REP. CARTER: Right.

MARY CONSOLI: But what we were doing is, the whole atmosphere of security was, the level of security that we felt comfortable with wasn't there. The presence of security in the emergency department

wasn't there and in the inpatient psych and the general screening of visitors.

Now, since the consultant, since the shooting, all that has taken place. They've got training now that has been instituted that we had wanted. But it's just, the point is, you don't want a shooting to happen at every facility in Connecticut in order to have a program such as this in place, and we want to be able to work to see what the program is.

We don't know how it's being monitored to see if it's efficient, to see if it's working. Put the plan in place because all these attacks or assaults, it's not just the shooting.

And if you want --

REP. CARTER: Sure.

MARY CONSOLI: -- Helen probably could attest even more inpatient psych areas. But nurses, there's been written testimony that's submitted for people that aren't here that are hit, that are bitten, that have thrown their bodily fluids at the nurses and especially in emergency, verbal abuse. Society is getting more and more violent.

REP. CARTER: Well, obviously, too, you're working with --

MARY CONSOLI: And this happens in Connecticut and for three years we were the safest city in Connecticut, so.

REP. CARTER: Obviously, in your industry, too, you're working with some of the most difficult people coming into the emergency room at a difficult time.

And I wanted to say something that my colleague, Representative Taborsak had said, I think it is important that everybody has a say, because that gives people the ability to buy into programs.

In the voluntary programs that the hospital had before, did they have people coming from all walks of the hospital involved in these committees?

MARY CONSOLI: I didn't participate, so I --

REP. CARTER: You mentioned just at the end a couple.

MARY CONSOLI: -- don't know. There is a hospital security committee. How that functions, I don't know. But they didn't address our concerns that were addressed at all different levels, and that's why we raise it now.

And I brought this before at a labor/management meeting and through correspondence to the senior management and they weren't addressed.

REP. CARTER: Okay.

MARY CONSOLI: Most of it, a lot of it was because of the cost.

REP. CARTER: Sure. Okay.

MARY CONSOLI: But at what cost is the life of a healthcare worker?

REP. CARTER: Right. Well, thank you very much for your testimony, your time, and we'll look forward to talking to you soon. Thank you, Madam Chair.

REP. RITTER: Thank you. Representative Lyddy.

REP. LYDDY: Thank you, Madam Chair. I apologize for not being here during your testimony. I'll certainly read it. I have it in front of me.

I was wondering if you can just comment, if you haven't already, on how life and work at Danbury Hospital has changed as a result of the incident, the shooting incident.

MARY CONSOLI: What the hospital did is brought in a consultant, and they are addressing concerns that the employees, not just the union members, have had for many years. We've had people at the door security there. They increased a number of security. They put patrols in.

They have also put in place training that has been improved, and made people aware of how to approach people who are violent, patients, visitors and things like that.

What's not in place yet is the monitoring when there is an assault, how is that monitored and what's the follow through and there's the collaboration is not in place as how to prevent things in the future, what changes need to be done, how is the plan assessed?

Also, these are assaults. How can the assaults be reported to the local police, because there are all really assaults. And the fact that the people may have a psychiatric history or they're a patient in the hospital should not have a bearing on the fact that these are criminal offenses.

REP. LYDDY: Thank you for that. And I visited the hospital just the other day, and I was impressed with the amount of security that is in place, everything from the name tag I had to wear to showing and taking a picture of my license, to a number of exits --

MARY CONSOLI: There's great improvements and we're very happy for it. It's just unfortunate that it took the shooting to get to this place, and that's the point.

REP. LYDDY: Certainly. Certainly. And as a social work and a nurse, I assume. Right? You're a nurse.

MARY CONSOLI: I'm a nurse, yes.

REP. LYDDY: We serve on the front lines every day and put ourselves in harm's way, potential harm's way, so I'm certainly sympathetic to the need for a plan and follow through plans, and hopefully we can continue to look at that issue in collaboration with the hospitals and with the unions.

MARY CONSOLI: Thank you for recognizing that, but it's not only nurses and social workers. You've got the front-line workers that are the --

REP. LYDDY: Absolutely.

MARY CONSOLI: -- aides and orderlies, whatever term that's used, the patient (inaudible) that probably even have it more, and especially down in the ED when a patient's coming in and the security guards that have to deal with the patients that are in crisis intervention,.

REP. LYDDY: Great. Thank you so much, and I appreciate your collaborative tone as opposed to a finger pointing tone. Thank you.

REP. RITTER: Thank you. Representative Perillo.

REP. PERILLO: Madam Chair, thank you very much. One of the things that we will probably hear at some point in the discussion today or following, is

some concern perhaps from hospitals regarding a specific section of the language that has to do with an employer not forcing an employee to administer treatment to a patient who has in the past exhibited some sort of abusive behavior toward that employee.

How do we reconcile that with the hospital's need to treat patients? It's a very practical question and I just ironically don't know the answer. How do you make that work?

MARY CONSOLI: And I was here when the gentleman brought that up. What the issue is, especially probably people that came in that we have a term, frequent flyers, they're patients that have come to the hospital more than once and I think that we have this particularly on the psych unit.

A nurse has been threatened by patients in poetry that he was going to follow her, going to get her. That nurse shouldn't have to take that because the nurse or the healthcare worker cannot be therapeutic for the patient.

So it's not only the nurse should not be harmed, but how can the caregiver be therapeutic for that patient if there's been a past history, and I think there's enough, it's not only one employee at the hospital. I think there's others, and I think measures have to be taken place that would have, to make the healthcare workers' safety and also to be the most therapeutic environment for that patient.

REP. PERILLO: That point is really well taken and there are two sides of the coin.

I'm concerned about situations where, you know, maybe not at Danbury Hospital but another type of facility where bringing in another clinical provider to treat that patient just isn't

practical. There aren't enough providers, whether it be in an extended care facility or something else. There just isn't enough staff to go around.

MARY CONSOLI: There may be --

REP. PERIOLLO: It's problematic for me. I'm not sure how to resolve that in all instances.

In a hospital setting where you have multiple, you know, clinicians, you know, even ED where you can move people around it's a little more easy. But in a situation where for example, in an extended care facility you may have one RN in the entire facility. I just don't see how we make that work.

It's just something I think we need, as a group, need to wrestle with as we go forward. And thank you very much. I appreciate your help.

REP. RITTER: Thank you. Actually, Representative Perillo took my question, and so I would suggest that, you know, I understand your point of reference, of course is Danbury Hospital and the issues that you've had there, and I very much respect and appreciate that.

But if you have other thoughts to help us wrestle with this as we take it across institutions of varying sizes, I would very much appreciate hearing from you. Thank you very much.

No other questions? Thank you for, for the second time, that would be Representative Carter.

REP. CARTER: I'm sorry, Madam Chair, just one quick thing. I was doing some reading as I was listening to the rest of the questions, and looking at OSHA, they talk about some of the states that do have programs for workplace

violence, Connecticut being one, but it applies to the public sector. Are you familiar with those guidelines at all?

MARY CONSOLI: Yes, and the guidelines are very effective, but they're guidelines.

REP. CARTER: Right.

MARY CONSOLI: They're not mandates. It's not a law, and whether or not the facility chooses to follow them is up to the facility. And OSHA has very good comprehensive --

REP. CARTER: Oh, those are the same guidelines kind of proposed in this legislation?

MARY CONSOLI: Basically, yes.

REP. CARTER: Basically. Okay, thank you.

REP. RITTER: Thank you very much for your testimony.

MARY CONSOLI: You're welcome.

REP. RITTER: Our next speaker will be Kirk Lowry to be followed by Paula Amero.

KIRK LOWRY: Madam Chair and members of the Committee. My name is Kirk Lowry. I'm the Legal Director for the Connecticut Legal Rights Project. We're a statewide nonprofit legal services organization that represent low-income people with psychiatric disabilities.

CLRP, Connecticut Legal Rights Project, supports the reduction of workplace violence, but opposes those sections of Senate Bill 970 that are over broad and may criminalize behavior of people that may not be able to form a criminal intent to assault or to hurt someone.

When a person with a psychiatric disability goes to an inpatient treatment facility seeking treatment, they shouldn't then be subject to criminal prosecution for seeking that treatment that they need, and it's not a bright line issue, either. That's the difficult thing.

I think one of the more thoughtful examples of a way to handle this is the Commissioners of the Department of Mental Health and Addiction Services.

Commissioner's Policy Statement 6.23 addresses how, what may be a good way to try to address these issues and leaving it more to the clinicians to decide on a case-by-case basis.

You know, how disabled is the person? How much is this behavior a manifestation of their disability versus how serious is the conduct? You know, if somebody shoots someone then that's never something that the police should not get called on.

But if somebody hits someone and they're there for treatment because of that, either because they've got a developmental disability, they're autistic, they've got schizophrenia, then depending, and those are all things that are on a spectrum.

So depending on how impaired the person is, and how much it affects their ability to control their behavior versus how serious the condition is, those are all things that should be brought into consideration, and that's what Commissioner's Policy 6.23 says.

She also says that in the vast majority of cases, the person should be treated instead of having the police called. Again, it depends on that variation of how disabled they are versus how

serious the behavior is and how, you know, what the result was.

CLRP supports those provisions in new Section 1 that require the creation of a workplace safety committee, require a risk assessment, and require the implementation of a workplace violence plan. Those things all appear to be good things.

But we do have concerns about anything, especially in Section F that mandates that a person not, that a worker not treat someone or the mandatory calling of the police in all instances without taking into consideration the variations. Thank you.

REP. RITTER: Thank you. Are there questions from the Committee? Representative Perillo.

REP. PERILLO: Madam Chair, thank you very much. Just one question. I understand what you're saying about the appropriateness of calling the police in certain situations.

I guess my question for you would be, where do we draw that line? At what point is it appropriate to call the police and at what point is it not, and who would be the judge as to whether or not, to call or not to call? Many people would say assault is assault is assault regardless of who initiates it.

KIRK LOWRY: Right. And I think that's the point that I'm trying to make is that I can't draw that line, and I don't know that that is drawable by legislation.

I think that it's best made by the treating professionals on the inpatient psychiatric unit or the traumatic brain injury unit, or the unit that, or the home that deals with people with developmental disabilities, and it should not be

the policy that all of those people, no matter how disabled they are, or how slight the assault, have the police called on them for conduct that's a clear manifestation of their disability.

REP. PERILLO: Understood. I guess, and this isn't necessarily a committee of cognizance regarding the legal matter. But I guess my question is, if we were to not put that into statute, wouldn't patient A, wouldn't we run the risk of patient A who goes into the ED on Monday and is treated by nurse A, not be referred to the police, yet patient B who shows up on Tuesday and is treated by nurse B does the exact same thing and is? And is there not some inequity in that?

KIRK LOWRY: I think there's, there might be a resulting inequity but my concern is more that the people that I represent, low-income people with significant psychiatric disabilities and it would also apply to people with traumatic brain injuries or developmental disabilities, is that those people, the most disabled, have their behavior criminalized.

And so I think it's better to let the emergency room personnel or people on the psychiatric unit, as in Commissioner, DMHAS Commissioner's Policy 6.23 make those decisions on a case-by-case basis after doing an analysis of how disabled are they, how much of a clear, direct connection between their disability and the conduct is there, and then how serious is the conduct.

And all of those things are a balancing factor, so that's why it's so tough to do it by legislation.

REP. PERILLO: Are all clinicians able to make that determination? The situation you're suggesting is one in which the clinician is very knowledgeable as to the specific condition of any

patient, and I'm not sure, particularly in an emergent setting, whether or not the clinician treating that patient would have that knowledge.

KIRK LOWRY: I agree.

REP. PERILLO: Is that a concern?

KIRK LOWRY: Yes. I agree with that.

REP. PERILLO: Thank you.

REP. RITTER: Are there questions from the Committee? Along the line of the questions that Representative Perillo had, and I think these are questions we all have when we're looking at situations like this, I think I would welcome continuing discussion as we try to reconcile these, especially for issues in emergency situations, and there are other instances when you see this happen. Law enforcement is one of them.

It's, I agree. Not only are the lines very, very difficult if not impossible to draw, time is also not an option for either or all of the individuals involved, and that places, perhaps, a different level of emergent, a different level of necessity or a higher response level.

And I think we're all sensitive to, actually, all saying kind of the same thing. So in order to get to a result that works, I would hope that you would continue to follow this and feel free to give us your suggestions now only as to what we should not do, but maybe how we could work toward something that can work out for, if not every single person, close to every single person.

KIRK LOWRY: Be happy to.

REP. RITTER: Thank you very much. Are there any other questions from the Committee? Thank you for your testimony.

