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Preventing Violence in the Workplace



1. Introduction

Workplace Violence Prevention: A Pervasive Challenge

Workers in hospitals, nursing homes, and other healthcare settings face significant risks of workplace violence, which can refer to any physical or verbal assault toward a person in a work environment. Violence in healthcare facilities takes many forms and has different origins, such as verbal threats or physical attacks by patients, gang violence in an emergency department (ED), a distraught family member who may be abusive or even becomes an active shooter, a domestic dispute that spills over into the workplace, coworker bullying, and much more. The healthcare industry has many unique factors that increase the risk of violence, such as working directly with people who have a history of violence or who may be delirious or under the influence of drugs. In some cases, employees or patients might perceive that violence is tolerated as “part of the job,” which can perpetuate the problem.

Statistics collected by the Bureau of Labor Statistics show the magnitude of the problem:

- From 2011 to 2013, U.S. healthcare workers suffered 15,000 to 20,000 workplace-violence-related injuries every year that required time away from work for treatment and recovery (i.e., serious injuries). Healthcare accounts for nearly as many injuries as all other industries combined.¹
- Violence is a more common source of injury in healthcare than in other industries. From 2011 to 2013, assaults constituted 10–11 percent of serious workplace injuries in healthcare, compared with 3 percent among the private sector as a whole.²
- Healthcare and social assistance workers experienced 7.8 cases of serious workplace violence injuries per 10,000 full-time equivalents (FTEs) in 2013. Other large sectors such as construction, manufacturing, and retail all had fewer than two cases per 10,000 FTEs.³

These statistics do not include the many additional assaults and threats that do not lead to time away from work. Studies also show that violence in healthcare workplaces is under-

Defining Workplace Violence

Organizations have defined workplace violence in various ways. The National Institute for Occupational Safety and Health defines workplace violence as “violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty.” Enforcement activities typically focus on physical assaults or threats that result or can result in serious physical harm. However, many people who study this issue and the workplace prevention programs highlighted here include verbal violence—threats, verbal abuse, hostility, harassment, and the like—which can cause significant psychological trauma and stress, even if no physical injury takes place. Verbal assaults can also escalate to physical violence.

reported; thus, the problem is considerably larger than the official statistics suggest.

Workplace violence comes with a high cost. First and foremost, it harms workers—often both physically and emotionally—and makes it more difficult for them to do their jobs. Employers also bear several costs. A single serious injury can lead to workers’ compensation losses of thousands of dollars, along with thousands of dollars in additional costs for overtime, temporary staffing, or recruiting and training a replacement. Even if a worker does not have to miss work, violence can still lead to “hidden costs” such as higher turnover and deterioration of productivity and morale.

Despite the complex nature of the problem, many proven solutions exist. These solutions work best when coordinated through a comprehensive workplace violence prevention program.

About This Road Map

OSHA has developed this resource to assist healthcare employers and employees interested in establishing a workplace violence prevention program or strengthening an existing program. This road map is related to another

¹ Source: Bureau of Labor Statistics data for 2011–2013, covering injuries that required days away from work. These statistics are restricted to private industry to allow for proper comparison. “Healthcare” data cover three large industry segments: NAICS 621, “Ambulatory Health Care Services”; 622, “Hospitals”; and 623, “Nursing and Residential Care Facilities.”

² Ibid.

³ Source: Bureau of Labor Statistics data for 2013, covering injuries that required days away from work. These statistics are restricted to private industry to allow for proper comparison. They are also restricted to intentional injuries caused by humans, excluding self-inflicted injuries. These data cover the large industry group known as NAICS 62, “Health Care and Social Assistance.”

OSHA publication called *Guidelines for Prevention of Violence in Healthcare*—available at www.osha.gov/SLTC/workplaceviolence—which introduces the five building blocks and offers recommendations on developing effective policies and procedures. Like the guidelines, this road map describes the five core components of a workplace violence prevention program. In addition, this road map is intended to complement OSHA's guidelines by providing real-world examples of how healthcare facilities have put workplace violence policies and procedures into practice.

Examples have been drawn from about a dozen healthcare organizations nationwide, representing a range of facility types, sizes, geographic settings, and approaches to addressing workplace violence. Facilities profiled here

include several privately run acute care hospitals, private and state-run behavioral health facilities, and a group of nursing homes. These facilities have agreed to share their successful models, tools, and “lessons learned” to help inform and inspire others.

OSHA obtained some of the examples in this road map from published sources, but obtained most of the information from the facilities themselves through site visits, meetings, and interviews. OSHA appreciates the time and knowledge the facilities shared. In deciding what information to use, OSHA highlighted selected components of each facility's program. All facilities acknowledged that their violence prevention programs were “in progress” and that “continuous improvement” is an important goal.



2. Comprehensive Workplace Violence Prevention Programs: An Overview

Although OSHA has no standard specific to the prevention of workplace violence, employers have a general duty to “furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.” This requirement comes from Section 5(a)(1) of the *Occupational Safety and Health (OSH) Act of 1970* and is known as the General Duty Clause.

OSHA has determined that the best way to reduce violence in the workplace is through a comprehensive workplace violence prevention program that covers five core elements or “building blocks”:

- **Management commitment and employee participation.** Managers demonstrate their commitment to workplace violence prevention, communicate this commitment, and document performance. They make workplace violence prevention a priority, establish goals and objectives, provide adequate resources and support, appoint leaders with the authority and knowledge to facilitate change, and set a good example. Employees, with their distinct knowledge of the workplace, ideally are involved in all aspects of the program. They are encouraged to communicate openly with management and report their concerns without fear of reprisal.
- **Worksite analysis and hazard identification.** Processes and procedures are in place to continually identify workplace hazards and evaluate risks. There is an initial assessment of hazards and controls, regular reassessments, and formal re-evaluations after incidents, through accident review boards or after-action reviews.
- **Hazard prevention and control.** Processes, procedures, and programs are implemented to eliminate or control workplace hazards and achieve workplace violence prevention goals and objectives. Progress in implementing controls is tracked.
- **Safety and health training.** All employees have education or training on hazard recognition and control, and on their responsibilities under the program, including what to do in an emergency.
- **Recordkeeping and program evaluation.** Accurate records of injuries, illnesses, incidents, assaults, hazards, corrective actions, patient histories, and training can help employers determine the severity of the problem, identify trends or patterns, evaluate methods of hazard control, identify training needs, and develop solutions for an effective program. Programs are evaluated regularly to identify deficiencies and opportunities for improvement.

The core elements are all interrelated, and each is necessary to the success of the overall system. When integrated into a comprehensive workplace violence prevention program, particularly a written program, these elements offer a systematic approach—used by employers and employees, working together—to find and correct workplace hazards before injuries occur and on an ongoing basis. These components also align with the core elements of a safety and health management system (also known as an injury and illness prevention program, or I2P2), which can provide an overarching framework for planning, implementing, evaluating, and improving all workplace safety and health management efforts—for example, programs addressing violence prevention, bloodborne pathogens, and patient handling.

To learn more about connections and synergies between workplace violence prevention, safety and health management systems, and patient safety, see *Workplace Violence Prevention and Related Goals: The Big Picture* at www.osha.gov/Publications/OSHA3828.pdf.

3. Getting Started

Some healthcare organizations have begun to take serious action on workplace violence after an “eye-opening” incident—e.g., a shooting or a hostage situation—or after caring for a particularly challenging patient. Others have taken action after learning about incidents elsewhere in the news, or perhaps simply as a result of gaining a greater awareness of the problem. Whether an organization’s decision to create or strengthen its workplace violence prevention program is more reactive or proactive, it can be difficult to know where to start in crafting a strategy that affects so many aspects of an organization, from the physical environment to policies, procedures, and management priorities.

