38 Workplace violence—Insp # 1707386 Dowell Springs Behavioral Health, LLC

A 61 year old female employee was injured while attempting to separate two patients that were in an altercation. The victim was a registered nurse caring for mental health patients at East Tennessee Behavioral Health. The position required close contact with psychiatric patients that are at times unpredictable. She was pushed to the ground by the assailant and fractured her hip. Unable to recover from her injuries, she passed away while admitted to Fort Sanders Regional Medical Center.

The incident was recorded via the facility's surveillance cameras. Two patients began to verbally argue with each other, and the incident quickly escalated; the staff immediately intervened to deescalate the situation and attempted to separate the two patients. When the victim walked out of the medication room to assist with the altercation, the assailant, while attempting to attack the other patient, pushed her to the ground. The staff was able to subdue the assailant and walk him to the seclusion room. However, the victim was unable to stand after the incident and when staff attempted to assist her up, she screamed in pain. The staff contacted 911 and requested an ambulance which transferred her to Fort Sanders Regional Medical Center where she was diagnosed with a hip fracture as a result of the fall. She underwent surgical intervention to repair it. During her inpatient stay at the hospital, there were complications with the treatment, including sepsis. The victim was unable to recover from the injury and passed away at the hospital.

Through witness interviews and documentation, it was determined that workers at this psychiatric hospital were frequently exposed to high instances of workplace violence when interacting with patients. According to the OSHA 300 Logs, and incident reports there were approximately thirty workplace violence incidents that resulted in injuries between 2022 and 2023. The witnesses all claimed that they do not feel safe at work, especially while working on the weekends. Most expressed that they were aware of a security guard within the facility, but only in the evenings at around 6:00 pm or 7:00 pm during the weekdays. When asked about security on the weekends, most were unsure as security is not typically present on the units. Witnesses also expressed concerns with the inability of staff to communicate with each other. They feared if isolated from other staff, there was no panic button or communication device to alert staff for help if attacked. Additionally, witnesses stated that patients have "jumped" over the glass to gain access behind the nurse's station and have also shattered the glass in the past. Furthermore, it was stated by one employee that reporting such concerns to management would lead to reprisal.

Employees received workplace violence training which included a computer-based training through "Acadia Healthcare" and hands-on restraining techniques through a program called "Handle with Care." Engineered controls consisted of a duress alarm that sounded an audible alert, however witnesses stated that they were not sure if it called anyone. The facility had established time-out procedures such as a "seclusion room" and "quiet room" in order for

patients to reestablish their composure. Door to staff counseling rooms, counseling rooms, treatment rooms, other units and corridors were secure and locked. Furniture was arranged to prevent entrapment of staff. Lockable and secure bathrooms for staff members separate from patient/client and visitor facilities were also provided. Witnesses stated that patients with assaultive behavior problems were discussed during change of shift meetings to keep staff updated on the special needs of some patients.

Although East Tennessee Behavioral has some components of a workplace violence prevention program in place, it has failed to provide a cohesive and comprehensive prevention program to address these hazards.

Citation(s) as Originally Issued

A complete inspection was conducted at the accident scene. Some of the items cited may not directly relate to the fatality.

Citation 1 Item 1 **Type of Violation: Serious** **$5400**

TCA 50-3-105(1): The employer did not furnish employment and a place of employment which were free from recognized hazards that are causing or likely to cause death or serious physical harm to employees.

In that 5 employees were exposed to injuries from physical violence perpetrated by mental health patients/residents and there was no workplace violence prevention program or relevant protective procedures established; one employee was physically assaulted resulting in the healthcare worker's death.

Citation 2 Item 1 **Type of Violation: Other-than-Serious** **$600**

TDLWD Rule 0800-01-03-.03(27)(b)1: The log of all recordable work-related injuries and illnesses (OSHA Form 300 or equivalent), was not completed in the detail as required by the rule.

In that the employer did not ensure that the OSHA Form 300s were completed in the detail required by the rule, OSHA Form 300s maintained by the employer lacked information in the following instances:

a) 2022 OSHA Form 300 - case no. "1 through 4" - column (F): These entries did not adequately describe the injury or part of the body that was injured or the object or substance that directly injured or made the
person ill.

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b) 2023 OSHA Form 300 - case no. "1 through 6" - column (F): These entries did not adequately describe the injury or part of the body that was injured or the object or substance that directly injured or made the person ill.

Injuries were vaguely described as "slipped on ice in parking lot" or "left forearm" and were not classified as to the extent of the injury, type of injury, or a description of the body part as required by the standard. Additionally, some entries were incorrect such as "hit in face by employee", however the employee suffered an injury from being struck in the face by a patient while at work.

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