Next we will be hearing from Paula Amero and followed by Dr. Charles Herrick.

PAULA AMERO: Hi. Good afternoon, Representative and members of the Public Health Committee. I'm sorry I can't ad lib. I'm going to read my testimony.

My passion for healthcare began at the age of 17. During my journey, I have been spit at, pushed, slapped, hit, kicked, beaten, choked, even had my jaw broken. Today I can add, being shot at by a patient.

I'm 53 now and my name is Paula Amero and I work at Danbury Hospital as an RN. I bring this experience to you today to show the need for support of Senate Bill 970. We must have a uniform policy for our workplace violence program in our healthcare institutions not only for the worker, but also for you and your family.

The day of the shooting was about seven months ago. I work on a cardiac unit. My patient, or shooter, as most like to call him, was beginning to act more paranoid, hallucinating that the IV pole was going to hurt him.

As his agitation grew, I saw the fear of the nurse's aide. And also, you know, in nursing school to become a nurse, become extremely fearful.

As I attempted to get an MD to assess the patient, and possibly medicate him, my assistant nurse manager went to assist in getting the patient under control. I heard two shots.

Everyone stood in shock in disbelieve of what they heard.

Instinct, I ran down the hall toward my patient's room, which was three rooms away from the nurse's station. What I saw was my patient lying on the floor, my clinical leader on top of him. My patient's arm was pointing toward the ceiling holding a small caliber semi-automatic handgun.

There was blood on the floor and the wall. My patient kept yelling that he was going to shoot everyone. I ran to grab his arm and the gun, but I fell short of doing that, and I watched my boss get shot two more times as I ducked behind the laundry cart. That was all that was between me and a gun.

He shot the gun several more times randomly toward the nurse's station down the hall. There was a lot of screaming. So much happened in a very short period of time. Hospital security were all around that I could see, one of which took the shooter, who was still lying on the floor from behind and got the gun out of his hand.

By then a SWAT team was there and many more guns. No matter how I felt, my passion stepped in and I got down on the floor next to my patient, and I took care of him. He also got shot that day.

There were, you know, a lot of heroes and several of them had the gun, one pointed at her forehead, another one in his abdomen and you know, we continue to fight for assistance, policy changes, security changes, and a heightened awareness, not only of the aggressive patients, but also the aggressive visitors and family members.

I love my job, but I love my 11-year-old child more and I need to go to work feeling safe, and

she needs to know, go to school knowing her mommy won't get shot at again.

No one loses with this bill, not even the person that commits the violent act.

In working in this profession for 32 years, and plus as a nurse's aide, this isn't just all about the psychiatric patients, you know, and so far that's what I'm hearing. I just got pushed last week by an angry visitor because they didn't get their way.

Are there demented people? This guy obviously was mentally ill, this shooter, you know, yes. But are there also those people that don't have mental illness that are just angry. They're just angry, and they take it out on the medical staff. So that is also, you know, a big part of my, you know, experience, not just the old demented or the mentally ill that I deal with on a daily basis. Thank you.

REP. RITTER: Thank you for what you do, and thank you for your testimony. Are there questions from the Committee? Yes, Representative Carter.

REP. CARTER: Thank you, Madam Chair. I just want to comment on something, because we have had opportunity. I ran into you in the hall and you said something that you know, really touched me and obviously in these situations, you know, we talk about the shooter, we talk about the person who's shot, we forget those people standing around.

So thank you very much for your courage and coming to testify before us today, because to often, you know, you're the people who are forgotten and missed. So thank you.

REP. RITTER: Representative Taborsak.

REP. TABORSAK: Thank you, Madam Chair. I just want to thank you for coming up here and testifying on this very important bill, and giving us a face behind this sad situation we had in Danbury, and I really appreciate you taking the time coming up here and your advocacy, so thank you. Thank you.

REP. RITTER: Thank you. Next we'll be hearing from Charles Herrick, followed by Lisa D'Abrosca.

CHARLES HERRICK: Thank you for the opportunity of having me here today to speak before you. Senator Stillman, Representative Ritter and the distinguished members of the Public Health Committee, my name is Charles Herrick and I currently serve as Danbury Hospital's Chairman of the Department of Psychiatry.

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You have my written testimony, so I will just touch on some of the highlights. We're concerned about two major issues.

First, we generally support this bill, and let me say that both hospitals, Danbury Hospital and New Milford Hospital of Western Connecticut Healthcare make employee safety and patient care our highest priority.

The two concerns that we have, have been touched on previously. One is subsection f, which would not only violate patients' rights, but would violate our hospital's care mission.

Quite often, patients arrive at a hospital in a sate of extreme distress resulting from a medical or a psychiatric condition. If subsection f's language were adopted, it would cause insurmountable barriers to treatment.

Healthcare workers such as myself took an oath to provide care to all who need it and accept the

risk that the potential for violence may be the result of our patients' illness.

It is worth noting that the risk of imminent violence is, in fact, one of the major criteria mandated by the state for immediate involuntary psychiatric hospitalization.

We would not grant any other workers the opportunity to refuse to do the job that they were hired to perform, whether they were police or fire department. They also took oaths and accepted the risk involved. Healthcare workers also understand that there are risks involved in the performance of their duties.

The second issue I want to address is the issue of assault. Violence takes many forms, and is the result of many conditions. It is too broad in its definition of assault to have an appreciation for the complexities of behavior.

I have treated many violent patients in my 20 years as a practicing psychiatrist, and I have also been the victim of patient assaults. Only rarely is a patient's violence premeditated. The vast majority of alleged assaults can be directly attributed to a patient's medical or psychiatric condition, and increasingly, that medical condition includes Alzheimer's disease and other forms of dementia.

To report all these instances would tax both the healthcare system in the state, both in terms of labor, as well as cost, without actually addressing the intent of the bill.

We, at Danbury Hospital, have developed a very rigorous program to educate our healthcare workers on identifying potentially violent patients and teach them specific skills in de-escalating threatening patients, de-escalating,

I'm sorry, that distracts me, threatening patients and protocols for handling patients should de-escalation not work.

We believe that the way to lower the risk to healthcare workers is through education and a change in our culture, not through external reporting, which could even potentially violate patient's rights to privacy.

Region 5 lacks the bricks and mortars of a state institution. Danbury Hospital has become the de facto state inpatient facility as the transfer of these patients to a state facility is generally not a timely option.

We believe that the language in subsection f would seriously undermine our ability to continue to honor the commitment of caring for those patients, because we would not be obligated to either evaluate or care for those patients who are potentially violent.

We do support, however, many of the other important concepts enumerated in the bill.

REP. RITTER: Thank you for your testimony. Are there questions from the Committee? Looks like Representative Taborsak.

REP. TABORSAK: Thank you, Madam Chair. I just wanted to thank you, Dr. Herrick, for coming up here and Danbury Hospital for taking an active role in this legislation.

I think anything that we can do to improve the situation is a good thing, and that it's going to be critical for the hospital to be involved and this to be a collaboration of, you know, not only the hospital, the healthcare workers, all being at the table.

So I just appreciate, you know, the efforts that are being made currently that we're hearing about today to improve security at the hospital and workplace safety, and I look forward to hearing more about this collaboration that is underway and this legislation moving forward, so thank you.

Thank you, Madam Chair.

REP. RITTER: Representative Lyddy.

REP. LYDDY: Thank you, Madam Chair, and thank you, Doctor for your testimony. Just a quick comment regarding the region and our lack of facilities to support patients with mental illness.

I think you bring up a very important point and the funding that the state has or has not given to the Region is certainly worthy of further discussion and I hope you'll be willing to talk to us more about that and the types of situations that the state has inherently put Danbury Hospital in terms of taking these patients on without additional services in Region 5. Thank you.

CHARLES HERRICK: I'd certainly welcome the opportunity to speak more about that.

REP. LYDDY: Great. Thank you.

REP. RITTER: Thank you. A question that came to my mind, and you may have, this may be more detailed in your testimony or not, might have to do with additional education and training efforts made with the staffs who work most particularly with patients with psychiatric difficulties in Danbury Hospital, and how they've chosen to address that at this point in time or future plans.

Do you have anything to add to that point?

CHARLES HERRICK: The psychiatric staff have been trained in violence management. They have prior to this incident.

What's probably changed is the fact that now all of the clinical staff, all healthcare workers throughout the hospital are being trained in this. It includes an on-line training as well as involvement with a nurse educator on a regular basis to provide additional training techniques, de-escalation and following the policies and the protocols that the hospital has instituted.

REP. RITTER: Thank you. And are those the only staff at Danbury Hospital that those particular patients come in contact with?

CHARLES HERRICK: The psychiatric staff? All healthcare workers potentially come into contact with potentially violent patients throughout the hospital.

REP. RITTER: I understand that. But my question had to do with training particular to patients with, say, psychiatric disabilities?

CHARLES HERRICK: No, it's not. No, it's not specific for psychiatric patients. It's specific for potentially violent patients. They can be psychiatric, but you know, it can be anyone who presents a potential threat, including visitors.

REP. RITTER: Okay. Thank you. I understand. Are there any other questions from the Committee? Thank you for your testimony.

CHARLES HERRICK: Thank you.

REP. RITTER: Next, you will be hearing from Lisa D'Abrosca and she will be followed by Keith Inrig.

LISA D'ABROSCA: Thank you. I'll start again. Good afternoon, Representative Ritter and members of the Public Health Committee. My name is Lisa D'Abrosca and I'm a nurse at Lawrence and Memorial Hospital in New London, Connecticut. I've worked there for approximately seven years and the last five of which I've served on the executive board of my union, and the last three of which I've been the president of my union.

I represent approximately 500 members, and I'm here today to testify in favor for Senate Bill 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN THE HEALTHCARE SETTING.

I must impress upon you how important this bill really is. Workplace violence is a problem in every healthcare facility throughout Connecticut, and I've seen it firsthand at my own hospital.

It's very frustrating to see workers injured all the time and see nothing done about it. In my tenure as president, I've worked very hard, but very much in vain to stand up for these injured individuals.

I've encountered all sorts of obstacles in this attempt. From the labor management standpoint I've encountered much frustration and roadblocks, and from a legal standpoint, I actually had a police official tell me, and I quote, "Getting hurt is a part of a nurse's job so you all need to learn to just deal with it".

If Senate Bill 970 is passed, there will be checks and balances in place to help stop healthcare workers from getting injured. Furthermore, plans will be put into place to make sure that if a major event does happen, something like this will not happen ever again.

Senate Bill 970 will implement an effective safety committee at each and every healthcare facility. There's a safety committee at my hospital. However, there's much frustration on the part of the employees because it seems that nothing ever gets accomplished at these meetings.

There's certain personality conflicts. There's poor labor relations to deal with, and just other nonproductive rhetoric to block our success.

This bill will provide accountability that will ensure that the safety committee is actually effective. Said committee will not only review each actual instance of workplace violence, but it will be held accountable to assess the broad spectrum of risk factors that put people at risk for being a victim.

Furthermore, the hospital will be liable to implement a written workplace violence prevention and response plan, and this plan will address all of these particular risk factors.

Furthermore, it will create a system to which we can track and monitor every instance that does happen of workplace violence.

Taking it a step further, the hospital will be held accountable to actually educate all of its employees about this plan. It will need to develop an employee public safety training that will be reinforced to everyone on an annual basis, as well as new employees will be taught about it as a part of their orientation process.

And furthermore taking it a step even further, this plan will be available for people to access at any time upon their request.

Again, I really want to, I'll finish quick. I implore you to pass this bill. It's the right thing to do. Please look at the real issue. It's the safety of the healthcare workers. Don't look a healthcare worker in the eye and say that his or her safety is not important. Do you have any questions? Feel free.

REP. RITTER: Thank you, Lisa. Are there questions from the Committee? I want to thank you in particular for the work that you do at Lawrence and Memorial.

LISA D'ABROSCA: Thank you.

REP. RITTER: And thank you also on behalf of Senator Stillman. She's very sorry that she could not be here to greet you personally. We have several committee hearings going on today and so we're a bit distracted.

LISA D'ABROSCA: I understand.

REP. RITTER: I did have a question, and it goes along the line a little bit of what I was asking before, and it's my understanding that the provisions of this bill affect essentially anybody that works in a healthcare institution, regardless of whether they are clinically oriented in their job or not. Am I correct?

LISA D'ABROSCA: That is correct. That's my understanding of the bill as well.

REP. RITTER: And it's also my understanding that particular to Lawrence and Memorial there have been incidents of workplace violence involving non-clinical and employees, often employees that in general might work almost all day without encountering say, patients or other uses of the hospital. Am I correct?