Developing a workplace violence prevention program typically begins by convening a planning group or task force to tackle the issue. Alternatively, an organization may charge an existing safety and health committee with addressing workplace violence. No matter the starting point, management needs to ensure that whoever is leading the initiative has the authority and knowledge to convene the group and require participation, facilitate the necessary changes to policies and procedures, and ensure that adequate resources are available and committed for building and sustaining an effective program.

The composition and commitment of the committee or task force are key factors in its success or failure. Management must be committed to creating an effective program. Staff

from all affected areas should be included to bring important knowledge and perspectives to the planning process. In addition, involving them from the outset can ensure buy-in when the plan is enacted. If the workforce is unionized, labor/management discussions can provide an important forum for voicing employees’ concerns, making collaborative decisions, and bringing significant expertise and resources to the table. Patient advocates and other stakeholders can also provide valuable input.

Once the group is convened, the development process typically requires the collection of baseline data and other information to identify issues and inform decisions. Employees’ opinions and experiences, which can be gathered through surveys, interviews, and focus groups, are crucial in assessing conditions and tailoring a program that will serve the needs of the specific healthcare setting.

When drafting questions for an employee or patient survey, it is important to consider how the data will be used and to frame questions in a way that will elicit the most helpful information. Responses should be confidential, and the survey should be simple to complete. Allowing employees to complete surveys on work time can increase participation. Focus groups, in which small groups of staff meet with a neutral facilitator, can also generate robust discussion about perceived risks and potential solutions.



Examples

Veterans Health Administration: convening stakeholders across a large organization

The Veterans Health Administration (VHA) is America's largest integrated healthcare system, with more than 1,700 sites serving 8.76 million veterans each year. The VHA has faced several challenges in addressing workplace violence: the vast size of the organization, a wide variety of settings (inpatient, outpatient, community settings, and specialty services), and a special population with notable incidence of post-traumatic stress disorder and other trauma. In 2000, the VHA formed a National Taskforce on Violence with representation from a variety of stakeholders from important VHA organizational units, labor partners, and outside agencies and experts. The taskforce reviewed violence within VHA, identified policy weaknesses and potential solutions, and made recommendations that included conducting a national survey. Results of this survey are described in "Worksite Analysis and Hazard Identification" on page 11.

Providence Behavioral Health Hospital: from labor concerns to collaborative action

In the late 1990s and early 2000s, registered nurses at Providence Hospital—a 104-bed behavioral health facility in Holyoke, Massachusetts—raised concerns about rising levels of violence and high rates of assaults by patients. With assistance from their union, the Massachusetts Nurses Association, the nurses brought their concerns to the bargaining table during contract negotiations. The union proposed research-based changes to hospital policies to address workplace violence. Through detailed negotiations, the nurses and hospital administrators worked together to include the following definitions and policies in the nurses' new contract:

Violence is assaultive behavior from patients, visitors, other workers, physicians, or even family members. Violence is defined as, but not limited to, physical assaults, battering, sexual assaults, or verbal or non-verbal intimidation. ID badges will not reveal last name. The Hospital will have a policy and procedure relating to the detection, removal, storage, and disposition of potential or actual weaponry at admission or at any time during the Hospital stay. The Hospital agrees to provide security surveillance of Hospital grounds and parking areas. Both will be well lighted. Upon request, the Hospital will provide escorts to cars and physical protection to workers if necessary.

The Hospital will initiate a policy and procedure for the prevention of violence or potential violence. It will also give training programs on how to safely approach potential assaults and prevent aggressive behavior from escalating into violent behavior. Consistent with the Hospital "Code Yellow" policy the Hospital will form a trained Response Team, available 24 hours and 7 days a week that, similar to a code team, can be immediately called to assist a nurse in any situation that involves violence. The employer will report the injury or illness to the appropriate agencies, i.e., Department of Industrial Accidents, police, etc. The employee also has the right to notify the police if he/she is being physically assaulted. Incidents of abuse, verbal attacks or aggressive behavior—which may be threatening to the nurse but not result in injury, such as pushing or shouting and acts of aggression towards other clients/staff/visitors—will be recorded on an assaultive incident report. The incident will be reported to the Risk Manager, the Providence Hospital Safety Committee, [and] Injury Review Committee for review and appropriate intervention. Copies of any documents relating to the incident will be given to the nurse affected. The employer will provide and/or make available to workers injured by workplace violence medical and psychological services.

The joint efforts of labor and management have led to more than a decade of collaboration on preventing workplace violence, a multidisciplinary task force, an open dialogue, a greater emphasis on prevention and de-escalation instead of restraint, and ultimately a decrease in the number and severity of assaults by patients.

New Hampshire Hospital: recognizing and adapting to change

As a state-run behavioral health hospital in operation since 1842, New Hampshire Hospital in Concord, New Hampshire, has a long history of treating patients with severe psychiatric conditions. However, a changing landscape has led to new challenges related to workplace violence. Until a few decades ago, the hospital had many more patients than it does today, and staff became very familiar with their patients because they were often committed for life. Now the hospital sees patients for shorter stays, and some of these patients have more acute challenges and pose more serious threats and problems than in the past, particularly with an uptick in involuntary commitments and referrals from EDs. New Hampshire Hospital has become more of a “last resort” as other facilities have closed or become full; at the same time, the medical community has pushed to reduce the use of restraints and seclusion. These changes in patient population, acuity, and treatment techniques—along with concerns raised by staff—led New Hampshire Hospital to realize that they needed to give their workers new tools to prevent and respond to workplace violence.



The front entrance of New Hampshire Hospital.

Nursing managers began with a series of focus groups to solicit input from direct care staff on all three shifts. To encourage employees to speak freely, meetings were conducted without supervisors present and were separated by discipline (nurses, physicians, mental health workers). This input helped managers to realize that many workers believed that violence was part of the job, which perpetuated acceptance of violence. The hospital addressed these issues over a few years by discussing workplace violence in labor/management meetings, adapting existing models to create a “Staying Safe” program (see Section 6: “Hazard Prevention and Control”), fostering dialogue and collaboration between clinical staff and campus police, implementing daily safety briefings, and creating a robust training program. New Hampshire Hospital now helps other hospitals start their own violence prevention efforts by writing articles, presenting at conferences, and sharing data and strategies with similar facilities in other states.



4. Management Commitment and Employee Participation

A strong commitment by management is critical to the overall success of the workplace violence prevention program. It is important for administrators, safety managers, and front-line supervisors not only to show that aggressive or violent behavior is unacceptable and will result in appropriate consequences, but also to provide an environment of trust where errors and incidents are viewed as opportunities to learn, with the overall goal of continuous improvement.

By creating a written workplace violence policy and posting it in publicly visible locations, management can provide a clear statement of the organization's position on workplace violence, explain the consequences for violation, and inform patients, visitors, and others of their responsibilities and the conduct that is expected of them.

Clearly defined policies and procedures and visible management involvement can also help encourage employees to report violent incidents or related concerns. Visible responses from management can help reassure workers that proper action will be taken to address their concerns, without fear of reprisal for reporting incidents.

All employees can bring important knowledge and perspectives to the workplace violence prevention program—especially caregivers who interact directly with patients. A joint management–employee committee can foster a participatory

approach where employees and management work together on worksite assessment and solution implementation. The structure of management–employee teams varies based on the facility's size and the availability of personnel. Committees can include representatives from direct care staff; human resources, safety, security, and legal departments; unions; and local law enforcement departments. In addition, a focus on patient-on-employee versus employee-on-employee violence may require somewhat different human resources, legal, and clinician skills. It is essential that staff be given release time from patient care activities to attend meetings and conduct other committee work. To meet shared objectives, the committee can:

- Hold regular meetings and consider whether “ad hoc” meetings would be useful as well.
- Strongly encourage worker involvement in the decisions that affect their health and safety.
- Address employees' safety concerns in a timely manner.

Research has shown that interventions such as improved management commitment to a violence prevention program and employee engagement can lead to enhanced employee perceptions of safety.⁴



⁴ Lipscomb, J., McPhaul, K., Rosen, J., Brown, J.G., Choi, M., Soeken, K., Vignola, V., Wagoner, D., Foley, J., and Porter, P. 2006. Violence prevention in the mental health setting: The New York State experience. *Canadian Journal of Nursing Research*. 38(4): 96–117.

Examples

Saint Agnes Hospital: a strong stance against violence

At Saint Agnes Hospital—an urban acute care facility in Baltimore, Maryland—administrators have put many policies and procedures in place to encourage associates to raise concerns and report violent incidents, and they have also taken steps to clearly show associates, patients, and visitors that violence is unacceptable and will have consequences. For example:

- Saint Agnes uses a secure, accessible electronic incident reporting program and requires a follow-up discussion to reflect on why an incident occurred and how it could have been prevented—all taking place in a blame-free environment.
- Managers encourage victims of violence to use the Employee Assistance Program (EAP), even if the victim says that he or she does not need to do so. Referring an associate to the EAP might be particularly important in the case of a serious incident such as a sexual assault. Managers also encourage victims to request an alternative provider if they feel the hospital's EAP does not have the expertise or approach needed to address the incident.
- With top administrators' support, Saint Agnes has notified some of its most violent repeat offenders that they are no longer welcome at the facility, and the hospital will not readmit them. This does not include the ED, though, as the hospital is required by law to see a patient who requires emergency care.
- If an associate wishes to press charges against a patient who assaulted them, the hospital helps them navigate the legal process and provides financial support.
- Managers and front-line staff speak openly about their concerns during Emergency Department Performance Improvement Committee (EPIC) meetings, monthly leadership meetings, daily opening and closing "flash meetings," and unit-level huddles.



At Saint Agnes Hospital, everyone signs a nonviolence pledge: administrators, front-line associates, and affiliates (e.g., contractors). Signs and posters throughout the facility emphasize the hospital's mission and the roles that staff, visitors, and patients can all play in creating a healing environment.

St. John Medical Center: commitment from the top, input from the front line, and a stand against bullying

In 2013, administrators at St. John Medical Center—a large urban hospital with affiliated facilities in Tulsa, Oklahoma—met with all three nurse shifts to discuss action plans for dealing with a behavioral health patient who needed round-the-clock observation. Managers met with caregivers and listened to their concerns; based on these meetings, the hospital convened a workplace violence prevention group.

Now, nursing leadership, physician leadership, and other administrators all support workplace violence prevention. The CEO of each facility or another designated administrator leads an interdisciplinary safety meeting every morning to review activity from the past 24 hours and discuss potential concerns during the next 24 hours. The CEOs also periodically accompany physicians and others on daily rounds, and a Threat Assessment Committee brings physicians, nursing, behavioral health, security, occupational safety and health, and human resources staff together to address workplace violence issues twice a month, or more often if needed.

St. John's leaders have recognized that a nonviolent workplace also requires action against bullying. Because bullying sometimes stems from clinical hierarchies—for example, a physician behaving dismissively toward a nurse—it is particularly

important to engage physicians when designing and implementing anti-bullying policies. At St. John, this engagement starts at the top, where the head of the medical staff has stated unequivocally that bullying will not be tolerated. St. John's electronic incident reporting system allows staff to report bullying and to route this report around their supervisor if he or she is the perpetrator. Nurses have become confident enough to report occasional bullying events by physicians, thanks to a "no fear" environment.

Providence Behavioral Health Hospital and the Massachusetts Nurses Association (MNA): lasting collaboration

Providence Behavioral Health Hospital's joint labor/management workplace violence task force has been collaborating on this issue since 2004. The hospital has developed a written "culture of safety" policy that emphasizes everyone's responsibility to look for safety concerns and bring them forward, a "stop the process" policy that allows any employee to speak up if they feel uncomfortable with a situation, and a joint labor/management safety manual that describes hospital policies, employees' rights, incident reporting tools, and other resources.

Administrators, managers, and front-line workers meet together in several forums:

- The workplace violence task force meets quarterly to maintain the safety manual, review incident reports, and develop new solutions as needed. All departments are represented on the task force, along with human resources and union representatives.
- Managers and front-line staff speak openly at monthly leadership meetings to discuss concerns, acknowledge mistakes, and develop solutions.
- Daily "flash meetings" at the start and end of each day allow staff and managers to discuss concerns and strategies for specific patients.
- Administrators show their commitment to safety by participating in these meetings, taking an official stance on violence prevention in their labor contracts (see Section 3, "Getting Started," for contract language), making frequent rounds, and providing funds for training. Staff have strong champions for safety in both their MNA chief representative—an RN with 29 years of experience, including as an inpatient psychiatric nurse—and the senior vice president who oversees the entire facility. The senior vice president worked as a nurse in community mental health for 30 years and understands the challenges firsthand.



Resources

Author	Title	Description	URL
OSHA	Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers	Voluntary guidelines for reducing workplace violence in the healthcare and social service sectors. The guidelines emphasize the importance of management support and employee engagement.	https://www.osha.gov/Publications/osh3148.pdf
Emergency Nurses Association	Workplace Violence Toolkit	Toolkit with templates and examples designed specifically for the ED.	https://www.ena.org/practice-research/Practice/ViolenceToolkit/Documents/toolkitpg1.htm
American Nurses Association	Model "State" Bill: "The Violence Prevention in Health Care Facilities Act"	Example bill that requires healthcare entities to establish programs to protect workers from violence.	http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-WorkplaceViolence/ModelWorkplaceViolenceBill.pdf
ASIS International Healthcare Security Council	Managing Disruptive Behavior and Workplace Violence in Healthcare	White paper that provides supporting documentation on workplace violence for healthcare security professionals.	http://www.g4s.us/~media/Files/USA/PDF-Articles/Hospitals%20and%20Healthcare/Council_Healthcare_WorkplaceViolence.ashx
American Nurses Association	Incivility, Bullying, and Workplace Violence	Position statement containing detailed recommendations and suggested resources for registered nurses and employers.	http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/Incivility-Bullying-and-Workplace-Violence.html

5. Worksite Analysis and Hazard Identification

Ongoing worksite analysis and hazard identification is critical to the success of a comprehensive workplace violence prevention program. Many facilities have found it useful to engage senior management, supervisors, and both clinical and non-clinical employees to assess risks together. A comprehensive assessment can include a records review, a review of the procedures and operations for different jobs, employee surveys, and a workplace security analysis.

Risk Factors for Workplace Violence in Healthcare

A risk assessment will often reveal many factors that could contribute to violence in the workplace. Some of these risk factors relate to patients, clients, and settings, including:

- Working directly with people who have a history of violence, people who abuse drugs or alcohol, gang members, or distressed relatives or friends of patients or clients.
- Lifting, moving, and transporting patients and clients.
- Working alone in a facility or in patients' homes.
- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident.
- Poorly lit corridors, rooms, parking lots, and other areas.
- Lack of a means of emergency communication.
- Prevalence of firearms, knives, and other weapons among patients and their families and friends.
- Working in neighborhoods with high crime rates.

Other risk factors are more organizational in nature, including:

- Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff.
- Working when understaffed in general—and especially during mealtimes, visiting hours, and night shifts.
- High worker turnover.
- Inadequate security and mental health personnel on site.
- Long waits for patients or clients and overcrowded, uncomfortable waiting rooms.
- Unrestricted movement of the public in clinics and hospitals.
- Perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges.

- An overemphasis on customer satisfaction over staff safety.