LISA D'ABROSCA: That's absolutely correct. That is. There's been instances where housekeepers have been, I think, thrown at them, injured, been harassed by patients and others as well.

REP. RITTER: Thank you very much. Are there any other questions from the Committee? Thank you for your testimony.

LISA D'ABROSCA: Thank you. Thank you for all that you do.

REP. RITTER: Next, we'll be hearing from Keith Inrig. You can correct me. Everyone else does. And Mary Jane Williams will follow.

KEITH INRIG: Hi. Good afternoon, Representative Ritter and members of the Public Health Committee. My name is Keith Inrig. Like outrig, only in. And I'm a radiographer by trade. Presently, I'm the First Vice-President of the University Health Professionals Labor Union representing 2,500 non-faculty processionals at the UConn Health Center.

I'm here to speak in favor of Senate Bill 970. Other hospitals can look to John Dempsey Hospital and UConn Health Center to see that the essence of this bill can, and does work.

Most of the components of this bill are in place or being implemented at the Health Center. As a matter of fact, Dr. Summerer spoke about that, how many of these things were under way already.

Although the UHP management, health and safety committee has been dormant, we are already starting it up again as well, the Health Center has a safety initiative under way. I feel it would be appropriate to add the safety training as Senate Bill 970 does, to the mandatory training already under way.

Section 1(f) prevents an employer from requiring an employee from treating or providing services to a patient who has verbally or physically abused or threatened him or her. This provision carries special meaning for me and my wife, who is also employed as a nurse at the Health Center.

Some years ago, our neighbor came into my garage, assaulted me, threatened my wife. He is presently serving time in a Connecticut prison for taking a baseball bat to his mother and his aunt.

He came to the Health Center through the Department of Corrections program, you know, where we care for all the inmates. He was required to go through the Procedure Center where my wife works.

When the agreement with DOC and the Health Center came about, we asked, UHP asked that a victim of an inmate not have to treat that inmate, and DOC in their wisdom said that that was the right way to go.

So my wife was given appropriate duty in the Procedure Center. She was dong the pre-op calls. The other nurses in the area were able to prepare him for his treatment and then he went on to get the treatment that was needed.

Working in a sizeable healthcare facility can be a dangerous job. Senate Bill 970 requires management and front-line workers to come together to make the facility safer for everyone who spends time there and we ask you to let the healthcare workers know that you care about their safety and urge you to support 970.

Since I haven't heard the bell yet, I'll throw out one more incident. We had a fellow

radiographer, the radiology department at John Dempsey is right next to the emergency department.

A patient who was brought into the emergency department with psychiatric issues came out of the emergency department, punched this woman in the face, and you know, he was brought down and taken back to the emergency room.

But in addition, in him maybe running away, he slipped and fell and hurt his arm. Would it be appropriate for that radiographer to take the x-rays on that patient? Thank you.

REP. RITTER: Thank you very much for your testimony.

KEITH INRIG: You're welcome.

REP. RITTER: Are there questions from the Committee? Seeing none, I just, I want to just put out a thought or two.

When we were discussing this bill, particularly the discussion around that Section 1(f) that has brought a lot of attention in. I think it's reasonable to understand the relationship between that and the requirement of the bill, I believe that it be a facility with at least 50 employees.

There are instances, and I think we're all willing to understand and recognize that, where it might not be possible to give treatment to somebody as opposed to the instance in which your wife was involved. There were qualified professionals there who were able to in effect, take her spot and treat the patient as the patient should have been treated.

So I think what we're sort of wrestling with is perhaps that balance. There may be cases, indeed, when that doesn't happen, when there is

nobody else, and I wondered if you wanted to comment on that?

KEITH INRIG: Yes, I would, thank you. First off, I look forward to working with Dr. Summerer in trying to come to a reasonable accommodation on this section of the bill.

I think there are some concerns and I look forward to sitting down and talking with him. Maybe we can come up with something.

But on the point of not having another healthcare worker available goes to the point of I don't believe, and UHP strongly believes, that no healthcare worker should ever work alone.

REP. RITTER: Thank you. I appreciate that thought as well. Are there further questions? Seeing none, thank you for your testimony.

KEITH INRIG: You're welcome.

REP. RITTER: Our next speaker will be Mary Jane Williams and she will be followed by Dale Cunningham.

MARY JANE WILLIAMS: Good afternoon, Representative Ritter and members of the Public Health Committee. Thank you for the opportunity of providing testimony on behalf of the Connecticut Nurses Association for Senate Bill 970.

I am Mary Jane Williams. I currently chair Government Relations Committee for Connecticut Nurses Association, and I am here today because over the last 12 months, I received repeated calls from nurses who have been assaulted an/or have witnesses an assault and are working in an environment that they feel are unsafe, a threat to their health and their patients' health and

their patients' family health. So it is not only about nursing.

These incidents are increasing and are more prevalent in certain settings. They have specifically asked the Connecticut Nurse Association to work on legislation that mandates a process to address violence.

In getting ready to do this, I went through the literature. This is not only a problem in the United States. This is an international issue. Violence is increasing in all sectors. And violence against health professionals, it's high for nurses. It's high for social workers, but for nurses who work in psychiatric settings it's three times as high as it is for nurses in other settings.

The Department of Justice, National Crime Victimization Survey lists average annual rates for non-fatal violent crimes, for mental health professionals it's 68.2 percent. So, and for mental health custodial workers it's 69 percent.

As significant as these numbers are, the actual numbers of incidents is probably much higher. Incidents of violence are likely to be under-reported due in part to the persistent perception within the healthcare industries that assaults are part of the job. They are not. We did not buy into being assaulted.

Under-reporting may reflect a lack of institutional reporting policies. Employees believe that reporting will not benefit them or employees fear that employers may deem assault the result of an employee negligence or poor job performance.

I have included some websites for your access to look at what's going on. But in our two

neighboring states, Massachusetts and New York, they have mandated policies that hospitals must enforce so that the professionals who are working there can handle these situations, and they have also criminalized assault.

It was recently reported to me by a nurse in the state that she was suffocated, strangled by a patient. One of her co-workers pulled the patient off of her. She received medical attention. She was on a medical leave for a week. She had to go back in the same setting with the same patient.

She didn't want to do anything, because she is intimidated by her administration for fear that she will lose her job.

I believe that we have a responsibility to the individuals in our workforce and in our healthcare systems. We must write legislation that mandates programs to protect them and their patients, and we need to criminalize this behavior, not tolerate it.

We must ultimately protect the health of the public we serve. Thank you.

REP. RITTER: Thank you very much for your testimony. Are there questions from the Committee? I would expect nothing less than a review of the literature from you, so thank you very much for that, Mary Jane.

Our next speaker will be Dale Cunningham, to be followed by Lynn Betta.

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DALE CUNNINGHAM: Good afternoon, Representative Ritter and members of the Public Health Committee. My name is Dale Cunningham. I'm a registered nurse. I work in the neonatal

intensive care unit at Lawrence and Memorial Hospital in New London.

As well as being a nurse in the hospital, I'm presently the treasurer of Local 5049, which represents the nurses. Previously, I was vice-present and president, so have been dealing with this subject matter for at least 10 years.

I'm here today to testify in favor of S.B. 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTHCARE SETTINGS. Physicians, nurses, nurse technicians, therapists and even clerical employees face a certain level of danger when they work in a hospital or other sizeable healthcare facilities.

These professionals operate in a dynamic work environment, which is often complicated by the emotional stresses experienced and projected by the patients they treat and the families they counsel. This is a hazard on the job but front-line workers and administrators can come together to make these risks manageable.

S.B. 970 helps make this happen. I have been a member of Lawrence and Memorial Hospital's safety committee for 10 years, and many complaints and grievances, especially from workers in the emergency room department. The hospital has moved to improve some environmental conditions, has increased security, is working somewhat to prevent violent incidents.

But we would like to see more done. The hospital has even implemented several OSHA recommendations at the suggestion of the safety committee. We still struggle with appropriate staffing levels, but our safety committee and the progress it has made is proof that the provisions in S.B.970 can be implemented without significant obstacles.

At L&M, I've experienced workplace violence on the neonatal unit and pediatric units with dealing with families of infants and children who are critically ill and placed in protective custody with the Department of Child and Families.

Stressful situations can be very tense and not all people deal well with the level of stress. Anxiety and feat can also drive the emotions of patients and their loved ones.

I urge you to make the safety of hospital employees, patients, families and visitors a priority and support S.B.970. Thank you for the opportunity to testify today.

REP. RITTER: Thank you very much for your testimony. One question that I've been asked particular to our part of Connecticut, L&M, is the extent to which violent actions have often been directed against non-clinical care employees and I didn't know if you wanted to offer us any additional information about that.

MARY JANE WILLIAMS: Well, we have, especially, one thing that all hospitals should look at as your environmental, entering the emergency room. Your clerical people are very prone to being injured if your environment is not set up.

L&M has taken some measures to really protect the people that they walk in. We are having issues more with increased security. We have had weapons confiscated in the emergency room, and we would like to see more actions taken to prevent that.

You know, we've even, and working with the police who bring patients in, they shouldn't just, they should really make sure they have nothing on them. And we've had, they've found weapons on

people after they have been dropped off by the police and that kind of stuff.

It's just a continual work in progress. But the fact is, we did not, as the individual from our Connecticut Nurses Association said, it's not our job to be injured. It's not right when someone, when a police officer says to you, but this is your job. They're protected if they're assaulted. That's how I feel.

REP. RITTER: Thank you. Are there any other question from the Committee? Thank you very much for your testimony.

MARY JANE WILLIAMS: Thanks.

REP. RITTER: Next we'll be hearing from Lynn Betta.

SB970

LYNN BETTA: Good afternoon. Thank you for giving me time to speak. I also work at Lawrence Memorial Hospital in New London, Connecticut. I've been a nurse, well, I've been employed there for 11 years. I work right now in the emergency room.

My specialty is crisis intervention. I work with psychiatric patients and I also care for all the intoxicated patients that come in and all the patients that come in on various substances such as PCP and all the things that are around these days. So obviously, my job comes with some burden of possible violence.

I would like to just drive home one incident that I did witness. I've witnessed many incidents over my years, but one particular that happened over this summer to a social worker.

A young man was brought in by the police, as many of my patients are brought in by the police. He was brought in for a psychiatric evaluation and

the report I got was that he was brought in because he got angry at a tag sale.

The social worker walked in to speak with this young man. He was only 18 years old. He wanted to use the phone. She said she needed to speak with him first, at which time, at no provocation, he jumped over the stretcher and started beating her. He grabbed her by the hair, pulled her down the unit and hit her several, many, many times on the back of the head and the neck.

She had a clipboard that she held over her face but he got about 20 punches in before security arrived. I tried to kick him. I tried to trip him. I jumped on him. I tried to do everything that I could do with the lack of training that I have, to no avail.

She hasn't been back, and I believe the last I heard is that she has been diagnosed with a brain injury from that assault. She does work in the school system. She was working for us part-time, so she does continue to do that work, but she is fearful, obvious, from that experience.

This bill is important to me because I attended a couple of meetings after this incident. They're called root cause analysis where the hospital and administration goes through the event and finds out what could be done better, you know.

One of the things that came out when they investigated it, they didn't talk to me at all. I was the only one that witnessed this event. Nobody ever asked me what happened. They watched a time lapse tape, which has no audio on it. They actually said to the social worker that, you know, after reviewing the tape, they found that she was not at fault, so that's the good news and that was very hurtful for her, obviously.

And since these meetings have occurred, there's been very little that has been put in place to protect us.

I agree, I am a very big patient advocate. I've worked in psychiatry for five years and I'm knowledgeable in the difference between a sociopath and a psychotic patient.

But sometimes when people are charged with assaults and things like that, there are, there is help in a prison system. There is mental health in the prison system and sometimes people need to know, you know, they have to be charged with things.

So, I don't know what the answer is. This particular incident was very disturbing, especially that the hospital didn't take us seriously as far as suggestions we had made, so, thank you.

REP. RITTER: Thank you very much, and thank you for coming to help us with this today. Are there any other questions from the Committee? Seeing none, that concludes our testimony on this bill.

We're going to go next to Senate Bill 972 AN ACT PROTECTING MINORS FROM THE HEALTH RISKS ASSOCIATED WITH THE USE OF TANNING DEVICES. Our first speaker will be Nancy Alderman, to be followed by Mike Morrissey.

NANCY ALDERMAN: Hi. Good afternoon, Chairs Andrea Stillman, Representative Betsy Ritter, members of the Public Health Committee. My name is Nancy Alderman. I am President of Environment and Human Health, Inc., a group of nine physicians and public health professionals dedicated to protecting the public from environmental harm. We take no money from businesses or corporations.