Reviewing Records, Procedures, and Employee Input

Facilities may find it useful to review the following types of records to identify trends and risk factors:

- Violence-related medical, safety, threat assessment, workers' compensation, and insurance records.
- Logs of work-related injuries and illnesses, as required by OSHA (OSHA Forms 300 and 301).
- First reports of injury, incident/near-miss logs, and other incident reports, including police reports, general event logs, or daily logs.

In addition to reviewing records, the workplace violence prevention committee can review procedures and operations for different jobs and conduct employee surveys to identify violence hazards. Employee questionnaires and detailed baseline screening surveys are useful tools for pinpointing tasks that put workers at risk of violence. Periodic anonymous employee surveys, conducted at least annually or whenever operations change or incidents occur, can help to monitor the effectiveness of previously implemented hazard control measures and identify new or previously unnoticed risk factors and deficiencies in the environment, training, or work practices.

Patient Input

Patients and their families can also provide valuable input to help the workplace violence prevention team identify risk factors, understand patients' perspectives, and design effective solutions. Facilities have sought patient input in many different ways, such as:

- Patient surveys or other formal surveys.
- Informal surveys or focus groups. For example, one behavioral health hospital asked patients for input about what type of security presence in their unit (uniformed, etc.) would make them feel most comfortable and safe.
- Interviewing or surveying patients both before and after an intervention. For example, one behavioral health hospital installed a metal detector at its methadone clinic, and learned from clients that this intervention made many of them feel safer.
- Enlisting patients to participate in research to identify triggers to violence, daily activities that may lead to violence, and effective responses.

Walkthrough Assessment

Regular walkthrough assessments (such as environment of care rounds) can play a vital role in identifying and assessing workplace hazards. Walkthroughs may be conducted by members of the workplace violence prevention committee, including staff from each area and each shift, as well as facility maintenance or management personnel. They should cover all facility areas. The walkthrough itself is not the end of the

assessment and review process: a complete process also includes post-assessment feedback and follow-up.

Violence can occur anywhere, but psychiatric services, geriatric units, and high-volume urban EDs, admission areas, and waiting rooms often present the highest risks. The key to protecting employees and patients is inspecting all work areas, including exterior building areas and parking areas, as well as evaluating security measures.

Examples

Veterans Health Administration: a comprehensive employee survey

In 2000, the VHA formed a National Taskforce on Violence with representation from VHA organizational units, labor partners, and outside agencies. After reviewing violence within the VHA and identifying policy weaknesses and potential solutions, the Taskforce conducted a national survey that generated responses from more than 70,000 full- and part-time VHA employees at 142 facilities.⁵ The survey asked employees about job satisfaction, perceptions of safety, and whether they have experienced various types of violence in the workplace. Responses were analyzed by department/unit and by job category. The survey revealed the highest-risk departments (geriatrics, mental health, rehabilitation, and acute/specialty care) and occupations (registered nurses, licensed practical nurses, nursing assistants, and police/security) for assaults by patients. It also found that facilities with higher penetration of alternative dispute resolution training tended to have lower rates of assaults. Other results included information about coworker violence, including prevalence, the most common triggers, and the groups of employees who appear to be at the highest risk.

St. Cloud Hospital: from systematic “failure modes” analysis to proactive solutions

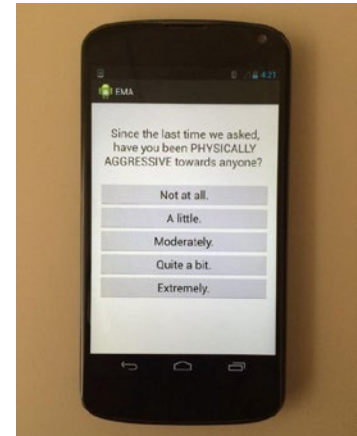
At St. Cloud Hospital, a 489-bed acute care hospital in St. Cloud, Minnesota, a string of violent events in 2010 prompted the Medicine care center director to conduct a chart review and start a dialogue with a wide range of colleagues to learn more about the prevalence of violence and try to identify precipitating factors or warning signs. The director's initial findings led administrators to establish an interdisciplinary workplace violence prevention group. This group used a technique called failure modes and effects analysis (FMEA) to identify and prioritize vulnerabilities. FMEA was originally created by reliability engineers for military and aerospace applications, and it has since spread to many other industries that are concerned with safety or quality. The technique takes various forms, but it generally involves a stepwise process to anticipate potential problems, identify causes and effects, and prioritize recommendations for improvement. At St. Cloud, an interdisciplinary team composed of leaders and direct care providers looked at each unit in the facility, then identified what could possibly go wrong (“failure modes”), root causes, and effects. Next, they scored each failure mode based on its probability of occurrence and the severity of the effects, which allowed the team to develop and prioritize a set of recommendations for proactive controls. One example of a potential failure mode was communication among the staff from one care area to another or from shift to shift about patient's risk of violence. FMEA tools are available from a variety of organizations, including a few that have tailored the approach for healthcare facilities.

⁵ For more information about the VHA's survey methods and results, see: Hodgson, M.J., Reed, R., Craig, T., Murphy, F., Lehmann, L., Belton, L., and Warren, N. 2004. Violence in healthcare facilities: Lessons from the Veterans Health Administration. *Journal of Occupational and Environmental Medicine*. 46(11): 1158–1165.

New Hampshire Hospital: exploring triggers for violence through research

New Hampshire Hospital, a state-run behavioral health facility, serves as a teaching hospital through its affiliation with the Geisel School of Medicine at Dartmouth College. This connection allows New Hampshire Hospital to serve as a living laboratory for ongoing research to identify precursors to violence and test new practices. Physicians engage patients as partners in their research, which is part of the hospital's drive for continual improvement. This connection to academic studies also helps to raise awareness of other new research and encourage staff members to adopt the best available evidence-based approaches.

One ongoing example is "Project Pause," which is examining whether a smartphone app can predict violence among a select group of acutely ill patients. During the research phase, patients carried smartphones (with cameras and games disabled) for seven days. Every two hours, the app would prompt them to answer questions about how they felt. The phones could detect ambient sounds (for example, if someone was screaming or talking to themselves) and track the location and movement of patients. Ultimately, the researchers aim to compare these self-assessment data with violent incidents and restraint and seclusion reports to determine whether the self-assessment tool has predictive value.



New Hampshire Hospital's "Project Pause" is a smartphone app for predicting violence. Patients answer self-assessment questions like the one shown here, and researchers compare the data with violent incident reports.

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6. Hazard Prevention and Control

Once the records review and a walkthrough assessment are complete, the workplace violence committee can work toward addressing the hazards identified. To do so, healthcare facilities can choose from a variety of methods, procedures, and technologies intended to prevent violent incidents or to respond to them in the most effective manner when they do occur. Prevention and control allows employers to minimize or eliminate risks and liabilities as well as to meet their legal obligation to provide employees with a safe and healthy work environment.

In the field of workplace safety, the ideal choice is generally to eliminate a hazard altogether or to substitute a safer work practice. In healthcare, one example may be transferring patients to a more appropriate facility if they exhibit violent behavior that may not be appropriate in a less secure environment. Substitution is not always possible in a healthcare environment, though, but other options are available. These options fall into two major categories, **engineering controls** and **administrative and work practice controls**, which are best when used in combination to maximize prevention and control.

Engineering controls are physical changes to the workplace that either remove a hazard or create a barrier between workers and the hazard. These controls are often the next best option if elimination and substitution are not possible. Examples include:

- Changing floor plans to make exits more accessible and/or improve sightlines for staff.
- Improving lighting in remote areas or outdoor spaces for better visibility.
- Installing mirrors.
- Installing security technologies such as metal detectors, surveillance cameras, or panic buttons.
- Controlling access to certain areas (e.g., ICU, ED, birthing center, pediatric unit) with locked doors.
- Enclosing the nurses' station or installing deep counters.



Panic buttons can provide additional security in high-risk areas.

- Replacing furniture with heavier or fixed alternatives that cannot be easily used as weapons.

Administrative and work practice controls are changes to the way staff perform jobs or tasks, both to reduce the likelihood of violent incidents and to better protect staff, patients, and visitors should a violent incident occur. Administrative and work practice controls are appropriate when engineering controls are not feasible or not completely protective. Examples include:

- Procedures and tools for assessing and periodically reassessing patients with regard to their potential for violent behavior. Some facilities conduct threat assessments on a patient's admission and periodically afterwards. Research confirms the importance of formally assessing mitigating factors (including work, financial, psychological, social, and physical factors) as well as factors that increase risk (including anger and trauma, history of violence and arrests, alcohol use, and financial instability).^{6,7} Such tools can improve the structuring and organizing of risk-relevant data and may enhance communication and decision-making.^{8,9}

⁶ Meloy, J.R., White, S.G., and Hart, S. 2013. Workplace assessment of targeted violence risk: The development and reliability of the WAVR-21. *Journal of Forensic Sciences*. 58(5): 1353–1358.

⁷ Douglas, K.S., Ogloff, J.R., and Hart, S.D. 2003. Evaluation of a model of violence risk assessment among forensic psychiatric patients. *Psychiatric Services*. 54(10): 1372–1379.

⁸ Meloy, J.R., White, S.G., and Hart, S. 2013. Workplace assessment of targeted violence risk: The development and reliability of the WAVR-21. *Journal of Forensic Sciences*. 58(5): 1353–1358.

⁹ Meloy, J.R. 2006. Empirical basis and forensic application of affective and predatory violence. *Australian and New Zealand Journal of Psychiatry*. 40(6–7): 539–547.

- Procedures for tracking and communicating information regarding patient behavior.
- Special procedures for patients with a history of violent behavior.
- Adequate staffing on all units and shifts.
- Providing training in de-escalation techniques, workplace safety practices, and trauma-informed care. Trauma-informed care recognizes the lasting impacts of physical, psychological, and emotional trauma on a survivor, and it actively seeks to avoid re-traumatization. For example, caregivers should minimize coercive interventions and avoid introducing stimuli or cues that might remind the victim of a previous traumatic experience.
- Emergency procedures so all staff know what to do if an incident occurs.
- Policies and procedures that minimize stress for patients and visitors.

Engineering and administrative controls for various healthcare settings are discussed in more detail in OSHA's [Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers](#).

Engineering controls and administrative controls often work in concert to address risk in the healthcare setting. Both kinds

of controls should be selected with careful regard to the nature of the hazard identified and the nature of the healthcare setting. For example, controls suitable for an urban ED might not be appropriate for a community care clinic. Instituting any combination of control and prevention methods requires a careful balance between providing a safe healthcare setting and maintaining a calming, welcoming, and workable environment for staff, patients, and visitors.

Implementing controls does not conclude the process of addressing workplace violence. Once controls are in place, periodic review and evaluation can ensure that they are adequately addressing hazards identified during the site assessment process, highlight areas of weakness, and help to identify new or emerging risks that might require modification of existing controls or adoption of additional measures. In addition, if an incident occurs, employers can help their workers by providing timely medical and/or mental healthcare services (as appropriate) and conducting a post-incident debriefing where all involved or affected staff meet to conduct a blame-free root cause analysis that considers what happened, what should have happened, why the difference, and how to prevent a similar problem in the future. Access to an employee assistance program can help a worker cope with the ongoing trauma and stress that often accompany an assault or injury.



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Examples

St. Cloud Hospital: assessing every patient's risk of violent behavior

When St. Cloud Hospital's workplace violence committee convened in 2010 to review their incidents and risk factors, they recognized that their staff could benefit from a tool to assess individual patients and identify those who might require special precautions to prevent violent behavior.

The team reviewed existing tools and found one that was specific to behavioral health. They modified this tool to include identifying if the patient has any risk factors for violence; if risk factors are present, additional questions are asked. The tool is efficient to complete. It is now integrated within the hospital's regular nursing assessment for all adult patients, which is completed electronically and tied into patients' electronic medical records. Each patient is assessed for potential violence risk when admitted to the hospital and again every 12 hours thereafter. A nurse records risk factors and signs of impending violence, such as irritability or confusion. A risk level is then assigned to each patient depending on how many risk factors and signs of impending violence he or she exhibits. If a patient is marked as "high risk," a list of potential interventions will appear in his or her electronic medical record, based on the individualized treatment plan that the staff develops. For example, the record might advise removing extra furniture from the patient's room. Some high-risk patients also have magnets on their doorframes to alert staff to take precautions. St. Cloud's patient assessment tool has been recognized as a model by the Minnesota Department of Health.

St. Cloud Hospital's electronic medical records include a violence risk assessment conducted by a nurse every 12 hours, along with special precautions on the right side of the screen for patients deemed to be "high risk."

Veterans Health Administration: assessing patients and flagging records

The cornerstones of the VHA's violence prevention program are Disruptive Behavior Committees (DBC) and the patient assessment process. A multidisciplinary DBC at each facility reviews incident reports referred by staff who are concerned that a patient may pose a safety risk to himself, other patients, and staff. As per VHA policy, the DBC, which is chaired by a senior mental health clinician, determines whether a specific consistent approach, which may include a security escort, is warranted for each patient visit. If a patient is determined to present "an immediate safety risk for seriously disruptive, threatening, or violent behavior," a Patient Record Flag (PRF) may be put on the patient's electronic health record to alert staff to the safest and most therapeutic approach for handling their visit. VHA facilities nationwide use a standardized definition and criteria for "disruptive behavior" to ensure a consistent assignment of PRFs and avoid overusing this designation.¹⁰ DBCs are encouraged to convene at least monthly, and PRFs are activated in patients' electronic medical records the day after the DBC assigns them. PRFs are shared across all facilities that might treat a given patient.

¹⁰ See VHA Directive 2010-053 (http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2341) for specific criteria and other requirements related to PRFs.

The VHA's threat assessment process combines clinical and actuarial approaches that are informed by the empirical literature. The VHA incorporated veteran-specific risk factors, both static (e.g., gender, prior assault status) and dynamic (e.g., recent alcohol abuse, homelessness, and employment status); risk mitigation factors; and setting risk factors (e.g., staffing issues) into its violence risk assessment instrument. The VHA's approach also requires professional judgment. Studies have found that this type of structured professional judgment instrument is significantly predictive of violence and performs as well as or better than other types of violence risk assessment.

The VHA continues to review and improve its threat assessment process. For example, VHA researchers recently worked on a quick screening tool that will help clinicians identify candidates in need of a more comprehensive assessment.¹¹ They evaluated a rapid five-item screening tool, called the Violence Screening and Assessment of Need (VIO-SCAN), to determine its predictive validity. This evidence-based screen covers a combination of factors such as probable post-traumatic stress disorder, alcohol misuse, financial instability, combat experience, arrests, and history of violence.

Example: One large regional VHA system set up a DBC that includes key managers as well as representatives from five labor unions, police/security, and people with a full spectrum of clinical and service expertise. They took the lead and created a "Behavioral Rapid Response Team" (BRRT) to identify and address escalating behaviors through the intervention of a rapid response Mental Health Consult Team. The DBC also instituted a police check-in form for those outpatients who carry this order of behavioral restriction. The organization also addressed environmental design by using the Workplace Behavior Risk Assessment process to identify areas where physical safety aids such as panic alarms, locked doors, and furniture configuration should be considered. It created an "environmental risk assessment" in which an interdisciplinary team assesses a work site and recommends ways to mitigate risk. It also created a "Green Flag" alert system in which ancillary staff check with the inpatient's primary nurse to learn how to work safely with a patient who has a behavioral flag. Finally, the organization's Behavioral Emergency Review Committee evaluates all "code green" (mental health) emergencies and BRRT calls, as well as assault data.