**Testimony of Charles Herrick, M.D.**
**Chairman, Department of Psychiatry**
**Danbury Hospital**

**Senate Bill 970, An Act Concerning Workplace Violence Prevention and Response in Health Care Settings**

**Joint Committee on Public Health**
**February 23, 2011**

Senator Stillman, Representative Ritter and other distinguished members of the Public Health Committee, my name is Charles Herrick and I currently serve as Danbury Hospital's Chairman of the Department of Psychiatry. I have served in that capacity since 2006, having previously served as its vice chairman and Medical Director for the Hospital's Intensive Psychiatric Services.

I come before you today to express Danbury Hospital and New Milford Hospital's ("Western Connecticut Health Care, Inc.") concerns and support for the concepts contained within SB 970. From the outset let me say that both hospitals make employee and patient care their highest priority. While we fully understand why the bill is before you today given our own recent experience at Danbury Hospital, and we are generally supportive, we have major concerns for the bill's potentially harmful impact on patient care. Most importantly, we do not support the concept proposed in Subsection (f) of the bill.

Subsection (f) would not only violate patients' rights but would violate our hospitals' core mission by allowing health care employees to refuse to care for patients who the employer knows to have verbally or physically threatened that employee. As many of you are aware, quite often patients arrive at a hospital in a state of extreme distress resulting from a medical or psychiatric condition, or from the anxiety associated with being in a hospital setting, which in itself can be extremely frightening, particularly when one is cognitively impaired. If Subsection (f)'s language were adopted, it would be nothing short of catastrophic to the health care delivery system because it would pose insurmountable barriers to treatment. Our health care employees make difficult decisions every minute of every day in the care of many patients who struggle behaviorally, whether they are medically or psychiatrically ill. Health care workers such as myself, took an oath to provide care to all who need it, and accept the risk that the potential for violence may be the result of a patient's illness. It is worth noting that the risk of imminent violence is, in fact, one of the major criteria mandated by the State for immediate involuntary hospitalization to a psychiatric facility If an employee were to refuse to treat a patient because of a patient's violent behavior, that decision would have a detrimental effect on the entire health care team's ability to care for these patients. We

would not grant any other worker the opportunity to refuse to do the job they were hired to perform, whether they are the police or the fire department. They also took oaths and accepted the risks involved. Health care workers also understand that there are risks involved in the performance of their duties.

Violence takes many forms and is the result of many conditions. While I laud the intent SB 970 has in protecting health care workers, it is too broad in its definition of assault to have an appreciation for the complexities of behavior. While I am not a lawyer and have only a limited understanding of the legal definition of assault, I have treated many violent patients in my 20 years as a practicing psychiatrist and have been the victim of patient assaults. Only rarely is a patient's violence premeditated. The vast majority of alleged assaults can be directly attributed to a patient's medical or psychiatric condition. Increasingly that medical condition is Alzheimer's disease or other forms of dementia. To report all of these instances would tax both the health care system and the State both in terms of labor as well as cost, without actually addressing the intent of the bill at all, which is to ultimately lower the risk to health care workers. We at Danbury Hospital have developed a very rigorous program to educate our health care workers on identifying potentially violent patients and teach them specific skills in de-escalating threatening patients and protocols for handling patients should de-escalation not work. We believe that the way to lower the risk to health care workers is through education and changing the culture, not through external reporting, which could even potentially violate patient's rights to privacy.

We at Danbury Hospital have maintained an unparalleled commitment to the patients and families in our care by ensuring that those who present at our Emergency Department with psychiatric needs do not languish for days waiting to be hospitalized, as so many do at other facilities. Because Region V lacks the bricks and mortar of a state institution, Danbury Hospital has become the de facto state inpatient facility as the transfer of these patients to a state facility is generally not a timely option. We believe that the language in Subsection (f) would seriously undermine our ability to continue to honor that commitment because we would not be obligated to either evaluate or care for those patients who are violent. We need to continue to identify and treat patients in crisis who pose a risk to themselves or others as well as the health care employees who treat them.

Beyond our serious concern for Subsection (f), we do support many of the other important concepts enumerated in the bill including:

1) establishing workplace violence committees with substantial employee participation;

2) developing and implementing a written workplace violence plan;

3) soliciting expert guidance from the Joint Commission and OHCA and implementing best practices.

We appreciate the Public Health Committee's thoughtful consideration of our concerns and look forward to an opportunity to serve as a resource to the committee going forward.

*Suggested Modifications to*

***SB 970, AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS***

Subsections (b) to (g), inclusive of Section 1 should be deleted and the following substituted in lieu thereof:

(b) Each health care employer shall, on or before October 1, 2011, establish and convene an ongoing workplace safety committee to address issues related to worker health and safety. A health care employer's workplace safety committee shall be composed of representatives from the administration, physician, nursing and other direct patient care staff, security personnel and any other staff deemed appropriate by the employer. Not less than fifty per cent of the committee membership shall be composed of non-management employees. A hospital may utilize an existing committee or committees to assist in the preparation of the workplace violence prevention and response plan, provided not less than fifty per cent of the members of such existing committee or committees are non-management employees. The committee shall meet not less than quarterly and shall make available meeting minutes and other records from its proceedings to all employees.

(c) On and after October 1, 2011, and annually thereafter, each health care employer shall undertake a risk assessment of the factors that may put any health care employee at risk for being a victim of workplace violence. Based on the findings of the risk assessment, on or before January 1, 2012, and on or before each January first thereafter, each health care employer, in collaboration with the workplace safety committee, shall develop and implement a written workplace violence prevention and response plan. In developing the plan, the health care employer may consider any guidance on workplace violence issued by any federal or state agency, including the federal Occupational Safety and Health Administration, the federal Centers for Medicare and Medicaid Services, the Centers for Disease Control, the Department of Public Health, the Labor Department, and hospital accrediting organizations.

(d) A health care employer may satisfy the requirements for a written workplace violence prevention and response plan as required in subsection (c) by utilizing existing policies, plans, or procedures if, after the risk assessment and consultation with the workplace safety committee, such existing policies, plans, or procedures are determined to be sufficient.

(e) The Labor Commissioner may adopt regulations in accordance with the provisions of chapter 54 of the general statutes necessary to carry out the purposes of this section.

Section 2 is deleted and the following is substituted in lieu thereof:

(NEW) A health care employer shall notify police within 24 hours of any crime on its premises involving the assault of a health care employee and shall provide the police with the identity and address of the person or persons involved.

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**Written Testimony of**

**Mary Consoli, President**
**Danbury Nurses' Union Unit #47, AFT Local 5047, AFL-CIO**

**To Representative Betsy Ritter, Senator Andrea Stillman**
**and Members of the Public Health Committee**

**Re: S.B. No 970 AN ACT CONCERNING WORK PLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS.**

**February 23, 2011**

My name is Mary Consoli and I am President of the Danbury Nurses' Union Unit #47, American Federation of Teachers Local 5047, AFL-CIO, a labor union representing 600 registered nurses at Danbury Hospital. I am speaking on behalf of our 600 members in support SB 970. We are asking you to require each health care employer to establish and convene an ongoing Safety Committee to address issues of worker health and safety.

This bill is needed because the federal requirements for health care security in the Centers for Medicare & Medicaid Services Conditions of Participation and the Joint Commission Standards are not enough. A mandate is needed because OSHA does not regulate workplace violence, and in Connecticut there is no specific law to help prevent it. And all health care facilities consider the cost associated with providing a safe work environment, but at what cost is the life of a healthcare worker? This is why we need Senate Bill 970 now. Health care workers in Connecticut should not fear for their safety when going to work.

We are not seeking voluntary programs. Nurses have shared their concern for safety at staffing meetings. Over the last ten years, I have communicated these concerns to senior management in correspondence and during monthly labor management meetings, with no changes implemented to improve safety. In 2008, union and non union employees circulated a petition about the lack of security and requested a meeting with Frank Kelly, CEO of Danbury Hospital to express their concerns. He refused a meeting.

We filed a grievance in January 2009, when a nurse on the Inpatient Psychiatric Unit was hit by a patient who then threatened daily to throw her down a flight of stairs. Our internal grievance process can correct site–specific concerns, but is limited in scope. It cannot provide for comprehensive, system wide work place safety improvements.

In October, 2009 we filed a complaint with OSHA and the Department of Public Health after another nurse on our Inpatient Psychiatric Unit was assaulted by a patient, fell and broke her hip. On March 2, 2010 a nurse was shot while disarming a patient with a gun. This brought about an OSHA inspection of the hospital that resulted in a formal citation for not providing a safe work environment. It was only after the OSHA citation that Danbury Hospital agreed to address these long standing safety issues.

They hired a consultant to review the security at the hospital and make recommendations. The Union had no role with the investigation by the consultant; individual members were invited to meet in focus groups with the consultant. The hospital set up a task force to review the recommendations. I was invited to be part of the task force after it was convened. I was given a last minute notice and attended the last two meetings. I made recommendations at the table and sent a letter to management with suggestions. To date, my letter has not been acknowledged and there has been no evidence that any of the union's suggestions were implemented.

We did our own assessment of workplace violence with a survey of our members and offered the data we collected to the hospital. They were not interested in our survey results. We offered to bring in nationally acclaimed experts from the Work and Health Research Center of the University of Maryland School of Nursing, to give presentations to all employees, including management, on developing a comprehensive workplace violence prevention program. They refused our offer. We conducted two workshops to educate our members and raise awareness of what can be done to prevent workplace violence, in June and September, 2010.

The Union had no input into developing the Hospital's workplace violence prevention plan, nor has the hospital complied with our request for a copy of their violence prevention plan. We are not aware of any specific mechanism for reporting workplace violence incidents or how the effectiveness of the program is being monitored. We do not know how assaults will be reported to the local police department. If we are not part of the process to develop a plan, the plan will not address our concerns and will not prevent future incidents.

Workplace violence is not part of a nurse's or health care worker's job. It is a recognized occupational safety hazard that can be controlled and prevented with a comprehensive violence prevention plan and a committed management. We do not want that commitment to be the results of shootings and assaults at every health care setting in Connecticut.

I urge you to vote in support of Senate Bill 970. Thank you for your consideration,

Mary Consoli, RN, BSN
President
Danbury Nurses' Union Unit #47
AFT Local 5047, AFL-CIO
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**Written Testimony of**

**Sandra Foley, RN**
**Danbury Nurses' Union Unit #47, AFT Local 5047, AFL-CIO**

**To Representative Betsy Ritter, Senator Andrea Stillman and Members of the Public Health Committee**

**Re: S.B. No 970 AN ACT CONCERNING WORK PLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS.**

**February 23, 2011**

I'm writing this letter in reference to the safety and security of co-workers at Danbury Hospital. Though improvements have been made recently, I feel as though there is much more that can be done. There have been several incidents that in my 20 year employment at Danbury Hospital that make you wonder if we are safe. Patients can be unpredictable and in the essence of illness, even family members can be irate in difficult situations. As tempers flare and in an environment that is strange and unusual, our security as workers is threatened in a daily basis.

Of course we are familiar with the recent shooting where a gunman severely wounded another coworker which was trying to help another co-worker calm her confused and angry patient. But what about the other incidents that go unreported but could have been just as serious?

I witnessed an angry patient who was in a drug-induced craze. He picked up his father and threw him onto the neighbor's bed, which the patient was in. As I watched the patient strangle his father, I desperately called out for help. I was unable to reach the phone to dial 55. No one heard my call and I was pushed into the hallway with the rumbling two men. Finally, I got the message for CODE BLUE to initiate a response. Our security staff at Danbury Hospital is excellent and they are hardworking people, but cannot be everywhere at all times. I think if we had the panic buttons that we had in the past, this incident could have been resolved much quicker without the emotional and physical trauma to patients and staff.

Another issue is the 3-11 PM shift leaving after 12:20 AM. Security is no longer in the parking lot and it can be very scary at night. Though the garage is well lit, it would be comforting to know that we are safe.

Some floors receive patients that are psychologically impaired, and questionably dangerous. They need to be cleared medically until they are discharged and admitted to psychiatry. These people should be identified and should have a 24 hour 1:1 sitter to help keep them and the staff safe until the transition can be made. I recently heard a manager state "There are no more sitters." How could this be? Not very well thought out!

I urge you to support SB 970 so we can continue working on the safety of our patients and staff. Thank you for your time.