Sheppard-Pratt Health System: "doing your homework" and lending a watchful eye



Milieu Safety Officers create a safe environment for staff and patients at Sheppard-Pratt.

At Sheppard-Pratt, a large behavioral health system headquartered in Towson, Maryland, many patients arrive upon referral from an ED. For these patients, violence prevention starts before they even arrive. Admissions staff can look up a patient's criminal record, and they take a detailed report from the ED, with nurses at Sheppard-Pratt talking with nurses at the ED, and physicians talking with physicians. These lateral conversations promote an open exchange of information. If the criminal record or ED report indicates a history of violence or aggressive behavior, Sheppard-Pratt can be prepared with extra clinical and security staff, and they can be ready to promptly administer emergency medications if needed to protect the patient or staff.

Sheppard-Pratt has also taken a unique approach with what it calls "Milieu Safety Officers"—specially trained, uniformed security staff who work in the milieu (common areas) in high-risk units. Milieu Safety Officers have no other assigned duties, so they can focus solely on the activity and mood in the unit, chatting with patients and keeping an unobtrusive eye on the area.

Milieu Safety Officers are specially recruited and trained for the job. Some have experience working in the Department of Corrections, so they can help other staff learn how to recognize and deal with criminal culture. They are also chosen for their

interpersonal and verbal de-escalation skills, and they receive training in both security and mental health. They meet with new patients to get to know them and set expectations; they also participate as members of the treatment team and receive daily clinical patient information.

¹¹ Elbogen, E.B., Cueva, M., Wagner, H.R., Sreenivasan, S., Brancu, M., Beckham, J.C., and Van Male, L. 2014. Screening for violence risk in military veterans: Predictive validity of a brief clinical tool. *American Journal of Psychiatry*. 171(7): 749–757.

Sheppard-Pratt's Milieu Safety Officers have succeeded on many fronts. Units with Milieu Safety Officers have seen a decrease in violent injuries to workers, and staff report feeling safer where Milieu Safety Officers are present. Patients have also expressed that they feel safer with a uniformed officer present, and they often approach the officer to discuss their concerns or to get help—a testament to the rapport these people are able to build.

“Staying Safe” at New Hampshire Hospital

Like other leading behavioral health facilities, New Hampshire Hospital emphasizes the use of comfort rooms that include comfortable furniture, soothing colors, soft lighting, quiet music, and other sensory aids to help reduce patients' stress levels. Patients are free to access these rooms as they wish.

Staff participate in the “Staying Safe” program, which trains staff to listen to patients, try to answer questions, and provide help to calm people and de-escalate situations before they turn violent. Before physical intervention with a patient, “Staying Safe” training demands that at least five staff be present and requires them to have a plan to manage the situation as safely as possible. Before the hospital implemented the five-person requirement, intervening alone was a major cause of injuries to staff.

Security is also an important part of New Hampshire Hospital's hazard control efforts. Campus police officers are commissioned by the state police force and are specially screened and trained for working in a mental health setting. Officers have been trained to respond to “code gray” (psychiatric) emergencies and assume a supportive role to staff. This type of response allows the officers to be present and immediately available if their services are needed. Campus police officers use defensive measures only when clinical staff have been unable to control the situation safely, there is extreme and imminent danger, and the nurse in charge specifically requests police assistance. This approach prevents the unnecessary use of force, which could escalate a situation and trigger a traumatic experience.



A member of New Hampshire Hospital's staff shows one of the facility's sensory rooms—a de-escalation strategy that has helped the hospital reduce patient-on-staff injuries.

St. Vincent's Medical Center: technological solutions and a behavioral response team



Associates at St. Vincent's Medical Center wear badges with alarms that will alert the security office if they feel threatened.

While hospital administrators can implement engineering and administrative controls to mitigate hazards present within a healthcare facility, protecting workers who work outside the hospital, such as in patients' homes, presents a different set of challenges. These challenges include being able to ascertain whether a worker is in a violent or potentially violent situation, and being able to quickly locate and respond to the incident. In 2015, St. Vincent's Medical Center in Bridgeport, Connecticut, evaluated the implementation of a GPS duress alarm system that case workers can wear while making home visits. The hospital plans to implement these GPS units in the year ahead.

GPS alarms are just the latest in a line of technologies that St. Vincent's Medical Center has adopted to keep its associates safe. The threat of violence is elevated at St. Vincent's hospital because this large urban hospital frequently treats “forensic” patients from nearby correctional institutions. Some of these patients are known to have histories of violent behavior, but all such patients must be considered a risk because they may view the hospital as an escape opportunity. St. Vincent's director of safety and security has implemented a multi-pronged strategy to minimize risk to

employees, patients, visitors, and the community, including:

- Protocols for information exchange before patient arrival.
- A locked vestibule system where incoming forensic patients disrobe and change into hospital attire while being observed by trained staff through a one-way mirror.
- Electronic staff identification badges with a card that can be removed to trigger an alert to the security office. These badges carry GPS locators so that security staff can respond to the exact location of the alarm without delay.

St. Vincent's Medical Center also formed a Behavioral Response Team to help reduce risks. This multidisciplinary team comprises a forensic psychologist, ethics staff, human resources, security, and others. They meet ad hoc to review specific patient, associate, and family risk cases, and they also meet monthly to recap workplace violence issues and identify new solutions. For example, St. Vincent's hospital removed last names from many staff identification badges in the behavioral health unit after a stalking incident. Within the broader community, St. Vincent's Medical Center participates in an initiative called Street Safe Bridgeport, which aims to reduce gang violence.

Saint Agnes Hospital: a wide array of engineering and administrative controls

Saint Agnes employs a variety of engineering controls to prevent violent incidents at its urban campus in Baltimore, Maryland, including security cameras and panic buttons. The hospital has also incorporated subtle environmental details such as soothing wall colors, designated quiet areas, and noise reduction pads on doors to help keep patients and visitors more calm.

The hospital uses several administrative controls, too. Hospital-wide safety policies allow all patients to be searched for weapons and contraband upon admission or return from a pass. Patients at risk of violence or development are indicated with flags in their medical records, gray door signs, and gray gowns that are secured with three arm holes instead of strings, to reduce suicide risk. The hospital also uses color-coded lights installed above patient room doors throughout its "co-attending" unit for patients being treated for a medical diagnosis who also have behavioral challenges. The different colors of lights indicate who from the staff (e.g., a nurse, sitter, or maintenance worker) is with the patient in the room.

Saint Agnes worked for several years to get off-duty police officers from the local community to serve in the ED. The hospital specifically wanted officers from Baltimore's Southwest district, as they know the community, they are familiar with some of the hospital's more challenging patients, and they have positive relationships with staff. The CEO successfully pushed to get these officers in the ED because their presence can help to deter bad behavior.



Patients at risk of violent behavior wear gray gowns so Saint Agnes's associates can quickly identify them and make sure to take extra precautions. The gowns are also designed with no strings, to reduce suicide risk.

Providence Behavioral Health Hospital: de-escalation and openness to new methods

Providence's de-escalation strategies start with the nursing assessment and getting to know each patient—what stimuli might trigger a violent episode and what approaches can help to calm them—then communicating this information to staff (for example, on patient care boards) and using it as a basis for personalized therapeutic interventions.

Providence has successfully employed alternatives to restraints, an effort spurred in part by a Massachusetts state mandate to reduce the use of restraints. The most common form of restraint used is the "geriatric chair": a chair with a built-in tray that is placed in front of the patient to prevent a patient with dementia from wandering. Beyond the requirements of the state mandate, the hospital has implemented a no-restraint policy in its child and adolescent units.