Sandra Foley, RN
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**Written Testimony of**

**Jane Sturges, RN, BSN**
**Danbury Nurses' Union Unit #47, AFT** Local 5047, AFL-CIO

**To Representative Betsy Ritter, Senator Andrea Stillman**
**and Members of the Public Health Committee**

**Re: S.B. No 970 AN ACT CONCERNING WORK PLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS.**

**February 23, 2011**

My name is Jane Sturges and I work as a staff nurse on the In Patient Psychiatric Unit at Danbury Hospital, Danbury CT. Three years ago on New Year's Eve, I was struck by a patient who had thrown a chair and broke a window in the patient's dining room. I was not aware of this event because our unit is two floors and I was upstairs at the time of the incident. Security was called and the patient was escorted upstairs which is where I was at the time. In an attempt to place the patient in our quiet room where he could deescalate and regain self control, the patient managed to strike me in the left shoulder with three security guards present. Luckily, I did not sustain any serious injury from the occurrence. However, the patient remained on our unit for another month. During that time the patient continued to make verbal threats to push me down the stairwell. The only support that I received from management was that I could arrange to use some of my accumulated sick or vacation time until the patient had been discharged. I was also informed that I could not press charges against the patient because it is a psychiatric unit.

I chose to stay a work and deal with the threats on a daily basis because I did not feel I should have to use my time. I thought my employer had a duty to provide a safe work environment where threats would not be tolerated.

Management also made it clear that psychiatry, by nature, can be a dangerous unit and that I was aware of this when I signed up for the position. This may be so, but it does not mean that the hospital shouldn't have sufficient, appropriately trained staff at all times including a security guard on the floor to help with a more immediate response to emergencies.

As I said, I was lucky not to have received any serious injuries. Others have however. About twelve years ago a nurse was attacked, beaten badly and sustained serious injuries and left the field of psychiatric nursing because of it. More recently another nurse was punched in the face, knocked down and broke her hip.

We cannot continue to allow violence in the workplace such as this to continue. Nurses and other healthcare professionals need to feel safe in their work environment to do the necessary work to heal our patients. At the same time, however, we need to be protected and feel confident that our employer stands behind us 100%.

With the challenging economic times, it is more important than ever to have a safe environment, not only for employees, but for our patients so that they will choose Danbury Hospital as their institution of care.

It is for these reasons that I strongly support and fight for the need for Senate Bill 970, to set a policy for a Work Place Violence Program in all Health Care Institutions. It is our right to feel safe and supported in the work place in order to do our job well.

Thank you.

Respectfully,
Jane Sturges
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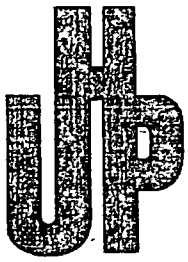

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Jean M Morningstar
President

Testimony of Keith Inrig, First Vice President

University Health Professionals, AFT Local 3837

**SB 970 An Act Concerning Workplace Violence Prevention and Response in Health Care Settings**

Public Health Committee

February 23, 2011

Good afternoon Senator Stillman, Representative Ritter and members of the Public Health Committee. I am Keith Inrig, a Radiographer by trade. Presently I am the First Vice President for University Health Professionals, the labor union representing the 2,500 non-faculty professionals at UConn Health Center.

I am here to speak in favor of SB 970. Other hospitals can look to John Dempsey Hospital and UConn Health Center to see that the essence of this bill can and does work. Most of the components of this bill are in place or being implemented at the Health Center. Although a joint UHP and management Health and Safety committee has been dormant, we are already starting it up again. As well, the Health Center has a safety initiative underway. I feel it would be appropriate to add safety training, as SB 970 does, to the mandatory training already required.

Section 1 (f) prevents an employer from requiring an employee from treating or providing services to a patient who has verbally or physically abused or threatened him or her. This provision carries special meaning for me and my wife, who is also employed by UConn Health Center as a nurse.

Some years ago, a neighbor came into my garage. He assaulted me and threatened my wife. He is now serving time in prison for assaulting his mother and his aunt. He later came to John Dempsey Hospital for treatment as a prison inmate. My wife works in the pre-op area where his treatment would have started.

When the Department of Corrections managed care program was brought to Dempsey, our union, University Health Professionals, asked that inmates not be treated by any of their victims. Thankfully, the Department of Corrections agreed. My wife was given

appropriate duties in another area of the Procedure Center so that he would not see her and she was not forced to see him. This type of arrangement protects healthcare professionals, patients and the institution.

Working in a sizable healthcare facility can be a dangerous job. SB 970 requires management and frontline workers to come together to make the facility safer for everyone who spends time there. Let healthcare workers know you care about their safety. I urge you to support 970.

Thank you for the opportunity to testify. I would be happy to answer any questions.

Testimony of
Lynn Betta, RN
Lawrence and Memorial Hospital RN's, AFT Local 5049

**SB 970 An Act Concerning Workplace Violence Prevention and Response in Health Care Settings**

Public Health Committee
February 9, 2011

Good afternoon Senator Stillman, Representative Ritter and members of the Public Health Committee. My name is Lynn Betta and I am a Registered Nurse, employed 11 years at Lawrence Memorial Hospital. I am here to testify in support of SB 970 An Act Concerning Workplace Violence and Prevention in Health Care Settings.

I currently work in the emergency room and I specialize in crisis intervention. I care for patients coming in for psychiatric evaluations for various reasons. I also care for intoxicated patients and patients that have used various substances who often arrive confused and combative. Many of my patients arrive with the police.

This past summer I witnessed a violent assault on one of our social workers. An 18 year old man with a psychiatric history was brought in by the police for an evaluation. The social worker entered the room at which time the patient asked to make a phone call. He was denied this request, as the social worker explained she needed to speak with him first. Then the patient jumped over the rail of the stretcher and started punching the worker. She fell to the ground when attempting to flee and he grabbed her by the hair and pulled her down the hall. Luckily she had a clipboard which she held over her face but she was punched in the neck several times. When security arrived, the patient was in need of being pepper sprayed as he would not back down.

I later found out that this young man had assaulted his neighbor earlier that day. This man had also bit one of the hospital security guards in the forehead on a previous visit, but this was not known to the staff that day. I believe if there was a standard for reporting such incidents, staff would have been aware of this man's history and more precautions would have been taken to keep employees safe.

Our hospital currently has a safety committee that meets monthly. I sit on this committee. However, there is so much on the agenda that there is not enough time to spend on this issue alone. I believe violence in the healthcare setting such as this should be reportable to an entity other than the hospital administration. I have requested, several times, more in depth training and increased security presence because the example I gave is unfortunately one of many incidents. Many close calls have come our way and verbal threats occur regularly.

The Public Health Department, General Assembly and the public at large should be aware that safety is often compromised in settings such as this. If left to the hospital administration, I

believe these things will continue to go unreported in order to "protect" the organization's reputation. I ask you to support SB 970 so that we, the healthcare workforce, may be protected.

Thank you again for the opportunity to speak today. I would be happy to answer any questions you may have.

Testimony of
Dale Cunningham, Treasurer
Lawrence and Memorial Hospital RN's, AFT Local 5049

**SB 970 An Act Concerning Workplace Violence and Prevention in Health Care Settings**

Public Health Committee
February 23, 2011

Good afternoon Senator Stillman, Representative Ritter and members of the Public Health Committee. My name is Dale Cunningham and I am a Registered Nurse in the Neonatal Intensive Care Unit at Lawrence and Memorial Hospital in New London. As well as being a nurse at the hospital, I am the treasurer of the nurses' union, representing approximately 500 members. I am here today to testify in favor of SB 970 An Act Concerning Workplace Violence Prevention and Response in Health Care Settings.

Physicians, nurses, nurse technicians, therapists and even clerical employees face a certain level of danger when they work in a hospital or other sizeable healthcare facility. These professionals operate in a dynamic work environment, which is often complicated by the emotional stresses experienced and projected by the patients they treat and the families they counsel. This is a hazard of the job, but frontline workers and administrators can come together to make these risks manageable. SB 970 helps make this happen.

I have been a member of Lawrence and Memorial's safety committee for ten years. After many complaints and grievances, especially from workers in the Emergency Department, the hospital has moved to improve environmental conditions and increase security throughout the hospital in order to prevent violent incidents. The hospital has even implemented several OSHA recommendations at the suggestion of the safety committee. We still struggle with appropriate staffing levels, but our safety committee, and the progress it has made, is proof that the provisions in SB 970 can be implemented without significant obstacles.

At L&M I have experienced workplace violence on the Neonatal and Pediatric Units when dealing families of infants and children that are critically ill or placed in protective custody with the Department of Children and Families. Stressful situations can be very tense and not all people deal well with that level of stress. Anxiety and fear can also drive the emotions of patients and their loved ones.

I urge you to make the safety of hospital employees, patients, families and visitors a priority and support SB 970. Thank you for the opportunity to testify today. I would be happy to answer any questions you may have.

University of Connecticut Health Center
*John Dempsey Hospital*

**TESTIMONY**

**SB 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS**

**Public Health Committee**
**February 23, 2011**

Senator Stillman, Representative Ritter, members of the Public Health Committee, thank you for the opportunity to speak with you today in support of SB 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS. I am Dr. Mike Summerer, Director of John Dempsey Hospital at the University of Connecticut Health Center.

The growing concern over workplace violence in healthcare settings becomes magnified as examples occur across the nation and in our own state. At our institution, the dual mission of education and healthcare co-located within the same buildings and campus requires balancing our commitment to provide our employees with a safe and secure work environment, our students with a safe learning environment and our patients with a safe environment of care. Towards this end, we have developed committee structures to review security management risks, and are reinvigorating our workplace violence threat assessment team that includes our Clinical Safety Committee, Public Safety and Human Resources Departments. We have also developed a training program for staff to build skills to "de-escalate" behaviors of patients and visitors. All of this is considered best practice and is consistent with the expectations of the Joint Commission, which accredits healthcare institutions nationally, including John Dempsey Hospital. Passage of this bill will enhance the work we are already engaged in.

The University of Connecticut Health Center (UCHC) provides 24 hour medical care, 365 days per year to a broad segment of the state's population, including the incarcerated through the Correctional Managed Health Care program, and a significant number of patients with psychiatric disorders. The medical care we provide includes in-patient, out-patient and emergency room services. While we support Section 1(f) of the bill in principle, we have some concerns with the language as drafted. We would very much like the opportunity to work with you and the proponents of the bill to redraft this section so that we can adequately balance the medical needs of our patients while also protecting the safety of our staff.

I urge your support of SB 970 with a modification to Section 1(f). Thank you for your attention and for your consideration.

*An Equal Opportunity Employer*

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**Written Testimony of**

**Paula Amero, RN**
**Danbury Nurses' Union Unit #47, AFT Local 5047, AFL-CIO**

**To Representative Betsy Ritter, Senator Andrea Stillman and Members of the Public Health Committee**

**Re: S.B. No 970 AN ACT CONCERNING WORK PLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS.**

**February 23, 2011**

My passion for health care began at the age of seventeen. During my journey I have been spit at, pushed, slapped, hit, kicked, beaten, chocked and even had my jaw broken! Today, I can add being shot at by a patient. I am 53, my name is Paula Amero, and I work at Danbury Hospital as an R.N.

I bring this experience to you today to show the need to support Senate Bill 970. We must have a uniform policy for developing workplace violence programs in our health care institutions, not only for the worker, but also for you and your family.

The day of this shooting was about seven months ago. I work on a cardiac unit. My patient, or "shooter " as most like to call him, was beginning to act more paranoid, hallucinating that the I.V. pole was going to hurt him. As his agitation grew, I saw the fear on the nurse's aide's face, herself being just a nursing student. As I attempted to get an M.D. to assess the patient and possibly medicate him, my assistant nurse manager went to assist in getting the patient under control.

I heard two shots. Everyone stood in shock and disbelief of what they heard. On instinct, I ran down the hall towards my patient's room which was three rooms away from the Nurses' Station. What I saw was my patient lying on the floor and my clinical leader on top of him. My patient's arm was pointing toward the ceiling, holding a small caliber semi-automatic hand gun. There was blood on the floor and the wall.

My patient kept yelling that he was going to shoot everyone. I ran to grab his arm and the gun, but fell short. I watched my boss get shot two more times as I ducked behind a laundry cart. That was al I that was between me and a gun. He shot the gun several more times randomly towards the Nurses' Station.

There was a lot of screaming. So much happened in a very short period of time. Hospital security was all around that I could see. One took the shooter (who was still lying on the floor) from behind and got the gun from his hand. By then Swat Team was there with many more guns.

No matter how I felt, my passion stepped in and I got down on the floor next to my patient and took care of him. He also got shot that day.

There were many "HERO'S" that day and several that had the gun pointed right at their abdomen and forehead. Yet, we continue to have to fight for assistance from hospital management. We need policy changes, security changes and a heightened awareness with not only aggressive patients, but also with visitors.

I love my job, but I love my eleven year old child more. I need to go into work feeling safe and she needs to go to school knowing mommy will not get shot at again. No one looses with this bill. Not even the person who commits the violent act. I urge you to support SB 970.

Thank you for your time.

**TESTIMONY OF**
**CONNECTICUT HOSPITAL ASSOCIATION**
**SUBMITTED TO THE**
**PUBLIC HEALTH COMMITTEE**
**Wednesday, February 23, 2011**

## SB 970, An Act Concerning Workplace Violence Prevention And Response In Health Care Settings

The Connecticut Hospital Association (CHA) appreciates the opportunity to submit testimony concerning **SB 970, An Act Concerning Workplace Violence Prevention And Response In Health Care Settings**. CHA supports the goals of SB 970, but we have significant concerns about the bill as written.

Mark Chassin, MD, MPP, MPH, president of The Joint Commission, the independent Commission that accredits hospitals in Connecticut and across the country, recently said "Healthcare facilities should be places of healing, not harm. But unfortunately, healthcare settings are not immune from the types of violence that are found in the other areas of our lives."

Incidents of violence are a growing national problem. Every week, sadly sometimes several times a week, we are confronted with tragic news of yet more senseless acts of violence in our schools, communities, and workplaces. **The goal of SB 970 is to reduce and prevent violence in the healthcare workplace, a goal that CHA and its member hospitals strongly support**. Protecting healthcare workers is one of the most important priorities for healthcare employers.

Hospitals want to ensure that healthcare worker safety remains a top priority.

The risk for isolated violent episodes is high in almost every healthcare setting, from the emergency room through long-term care. There is no way to control who becomes a patient. Our healthcare system is designed to help everyone in need of care and treatment. Often patients are in a state of physical or mental crisis that makes them more dangerous than they would be when stabilized and in their normal routine. Hospital workers are particularly vulnerable to the risks of workplace violence because they are often attending to patients with unknown diagnoses and problems, who are just entering the care continuum and who have yet to be evaluated.

CHA fully supports requiring the bedrock principles outlined in SB 970, which are:

- establishing workplace violence committees, with substantial employee representation;
- conducting a risk assessment by the employer, with committee input;
- creating, and annually updating, a written workplace violence prevention and response plan; and
- relying on existing sources of expert opinion and advice, such as OSHA and the Joint Commission.

SB 970 attempts to address the risk of workplace violence with a detailed series of mandates that would control how every healthcare facility approaches workplace violence prevention. CHA believes that the bill could be amended to achieve our shared goals and protect the safety of both patients and healthcare workers in a much less prescriptive manner that can be tailored to the unique characteristics of each facility.

CHA does object to subsection (f) of the bill, which would violate patient rights. Hospitals are not permitted to abandon patients because they present in an aggressive or abusive manner – a problem that often is the result of a physical or mental condition that the patient cannot control.

To accomplish these goals and move forward together on this important initiative, we respectfully request that the bill be revised to reflect these core obligations. We have attached a revised version of the bill to our testimony with our recommended changes.

Thank you for your consideration of our position.

For additional information, contact CHA Government Relations at (203) 294-7310.

JDI:pae

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SB970

**TESTIMONY RE: S.B. An Act Concerning Workforce Violence Prevention in Health Care Delivery Systems**

Public Health Committee
February 23, 2011

Good afternoon Senator Stillman, Representative Ritter and members of the Public Health Committee. Thank-you for the opportunity to provide testimony on behalf of the Connecticut Nurses' Association (CNA), the professional organization for registered nurses in Connecticut, for S.B, ***AN ACT CONCERNING Workforce Violence Prevention in Health Care Delivery Systems***

I am Mary Jane Williams Ph.D., RN current chairperson of Government Relations Committee for the Connecticut Nurses Association and professor emeritus from Central Connecticut State University. I have practiced nursing for over 45 years and have been educating nurses in Connecticut in both the public and private sector for over 35 years.

Over the last twelve months I have received repeated calls from nurses who have been assaulted and/or have witnessed an assault and are working in environments that they feel are unsafe and a threat to their health. These incidents are increasing and are more prevalent in certain settings.

In order to prepare this testimony in support of the concepts delineated in S.B. 970 I thought it would be helpful to look at what is happening nationally and internationally. This is an urgent problem that requires your attention. It is definitely a threat to our workforce and the individuals they care and advocate for in the health care delivery systems.

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty."[1] Violence in health care systems is an international problem and nurses world wide are finding their voice. Nurses are speaking out against work environments that continue to be unsafe and fail to provide adequate protection.

The problem is prevalent in the United States. The Bureau of Labor Statistics reports that 7% of workplace injuries to nursing, psychiatric, and home health aides between 1995 and 2004 resulted from assaults; for all workers over the same period, assaults caused only 1% of injuries.

The Bureau of Labor Statistics (BLS) reports that there were 69 homicides in the health services from 1996 to 2000. Although workplace homicides may attract more attention, the vast majority of workplace violence consists of non-fatal assaults. BLS data shows that in 2000, 48 percent of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. Most of these occurred in hospitals, nursing and personal care facilities, and residential care services. Nurses, aides, orderlies and attendants suffered the most non-fatal assaults resulting in injury.

Injury rates also reveal that health care and social service workers are at high risk of violent assault at work. BLS rates measure the number of events per 10,000 full-time workers in this case, assaults resulting in injury. In 2000, health service workers overall had an incidence rate of 9.3 for injuries resulting from assaults and violent acts. The rate for social service workers was 15, and for nursing and personal care facility workers, 25. This compares to an overall private sector injury rate of 2.

The Department of Justice's (DOJ) National Crime Victimization Survey for 1993 to 1999 lists average annual rates of non-fatal violent crime by occupation. The average annual rate for non-fatal violent crime for all occupations is 12.6 per 1,000 workers. The average annual rate for physicians is 16.2; for nurses, 21.9; for mental health professionals, 68.2; and for mental health custodial workers, 69. (*Note:* These data do not compare directly to the BLS figures because

DOJ presents violent incidents per 1,000 workers and BLS displays injuries involving days away from work per 10,000 workers. Both sources, however, reveal the same high risk for health care and social service workers).

As significant as these numbers are, the actual number of incidents is probably much higher. Incidents of violence are likely to be underreported, due in part to the persistent perception within the health care industry that assaults are part of the job. Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them or employee fears that employers may deem assaults the result of employee negligence or poor job performance. (AJN)

Health care workers must routinely handle patients who are delirious, agitated, and even aggressive, especially on psychiatric units, in EDs, and in nursing homes. Recent studies and news reports suggest that when agitation escalates into full-blown assault, nurses are often the victims. (AJN)

The World Health Organization (WHO), the International Labor Office, the International Council of Nurses, and Public Services International collaborated in 2000 to study the global implications of and approaches to the problem. In 2002 they released *Framework Guidelines for Addressing Workplace Violence in the Health Sector* (for links to the report go to **http://www.who.int/violence_injury_prevention/violence/activities/workplace/en/index.html**).

Violence in health care settings is a global issue that particularly threatens access to primary health care in developing countries, which already suffer shortages of health care workers. Underreporting of violence is also a widespread problem, the WHO report says, perhaps because workers see the abuse as an expression of patients' illnesses or as an acceptable part of the job. Another reason for the underreporting "is work pressures that do not allow time for staff to report." (WHO)

What should the victim do? Many nursing advocates say that all nurses who are victims of work-related physical assault should file a criminal report with the police and hold the perpetrators accountable. (WHO)

The Massachusetts Nurses Association identifies on its Web site (**http://www.massnurses.org/**) several other things that victims of any type of abuse should do, such as the following:

* Don't be silent; speak about what has happened to managers and coworkers.

* Photograph any injuries.

* Work with hospital administrators and union representatives to formulate procedures, such as "algorithms for prevention and intervention."

* Ask witnesses to document what they saw.

* Be cautious with patients known to have a history of violence.

But some nurses are saying that they don't see this type of workplace support. Nurses who have been assaulted are expected to return to work on the same unit with the same patients. They are fearful of losing their jobs so do not take any action.

I believe that we have a responsibility to the individuals in our workforce and in our health care systems. We must write legislation that provides programs that protect them and their patients. WE need to criminalize this behavior not tolerate it. We must ultimately protect the health of the public we serve.

Thank you

**Recommendations' From OSHA**

**Violence Prevention Programs**

A written program for job safety and security, incorporated into the organization's overall safety and health program, offers an effective approach for larger organizations. In smaller establishments, the program does not need to be written or heavily documented to be satisfactory.

What is needed are clear goals and objectives to prevent workplace violence suitable for the size and complexity of the workplace operation and adaptable to specific situations in each establishment. Employers should communicate information about the prevention program and startup date to all employees.

At a minimum, workplace violence prevention programs should:

- Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats and related actions. Ensure that managers, supervisors, coworkers, clients, 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.

***Elements of an effective violence prevention program***

The five main components of any effective safety and health program also apply to the prevention of workplace violence:

- Management commitment and employee involvement;

- Worksite analysis;
- Hazard prevention and control;
- Safety and health training; and
- Recordkeeping and program evaluation.

**Management Commitment and Employee Involvement**

Management commitment and employee involvement are complementary and essential elements of an effective safety and health program. To ensure an effective program, management and frontline employees must work together, perhaps through a team or committee approach.

Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence. This commitment should include:

- Demonstrating organizational concern for employee emotional and physical safety and health;
- Exhibiting equal commitment to the safety and health of workers and patients/clients;
- Assigning responsibility for the various aspects of the workplace violence prevention program to ensure that all managers, supervisors and employees understand their obligations;
- Allocating appropriate authority and resources to all responsible parties;
- Maintaining a system of accountability for involved managers, supervisors and employees;
- Establishing a comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents; and
- Supporting and implementing appropriate recommendations from safety and health committees.

Employee involvement and feedback enable workers to develop and express their own commitment to safety and health and provide useful information to design, implement and evaluate the program.

Employee involvement should include:

- Understanding and complying with the workplace violence prevention program and other safety and security measures;
- Participating in employee complaint or suggestion procedures covering safety and security concerns;
- Reporting violent incidents promptly and accurately;

- Participating in safety and health committees or teams that receive reports of violent incidents or security problems, make facility inspections and respond with recommendations for corrective strategies; and
- Taking part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior or criminal intent and discusses appropriate responses.

**Worksite Analysis**
***Value of a worksite analysis***

A worksite analysis involves a step-by-step, commonsense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific areas where hazards may develop. A threat assessment team, patient assault team, similar task force or coordinator may assess the vulnerability to workplace violence and determine the appropriate preventive actions to be taken. This group may also be responsible for implementing the workplace violence prevention program. The team should include representatives from senior management, operations, employee assistance, security, occupational safety and health, legal and human resources staff.

The team or coordinator can review injury and illness records and workers' compensation claims to identify patterns of assaults that could be prevented by workplace adaptation, procedural changes or employee training. As the team or coordinator identifies appropriate controls, they should be instituted.

***Focus of a worksite analysis***

The recommended program for worksite analysis includes, but is not limited to:

- Analyzing and tracking records;
- Screening surveys; and
- Analyzing workplace security.

***Records analysis and tracking***

This activity should include reviewing medical, safety, workers' compensation and insurance records, including the OSHA Log of Work-Related Injury and Illness (OSHA Form 300), if the employer is required to maintain one to pinpoint instances of workplace violence. Scan unit logs and employee and police reports of incidents or near-incidents of assaultive behavior to identify and analyze trends in assaults relative to particular:

- Departments;
- Units;
- Job titles;
- Unit activities;

- Workstations; and
- Time of day.

Tabulate these data to target the frequency and severity of incidents to establish a baseline for measuring improvement. Monitor trends and analyze incidents. Contacting similar local businesses, trade associations and community and civic groups is one way to learn about their experiences with workplace violence and to help identify trends. Use several years of data, if possible, to trace trends of injuries and incidents of actual or potential workplace violence.

***Value of screening surveys***

One important screening tool is an employee questionnaire or survey to get employees' ideas on the potential for violent incidents and to identify or confirm the need for improved security measures. Detailed baseline screening surveys can help pinpoint tasks that put employees at risk.

Independent reviewers, such as safety and health professionals, law enforcement or security specialists and insurance safety auditors, may offer advice to strengthen programs. These experts can also provide fresh perspectives to improve a violence prevention program.

***Conducting a workplace security analysis***

The team or coordinator should periodically inspect the workplace and evaluate employee tasks to identify hazards, conditions, operations and situations that could lead to violence.