As it works to continually reduce violence and improve patient care, Providence benefits from its medical and nursing staff's willingness to embrace new methods, more holistic approaches, biofeedback methods such as heart-brain coherence, and sensory strategies. Staff create individualized crisis prevention plans for patients and employ a variety of therapy options, including a sensory room with a cabinet full of activities that can occupy and calm patients, a weighted blanket (a known calming intervention), ball massage, a swing, talk therapy, and music therapy. These approaches have an added benefit because they can help patients learn coping strategies that will help them in their own lives after they leave the hospital.



Providence Hospital's sensory rooms provide a soothing environment for patients. The cabinet contains a variety of activities that can help to reduce a patient's stress and aggression.

Engineering controls also help Providence prevent violence. In addition to installing many security cameras, the hospital has installed a swipe card system on key entryways, the main staircase, and elevators. As a result of the MNA-negotiated labor/management violence task force, the hospital added metal detectors at two methadone clinics that it runs, where drug dependency and the anxiety of waiting in line had historically led to violent incidents. In a survey, patients reported that the metal detectors make them feel safer.

To provide a calmer environment for its patients, the hospital has reduced noise by limiting overhead pages and trying to reduce the instability and stress that can surround a shift change. For example, the children's unit runs a group activity at shift change time, led by someone who is not changing shift.

Holy Cross Hospital: a layered code system to drive appropriate response

Holy Cross Hospital—an urban acute care hospital in Fort Lauderdale, Florida—recognized that a single code (such as “code gray”) does not capture the wide range of situations that could involve a potentially violent person. A uniform code could lead to responses that are excessive in some situations but insufficient in others. Thus, the safety team developed a more precise set of “subcodes” to indicate the degree of assistance needed. They use three levels:

- Code Assist: calls for one security officer.
- Code Strong: calls for more support staff, including first responders, the nurse supervisor, and engineering staff. Engineering staff have been a helpful addition because they are available around the clock and can typically stop what they are doing and respond immediately. All of these responders take 8-hour training on crisis intervention and de-escalation.
- Code Strong with Intensivist: calls for the same response as a Code Strong, but also summons an intensive care physician who can immediately order medication or physical restraints if needed. Intensive care physicians are on site all day and night, and their participation in code response has eliminated what was previously a 20- to 60-minute wait that could leave caregivers vulnerable to an actively violent patient who needs more than just de-escalation.

“Here at Holy Cross, we have a strong commitment to the safety of our patients and our associates. We want the staff to always feel their calls for assistance for their personal safety will be heard and acted on. The healthcare world is ever changing: providing a safe workplace is a leading initiative for us.”

—Taren Ruggiero, Vice President and Chief Nursing Officer, Holy Cross Hospital

This nuanced code system works in conjunction with several other controls. For example, Holy Cross has a cross-organizational Violence Prevention Advisory committee that reviews every Code Strong event and can choose to flag the electronic chart of a patient who repeatedly demonstrates violent behavior. The hospital's electronic medical record software is connected to a

marker on the ED tracking board that is visible if one of the flagged patients checks in, thus alerting staff to the presence of those patients. Holy Cross has also configured its software to scan the daily census; if any of these particular patients are on site, the system generates an email alert to key staff. Holy Cross has also developed a protocol to protect patients who may be domestic violence victims—for instance, by not giving out information about them over the phone. Executives, security staff, and others often tell people that violence is not tolerated. The message: “We love our patients, but patients have responsibilities too.”

Altogether, Holy Cross’s program has generated positive results. The hospital has experienced an increase in the number of Code Strong calls, likely due to staff becoming familiar with the system and recognizing that it generates a response. A recent “Culture of Safety” survey found that staff have a substantially stronger perception of safety than they did a few years ago. Holy Cross’s parent organization, Trinity Health, is using Holy Cross’s program as a model for other facilities nationwide.

Rm	La...	Age	CC	P	MD	PA	S...	Ord	LAB	RAE	EKG	CT	US	UA	RT	LOS	CMT	C3	TX	MED	B
1	Brow...	65	CP	2			RECD									01:12					
2	Midnl...	41	CP	2	MEC		OOED	Ne...								460:12				TX Adm	Clean
4	Hchcc...	56	CP				FINAL									167:00					Clean
Y. 5	Hchcc...	55	CP				RECD									00:09					Clean
6																					Clean
7																					Clean
8																					Clean
9																					Clean
10	Hche...	37	HEA		KK	KM	SEEN									499:34				TX Med	Clean
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18																					Clean
19																					Clean
20	Pale,A	35	CEL																		Clean
21	Sepsi...	56	TRG																		Clean
22																					Clean
23																					Clean
24																					Clean
25																					Clean

Green highlighting and a “Yes” indicator in the left column on Holy Cross’s electronic patient tracking board indicate when a patient in the ED has a history of violence against staff.

St. John Medical Center: access control and color-coding

Like other leaders in workplace violence prevention, St. John Medical Center has employed a variety of engineering controls and administrative controls throughout its facilities. Engineering controls include installing access controls on the ICU, ED, and pediatric areas, and employing panic buttons in most of the hospital’s nursing units and all ICUs. In addition to the fixed-place alarms, nurse calls can now be sent from mobile devices, which set off alarms at the nurses’ station. The ED’s reception area is enclosed and locked, and the department is provided with impact-resistant glass.

Frequent patient assessments help staff assess risks. Staff assess patients on admission and every two hours thereafter using a risk assessment tool the hospital adapted from an Australian model found in a workbook called “Prevention and Management of Aggression in Health Services” (see “Resources” on page 24). For patients deemed to pose a risk of violence, St. John developed a “code orange” system in which orange magnets are placed on doorframes as a warning. Upon seeing an orange magnet, nurses look up a patient’s history and enter the room with a team or a security officer, depending on the patient’s care plan. Support staff consult the nurse’s station to learn the appropriate protocol.

7. Safety and Health Training

Training is a key component of a successful workplace violence prevention program. It helps healthcare workers learn to recognize potential hazards and learn how to protect themselves, their coworkers, and their patients. Training and reinforcement through role-playing and other means can provide employees with strategies that increase their confidence for handling potentially violent incidents before they arise and reduce the likelihood of violent incidents occurring. Education also reinforces that violence is not an acceptable part of healthcare work.

“Practicing strategies *before* issues occur helps ensure the safety of all involved and the best outcome for the patient(s).”

—Papa and Venella, 2013¹²

Objectives and Topics

Training programs are most effective when they are designed specifically for a facility or unit’s particular risk profile—for example, training ED nurses within the ED and focusing on the most common threats they face at their facility. Organizations can study, adapt, and combine elements of model programs that are relevant to their facilities’ conditions and needs.

Common training objectives include increased confidence among workers in de-escalating aggressive behavior and in managing aggressive behavior when it occurs. Specific topics might include:

- A review of the facility’s workplace violence prevention policies and procedures.
- Policies and procedures for obtaining a patient’s risk profile before admission, when feasible.
- Risk factors that cause or contribute to assaults.
- Policies and procedures for assessing and documenting patients’ or clients’ change in behavior.
- Location, operation, and coverage of safety devices such as alarm systems, along with the required maintenance schedules and procedures.

- Recognition of escalating behavior, warning signs, or situations that may lead to assaults.
- De-escalation techniques to prevent or defuse volatile situations or aggressive behavior.
- Approaches to deal with aggressive behavior in people other than patients and clients, such as relatives, visitors, or intruders.
- Proper use of safe rooms or areas where staff can find shelter from a violent incident.
- A standard response action plan for violent situations, typically referred to as “codes,” including the availability of assistance, response to alarm systems, and communication procedures.
- More generally, what to do in case of a workplace violence incident—i.e., responsibilities of others who are not directly responding to the event.
- Self-defense procedures where appropriate.
- Progressive behavior control methods, including when and how to use medications or physical restraints properly and safely when necessary.
- Ways to protect oneself and coworkers, including working in teams when necessary.
- Importance of getting early assistance.
- Policies and procedures for reporting and recordkeeping.
- Policies and procedures for obtaining medical care, counseling, workers’ compensation, or legal assistance after a violent episode or injury.