To find areas requiring further evaluation, the team or coordinator should:

- Analyze incidents, including the characteristics of assailants and victims, an account of what happened before and during the incident, and the relevant details of the situation and its outcome. When possible, obtain police reports and recommendations.
- Identify jobs or locations with the greatest risk of violence as well as processes and procedures that put employees at risk of assault, including how often and when.
- Note high-risk factors such as types of clients or patients (for example, those with psychiatric conditions or who are disoriented by drugs, alcohol or stress); physical risk factors related to building layout or design; isolated locations and job activities; lighting problems; lack of phones and other communication devices; areas of easy, unsecured access; and areas with previous security problems.
- Evaluate the effectiveness of existing security measures, including engineering controls. Determine if risk factors have been reduced or eliminated and take appropriate action.

**Hazard Prevention and Control**

After hazards are identified through the systematic worksite analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these

hazards. If violence does occur, post-incident response can be an important tool in preventing future incidents.

***Engineering controls and workplace adaptations to minimize risk***

Engineering controls remove the hazard from the workplace or create a barrier between the worker and the hazard. There are several measures that can effectively prevent or control workplace hazards, such as those described in the following paragraphs. The selection of any measure, of course, should be based on the hazards identified in the workplace security analysis of each facility.

Among other options, employers may choose to:

- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.
- Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones and private channel radios where risk is apparent or may be anticipated. Arrange for a reliable response system when an alarm is triggered.
- Provide metal detectors.
- Use a closed-circuit video recording for high-risk areas on a 24-hour basis. Public safety is a greater concern than privacy in these situations.
- Place curved mirrors at hallway intersections or concealed areas.
- Enclose nurses' stations and install deep service counters or bullet-resistant, shatter-proof glass in reception, triage and admitting areas or client service rooms.
- Provide employee "safe rooms" for use during emergencies.
- Establish "time-out" or seclusion areas with high ceilings without grids for patients who "act out" and establish separate rooms for criminal patients.
- Provide comfortable client or patient waiting rooms designed to minimize stress.
- Ensure that counseling or patient care rooms have two exits.
- Lock doors to staff counseling rooms and treatment rooms to limit access.
- Arrange furniture to prevent entrapment of staff.
- Use minimal furniture in interview rooms or crisis treatment areas and ensure that it is lightweight, without sharp corners or edges and affixed to the floor, if possible. Limit the number of pictures, vases, ashtrays or other items that can be used as weapons.
- Provide lockable and secure bathrooms for staff members separate from patient/client and visitor facilities.
- Lock all unused doors to limit access, in accordance with local fire codes.
- Install bright, effective lighting, both indoors and outdoors.
- Replace burned-out lights and broken windows and locks.
- Keep automobiles well maintained if they are used in the field.
- Lock automobiles at all times.

*Administrative and work practice controls to minimize risk*

Administrative and work practice controls affect the way staff perform jobs or tasks. Changes in work practices and administrative procedures can help prevent violent incidents. Some options for employers are to:

- State clearly to patients, clients and employees that violence is not permitted or tolerated.
- Establish liaison with local police and state prosecutors. Report all incidents of violence. Give police physical layouts of facilities to expedite investigations.
- Require employees to report all assaults or threats to a supervisor or manager (for example, through a confidential interview). Keep log books and reports of such incidents to help determine any necessary actions to prevent recurrences.
- Advise employees of company procedures for requesting police assistance or filing charges when assaulted and help them do so, if necessary.
- Provide management support during emergencies. Respond promptly to all complaints.
- Set up a trained response team to respond to emergencies.
- Use properly trained security officers to deal with aggressive behavior. Follow written security procedures.
- Ensure that adequate and properly trained staff are available to restrain patients or clients, if necessary.
- Provide sensitive and timely information to people waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
- Ensure that adequate and qualified staff are available at all times. The times of greatest risk occur during patient transfers, emergency responses, mealtimes and at night. Areas with the greatest risk include admission units and crisis or acute care units.
- Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
- Establish a list of "restricted visitors" for patients with a history of violence or gang activity. Make copies available at security checkpoints, nurses' stations and visitor sign-in areas.
- Review and revise visitor check systems, when necessary. Limit information given to outsiders about hospitalized victims of violence.
- Supervise the movement of psychiatric clients and patients throughout the facility.
- Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
- Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Do not allow employees to enter seclusion rooms alone.
- Establish policies and procedures for secured areas and emergency evacuations.
- Determine the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors.

- Establish a system, such as chart tags, log books or verbal census reports to identify patients and clients with assaultive behavior problems. Keep in mind patient confidentiality and worker safety issues. Update as needed.
- Treat and interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (such as rooms with removable partitions).
- Use case management conferences with coworkers and supervisors to discuss ways to effectively treat potentially violent patients.
- Prepare contingency plans to treat clients who are "acting out" or making verbal or physical attacks or threats. Consider using certified employee assistance professionals or in-house social service or occupational health service staff to help diffuse patient or client anger.
- Transfer assaultive clients to acute care units, criminal units or other more restrictive settings.
- Ensure that nurses and physicians are not alone when performing intimate physical examinations of patients.
- Discourage employees from wearing necklaces or chains to help prevent possible strangulation in confrontational situations. Urge community workers to carry only required identification and money.
- Survey the facility periodically to remove tools or possessions left by visitors or maintenance staff that could be used inappropriately by patients.
- Provide staff with identification badges, preferably without last names, to readily verify employment.
- Discourage employees from carrying keys, pens or other items that could be used as weapons.
- Provide staff members with security escorts to parking areas in evening or late hours. Ensure that parking areas are highly visible, well lit and safely accessible to the building.
- Use the "buddy system," especially when personal safety may be threatened. Encourage home health care providers, social service workers and others to avoid threatening situations.
- Advise staff to exercise extra care in elevators, stairwells and unfamiliar residences; leave the premises immediately if there is a hazardous situation; or request police escort if needed.
- Develop policies and procedures covering home health care providers, such as contracts on how visits will be conducted, the presence of others in the home during the visits and the refusal to provide services in a clearly hazardous situation.
- Establish a daily work plan for field staff to keep a designated contact person informed about their whereabouts throughout the workday. Have the contact person follow up if an employee does not report in as expected.

***Employer responses to incidents of violence***

Post-incident response and evaluation are essential to an effective violence prevention program. All workplace violence programs should provide comprehensive treatment for employees who are victimized personally or may be traumatized by witnessing a workplace

violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of its severity. Provide the injured transportation to medical care if it is not available onsite.

Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries. These may include:

- Short- and long-term psychological trauma;
- Fear of returning to work;
- Changes in relationships with coworkers and family;
- Feelings of incompetence, guilt, powerlessness; and
- Fear of criticism by supervisors or managers.

Consequently, a strong follow-up program for these employees will not only help them to deal with these problems but also help prepare them to confront or prevent future incidents of violence.

**Safety and Health Training**

Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their coworkers through established policies and procedures.

***Training for all employees***

Every employee should understand the concept of "universal precautions for violence" that is, that violence should be expected but can be avoided or mitigated through preparation. Frequent training also can reduce the likelihood of being assaulted.

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards. It also includes instructions to limit physical interventions in workplace altercations whenever possible, unless enough staff or emergency response teams and security personnel are available. In addition, all employees should be trained to behave compassionately toward coworkers when an incident occurs.

The training program should involve all employees, including supervisors and managers. New and reassigned employees should receive an initial orientation before being assigned their job duties. Visiting staff, such as physicians, should receive the same training as permanent staff. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations and drills.

Topics may include management of assaultive behavior, professional assault-response training, police assault-avoidance programs or personal safety training such as how to prevent and avoid

assaults. A combination of training programs may be used, depending on the severity of the risk.

Employees should receive required training annually. In large institutions, refresher programs may be needed more frequently, perhaps monthly or quarterly, to effectively reach and inform all employees.

***What training should cover***

The training should cover topics such as:

- The workplace violence prevention policy;
- Risk factors that cause or contribute to assaults;
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults;
- Ways to prevent or diffuse volatile situations or aggressive behavior, manage anger and appropriately use medications as chemical restraints;
- A standard response action plan for violent situations, including the availability of assistance, response to alarm systems and communication procedures;
- Ways to deal with hostile people other than patients and clients, such as relatives and visitors;
- Progressive behavior control methods and safe methods to apply restraints;
- The location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures;
- Ways to protect oneself and coworkers, including use of the "buddy system;"
- Policies and procedures for reporting and recordkeeping;
- Information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences; and
- Policies and procedures for obtaining medical care, counseling, workers' compensation or legal assistance after a violent episode or injury.

***Training for supervisors and managers***

Supervisors and managers need to learn to recognize high-risk situations, so they can ensure that employees are not placed in assignments that compromise their safety. They also need training to ensure that they encourage employees to report incidents.

Supervisors and managers should learn how to reduce security hazards and ensure that employees receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and to make any necessary changes in the physical plant, patient care treatment program and staffing policy and procedures to reduce or eliminate the hazards.

***Training for security personnel***

Security personnel need specific training from the hospital or clinic, including the psychological components of handling aggressive and abusive clients, types of disorders and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. At least annually, the team or coordinator responsible for the program should review its content, methods and the frequency of training. Program evaluation may involve supervisor and employee interviews, testing and observing and reviewing reports of behavior of individuals in threatening situations.

**Recordkeeping and Program Evaluation** ***How employers can determine program effectiveness***

Recordkeeping and evaluation of the violence prevention program are necessary to determine its overall effectiveness and identify any deficiencies or changes that should be made.

***Records employers should keep***

Recordkeeping is essential to the program's success. Good records help employers determine the severity of the problem, evaluate methods of hazard control and identify training needs. Records can be especially useful to large organizations and for members of a business group or trade association who "pool" data. Records of injuries, illnesses, accidents, assaults, hazards, corrective actions, patient histories and training can help identify problems and solutions for an effective program.

Important Records:

- OSHA Log of Work-Related Injury and Illness. Employers who are required to keep this log must record any new work-related injury that results in death, days away from work, days of restriction or job transfer, medical treatment beyond first aid, loss of consciousness or a significant injury diagnosed by a licensed health care professional. Injuries caused by assaults must be entered on the log if they meet the recording criteria. All employers must report, within 24 hours, a fatality or an incident that results in the hospitalization of three or more employees.
- Medical reports of work injury and supervisors' reports for each recorded assault. These records should describe the type of assault, such as an unprovoked sudden attack or patient-to patient altercation; who was assaulted; and all other circumstances of the incident. The records should include a description of the environment or location, potential or actual cost, lost work time that resulted and the nature of injuries sustained. These medical records are confidential documents and should be kept in a locked location under the direct responsibility of a health care professional.
- Records of incidents of abuse, verbal attacks or aggressive behavior that may be threatening, such as pushing or shouting and acts of aggression toward other clients. This may be kept as part of an assaultive incident report. Ensure that the affected department evaluates these records routinely.

- Information on patients with a history of past violence, drug abuse or criminal activity recorded on the patient's chart. All staff who care for a potentially aggressive, abusive or violent client should be aware of the person's background and history. Log the admission of violent patients to help determine potential risks.
- Documentation of minutes of safety meetings, records of hazard analyses and corrective actions recommended and taken.
- Records of all training programs, attendees and qualifications of trainers.

***Elements of a program evaluation***

As part of their overall program, employers should evaluate their safety and security measures. Top management should review the program regularly, and with each incident, to evaluate its success. Responsible parties (including managers, supervisors and employees) should reevaluate policies and procedures on a regular basis to identify deficiencies and take corrective action.

Management should share workplace violence prevention evaluation reports with all employees. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives or other employee groups.

All reports should protect employee confidentiality either by presenting only aggregate data or by removing personal identifiers if individual data are used.

Processes involved in an evaluation include:

- Establishing a uniform violence reporting system and regular review of reports;
- Reviewing reports and minutes from staff meetings on safety and security issues;
- Analyzing trends and rates in illnesses, injuries or fatalities caused by violence relative to initial or "baseline" rates;
- Measuring improvement based on lowering the frequency and severity of workplace violence;
- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate how well they work;
- Surveying employees before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness;
- Keeping abreast of new strategies available to deal with violence in the health care and social service fields as they develop;
- Surveying employees periodically to learn if they experience hostile situations concerning the medical treatment they provide;
- Complying with OSHA and State requirements for recording and reporting deaths, injuries and illnesses; and

Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving employee

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Written Testimony of Andrew Hull, BSN, RN
Danbury Hospital

**SB 970 An Act Concerning Workplace Violence Prevention and Response**

Public Health Committee

February 23, 2011

As way of introduction my name is Andrew Hull. I am a Registered Nurse at Danbury Hospital in Danbury Connecticut. I am writing in hopes that my story will shed some light on the struggles facing nurses in the workplace.

On March 2, 2010, I was working on a cardiac telemetry floor at Danbury Hospital. At the time I was the Assistant Nurse Manager. At around 14:30, I was in the nursing station when two nurses turned the corner and informed me there was a patient holding my colleagues at gunpoint. I turned the corner to find that the patient was pointing a small firearm at two staff members. I yelled at the patient in hopes of getting his attention, and proceeded to tackle him to the ground. The patient then discharged the weapon three times striking me in the hand, neck, and face. Fortunately I survived but needless to say, the following months were very trying for me, my family, and Danbury Hospital.

Although the events surrounding this particular event were extreme, nurses are exposed to violence in many different forms daily. Whether it is angry patients, family members, or colleagues, nurses are routinely subject to both physical and verbal abuse. Health care employees are more than three times as likely as workers in other industries to be injured by acts of violence. It is my sincere hope that something positive can come from my traumatic experience. Health care is facing an enormous challenge with the expected nursing shortage. We cannot allow the threat of workplace violence to be a deterrent to nurses. More importantly we have to work towards making the everyday work environment safe. I thank you for your time.

Sincerely

Andrew Hull BSN, RN

CONNECTICUT LEGAL RIGHTS PROJECT

P.

O. Box 351, Silver Street, Middletown, CT 06457
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TESTIMONY OF KIRK W. LOWRY
to the
Public Health Committee

February 23, 2011

OPPOSITION TO SB 970
Concerning Workplace Violence Prevention and Response in Health Care Settings

I am the Legal Director of the Connecticut Legal Rights Project, Inc. (CLRP) a statewide nonprofit organization that provides free legal services to low income adults with psychiatric disabilities.

CLRP supports reduction in workplace violence, but opposes those sections of SB 970 that are overbroad and may criminalize behavior of people with disabilities that is related to that disability. When a person with a psychiatric disability or developmental disability seeks treatment, that person should not be subject to criminal prosecution for exhibiting behavior for which they are seeking treatment. Generally, the Americans with Disabilities Act considers conduct resulting from a disability to be part of the disability itself, meaning that such conduct cannot constitute a separate basis for adverse action. (*Nanos v. City of Stamford*, 609 F.Supp.2d 260 (D. Conn. 2009), a case in the employment context.)

CLRP supports the provisions in New Section 1 that require the creation of a workplace safety committee, require covered employers to perform risk assessments, and require covered employers to develop and implement a workplace violence prevention plan. CLRP opposes subsection (f) of New Section 1 that prohibits a covered employer from requiring a health care employee to treat or provide services to a patient who has "verbally or physically abused or threatened" the employee. This provision is profoundly misguided, naïve, and betrays a deep misunderstanding of the treatment of people with disabilities. Many people with psychiatric disabilities or developmental disabilities exhibit behavior that is a direct and clear result of their disabilities, not the result of intent to harm or assault staff. In most instances, people with disabilities who exhibit behaviors should be treated with a treatment plan and a behavior modification plan, not by

calling the police or allowing staff not to provide the treatment they were hired to provide.

CLRP opposes New Section 2 which mandates that all covered health care employers report "any act that may constitute an assault or related offense" to local law enforcement and to DPH. This section is overbroad. A more thoughtful response is demonstrated by the DMHAS Commissioner's Policy 6.23 – Arrest of Clients. The Commissioner's policy allows for the use of professional discretion taking into account the seriousness of the behavior and the extent to which the behavior is a manifestation of the person's psychiatric disability. The policy recommends that in the vast majority of the cases, the behavior should be treated, not criminalized.

CLRP strongly opposes New Section 3, which amends by significantly expanding the scope of General Statutes § 53a-167c, Assault of public safety, emergency medical or public transit personnel. The current law makes is a class C felony to assault a public safety officer, emergency medical or public transit personnel. None of these categories of public civil servants are in the business of treating inpatient psychiatric patients with severe and persistent mental illness or people with significant developmental disabilities. The proposed amendment would require state hospitals and ICF-MR's, institutions that treat persons with severe disabilities, to call the police and subject patients to class C felony charges for nothing more than exhibiting behavior that is a clear and direct manifestation of their mental illness, is usually well-known, for which they may be receiving powerful medication to treat, and for which they may even have a professional behavior management plan. This is nothing more than disability discrimination that violates the Connecticut Constitution, the ADA, and the Rehabilitation Act.

The only practical effect may be to charge a person who is not able to form criminal intent with felony assault, have the court order a competency evaluation at Whiting Forensic Institute, transfer the person from CVH general psychiatric division to Whiting, confirm that the person is not competent and not restorable, resulting is unnecessary utilization of a bed at the overburdened WFI, or simply be transferred back to the CVH general psychiatric division.

**TESTIMONY**

**SB 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS**

**Public Health Committee**
**February 23, 2011**

Senator Stillman, Representative Ritter, members of the Public Health Committee, thank you for the opportunity to speak with you today in support of SB 970 AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS. I am Dr. Mike Summerer, Director of John Dempsey Hospital at the University of Connecticut Health Center.

The growing concern over workplace violence in healthcare settings becomes magnified as examples occur across the nation and in our own state. At our institution, the dual mission of education and healthcare co-located within the same buildings and campus requires balancing our commitment to provide our employees with a safe and secure work environment, our students with a safe learning environment and our patients with a safe environment of care. Towards this end, we have developed committee structures to review security management risks, and are reinvigorating our workplace violence threat assessment team that includes our Clinical Safety Committee, Public Safety and Human Resources Departments. We have also developed a training program for staff to build skills to "de-escalate" behaviors of patients and visitors. All of this is considered best practice and is consistent with the expectations of the Joint Commission, which accredits healthcare institutions nationally, including John Dempsey Hospital. Passage of this bill will enhance the work we are already engaged in.

The University of Connecticut Health Center (UCHC) provides 24 hour medical care, 365 days per year to a broad segment of the state's population, including the incarcerated through the Correctional Managed Health Care program, and a significant number of patients with psychiatric disorders. The medical care we provide includes in-patient, out-patient and emergency room services. While we support Section 1(f) of the bill in principle, we have some concerns with the language as drafted. We would very much like the opportunity to work with you and the proponents of the bill to redraft this section so that we can adequately balance the medical needs of our patients while also protecting the safety of our staff.

I urge your support of SB 970 with a modification to Section 1(f). Thank you for your attention and for your consideration.

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**S – 627**

# CONNECTICUT
# GENERAL ASSEMBLY
# SENATE

## PROCEEDINGS
## 2011

**VOL. 54**
**PART 16**
**4951 – 5268**

Yes, Mr. President, the next item I would like the Clerk to call is Calendar page 41, Calendar 322, Senate Bill 970.

THE CHAIR:

Mr. Clerk.

THE CLERK:

Calendar page 41, Calendar Number 322, File Number 533, substitute for Senate Bill 790 [sic], AN ACT CONCERNING WORKPLACE VIOLENCE PREVENTION AND RESPONSE IN HEALTH CARE SETTINGS; Favorable Report of the Committee on Public Health, and Judiciary.

The Clerk is in possession of amendments.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Mr. President.

Mr. President, I move acceptance of the Joint Committee's Favorable Report and passage of the bill.

THE CHAIR:

On acceptance and passage, will you remark?

SENATOR GERRATANA:

Yes, Mr. President. Thank you, so much.

This bill requires health care employees to develop and implement a plan concerning workplace violence prevention and a response. It requires health care employers to report incidents of workplace violence to local law enforcement and establishes criminal penalties for assault of a health care employee.

Before I go farther in explaining the bill, Mr.

President, the Clerk has an amendment, LCO 8099. Will he please call and I be allowed to summarize?

THE CHAIR:

Mr. Clerk.

THE CLERK:

LCO 8099, which will be designated Senate Amendment Schedule "A." It is offered by Senator Gerratana, of the 6th District.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Mr. President.

This amendment --

THE CHAIR:

Please move adoption.

SENATOR GERRATANA:

Oh. I'm sorry, Mr. President.

I move adoption.

THE CHAIR:

On adoption, will you remark?

SENATOR GERRATANA:

Thank you.

Mr. President, this bill clarifies what a health care employee is, a definition of a health care employee, and also limits the definition of people who we are regarding in the underlying bill, people with disability.

THE CHAIR:

Thank you, Senator.

SENATOR GERRATANA:

I moved adoption.

THE CHAIR:

Thank you, Senator.

Will you remark further on the amendment? Will you remark further on the amendment?

If not, I'll try your minds. All those in favor, please signify by saying, aye.

SENATORS:

Aye.

THE CHAIR:

Those opposed, nay? The ayes have it. The amendment is adopted.

Remark further on the bill as amended? Will you remark further on the bill as amended?

SENATOR GERRATANA:

Yes, Mr. President.

THE CHAIR:

Senator Gerratana.

SENATOR GERRATANA:

Thank you.

The bill came before the Public Health Committee, and it was raised in response to an incident that happened at one of our hospitals in the state where a patient -- actually I, as I understand it because I read the article in the newspaper -- assaulted one of the health care employees there with a gun. And at that time after the incident happened, there are many people in the community and then in the state who talked about this incident and said we should have protocol set in place that will at least address, if

this happens again, the necessity and the discussion that ensued that actually said, yes, we need a law to address workplace violence.

Our health care employees are a group of individuals -- I know I worked in a hospital, for ten years -- who daily come into contact with all kinds of people, including patients that they treat. And this underlying bill, of course, would address the incidents that had happened during that time and protect our health care employees in the state.

Thank you, Mr. President.

THE CHAIR:

Thank you, Senator.

Senator McLachlan.

SENATOR McLACHLAN:

Thank you, Mr. President.

I rise in support of this bill. Unfortunately, in my community at Danbury Hospital, we had an unfortunate incident where it was a patient who shot a -- a registered nurse and although the hospital had a -- a good program of security in the building, I think that it raised the bar of where they needed to go. I think that this bill is constructive, is a good idea, and I thank the leadership of the committee for working on this and stand to support it. I hope this Senate will unanimously approve it.

Thank you.

THE CHAIR:

Thank you, Senator.

Senator Welch.

SENATOR WELCH:

Thank you, Mr. President.

I, too, rise in support of this bill. It is a more-than-reasoned solution to a very tragic situation. The support for this bill was a broad-based support in all aspects of the community and the industries that it impacts got behind it.

Thank you, Mr. President.

THE CHAIR:

Thank you.

Senator Looney, did you want to speak?

SENATOR LOONEY:

No.

THE CHAIR:

And would you remark further on the bill as amended? Will you remark further?

Senator Gerratana.

SENATOR GERRATANA:

Thank you, Mr. President.

If there is no objection, I ask that this item be placed on Consent.

THE CHAIR:

Without objection, so ordered.

SENATOR GERRATANA:

Thank you.

THE CHAIR:

Senator Looney.

SENATOR LOONEY:

Thank you, Mr. President.

If the Clerk would call as the next three items,

If we might stand at ease for a moment, Mr. President.

THE CHAIR:

The Senate will stand at ease.

(Chamber at ease.)

SENATOR LOONEY:

Mr. President?

THE CHAIR:

The Senate will come back to order.

Senator Looney.

SENATOR LOONEY:

Yes. Thank you, Mr. President.

If we might call the First Consent Calendar, at this time.

THE CHAIR:

Mr. Clerk, please call the First Consent Calendar.

THE CLERK:

Immediate roll call -- immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber. An immediate roll call has been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

Mr. President, the items that were placed on the First Consent Calendar begin on Calendar page 4, Calendar Number 222, substitute for Senate Bill 973; Calendar page 13, Calendar Number 490, substitute for

Senate Bill 929; and, Calendar page 39, Calendar Number 272, substitute for Senate Bill 1112. In Calendar page 41, Calendar Number 322, substitute for the Senate Bill 970.

Mr. President, that completes the items placed on the First Consent Calendar.

THE CHAIR:

The machine will be open.

THE CLERK:

The Senate is voting by roll call on the Consent Calendar. Will all Senators please return to the Chamber. The Senate is voting by roll on the Consent Calendar. Will all Senators please return to the Chamber.

THE CHAIR:

Have all Senator voted? Have all Senators voted?

Please check the board to make sure your vote is accurately recorded. If all Senators voted, the machine will be closed.

And the Clerk will take the tally.

THE CLERK:

Motion is on adoption of Consent Calendar Number One.

| | |
|---|---|
| Total number voting | 36 |
| Those voting Yea | 36 |
| Those voting Nay | 0 |
| Those absent and not voting | 0 |

THE CHAIR:

The Consent Calendar passes.

The Senate will stand at ease.