General recommendations for training content include:

- Add information about facility-specific policies, procedures, and potential risk factors when using existing packaged training programs.
- Ensure that training and policies cover all types of workplace violence, not just violence by patients against employees. Many training programs, policies, and procedures focus exclusively on the latter. These programs fail to address employee-on-employee or employee-on-patient violence, robbery and theft (such as theft of drugs, or of hospital or employee property), and domestic violence.
- Provide frequent opportunities to practice skills and demonstrate competency.

¹² Papa, A., and Venella, J. 2013. Workplace violence in healthcare: Strategies for advocacy. *The Online Journal of Issues in Nursing*. 18(1): Manuscript 5.

Who Gets Trained

All workers who are reasonably expected to interact with patients, including admissions staff, can benefit from workplace violence prevention training. So can supervisors and managers. Other support staff can benefit from awareness about their responsibilities in the event of a workplace violence incident. Affiliated physicians, temporary staff, and contract workers should receive the same training as permanent staff, and new and reassigned workers should receive an initial orientation that includes training in the prevention of workplace violence.

Because duties, work locations, and patient interactions vary by job, violence prevention training can be more effective if it is customized to address the needs of different groups of healthcare personnel, particularly:

- Nurses and other direct caregivers
- ED staff
- Support staff (e.g., dietary, housekeeping, maintenance)
- Security personnel
- Supervisors and managers

Nurses and other direct caregivers

Nurses, nursing assistants, mental health workers, and other direct caregivers spend much of their time interacting directly with patients, and they are often the first to encounter difficult situations. They can benefit from training in:

- The facility's workplace violence prevention plan
- Warning signal recognition
- Threat assessment
- Working with patients with violent behavior
- Violence escalation cycle and violence-predicting factors
- Verbal and physical de-escalation techniques
- Self-defense, with a hands-on component

Direct caregivers can also benefit from specialized violence prevention training tailored to the specific patient populations they work with—for example, behavioral health patients, the developmentally disabled, and geriatric patients with Alzheimer's and other forms of dementia.

Emergency department staff

ED nurses experience physical assaults at one of the highest rates of all nurses. Nurses in the ED may find themselves

exposed to patients who have a history of violence, aggressive behavior associated with certain psychotic disorders, substance abuse, dementia, and other conditions. The ED is a fast-paced, unpredictable environment; when patients arrive, the staff must treat them—sometimes without knowing much about their history or what drug(s) might be influencing their behavior. Many EDs, particularly those in large urban settings, treat patients who are themselves the victims of traumatic violence, and the background level of violence in the community can spill over into the ED. Moreover, the experience of traumatic injury or mental illness, pain, and the anxiety of an emergency room visit can trigger aggressive reactions. In addition to general training common to all direct caregivers, ED nurses should be trained in safety procedures related to restricting access or movement in the physical environment, such as locking access doors to prevent secondary violence from retribution in cases of gang violence or domestic violence.

Support staff

Housekeeping, food service, maintenance, and other support staff can benefit from workplace violence prevention training, especially if their duties take them to patient areas or if they otherwise have contact with patients. All staff should be aware of systems that rely on environmental symbols, such as color codes to convey safety information about individual patients, as well as what code situations announced over the public address system (e.g., "code gray") mean and how they should respond. Other safety precautions include staying a safe distance from the patients, not leaving maintenance tools unattended, and not allowing patients to reach for gowns and bags with strings while delivering laundry.

Security personnel

Security personnel need to know the layout of the facility, including entrance and exit points and how to restrict or control access. They need specific training on the unique needs of providing security in the healthcare environment, including the psychological components of handling aggressive and abusive behavior, and ways to handle aggression and defuse

"Security training must balance the need to provide patient-focused care with the need to protect one's personal safety."

—The Joint Commission, 2009¹³

¹³ The Joint Commission. 2009. Preventing violence in the emergency department—ensuring staff safety. *Environment of Care News*. 12(10): 1–3, 11.

hostile situations. They also need training in policies and procedures detailing how and when security personnel interact with patients during code situations.

Supervisors and managers

Supervisors and managers must be trained to recognize high-risk situations, reduce safety hazards, encourage employees to report incidents, and ensure that employees seek appropriate care after experiencing a violent incident. Additional training should involve the process for post-event management of employees who were directly involved in a workplace violence event.

Format and Frequency

Safety training can take several forms:

- **Classroom plus hands-on instruction.** Workplace violence prevention training has traditionally taken the form of classroom instruction (e.g., seminars) combined with active “learning by doing” in the form of role-plays, simulations, and drills. Interactive exercises make training more effective by allowing participants to practice and apply the skills they have learned, such as de-escalation and self-defense techniques.
- **Just-in-time training.** Some facilities have designated one or more trainers or “safety coaches” for each unit or floor. These individuals can offer guidance and coaching in real-time—for example, if they see a colleague struggling to de-escalate an agitated patient. They can also run ad hoc or scheduled refresher sessions, which may be particularly useful and relevant to workers because the training takes place in their own work environment.
- **Web-based training.** This increasingly popular approach offers fidelity of presentation and automated documentation while requiring minimal supervision and allowing flexible timing and pace. However, it does not provide hands-on practice with physical skills, which are widely considered to be an essential element of many programs. Thus, Web-based training may be more effective when paired with live instruction and practice—a “blended” approach. The National Institute for Occupational Safety

and Health (NIOSH) has developed a Web-based training program (www.cdc.gov/niosh/topics/violence/training_nurses.html) to help healthcare workers learn about the key elements of a comprehensive workplace violence prevention program, how organizational systems impact workplace violence, how to apply individual strategies, and how to develop skills for preventing and responding to workplace violence.

Regardless of format, healthcare organizations often find it helpful to have a team of trained workplace violence prevention trainers in-house. These trainers can attend a more in-depth course offered by an outside training provider, then become certified to train others.

Many healthcare organizations have improved results by providing annual refresher training for their direct caregivers. In high-risk settings and institutions, refresher training may be needed more often, perhaps monthly or quarterly, to effectively reach and inform all workers. For example, in a review that evaluated the effect of nonviolent crisis intervention (NCI) training on the number of code purple (security) incidents in an acute-care tertiary ED, the authors expected code purples to decrease as progressively larger numbers of staff were NCI trained. However, this did not occur. Rather, reduction of code purples was correlated with the number of staff who had been recently trained (in the past 90 days), implying a temporary effect of NCI training and suggesting that more frequent training is needed.¹⁴ Managers can increase participation by compensating employees for the time they spend in training and by making the training available for all shifts.

Evaluating and Improving Training Programs

All training programs should include an evaluation component. At least annually, the team or coordinator responsible for the program should review the content, methods, and frequency of training. Program evaluation may involve supervisor and employee interviews, testing, observing, and reviewing reports of how staff have responded to threatening situations.

¹⁴ Gillam, S. 2014. The quantitative impact of nonviolent crisis intervention training on the incidence of violence in a large hospital emergency department: A quality improvement study. *Proceedings of the Fourth International Conference on Violence in the Health Sector: Towards Safety, Security and Wellbeing for All*. 116–120.

Active Shooter Preparedness

An increasing number of healthcare facilities have begun to incorporate violence-themed situations called “active shooter” scenarios into their training programs. An active shooter is a person who is actively engaged in killing or attempting to kill people in a confined and populated area, such as a hospital ED. The shooter might target specific people or choose victims randomly. Scenarios that could lead to an active shooter situation might include rival gang members being treated in the ED, an estranged ex-husband visiting the maternity unit in violation of a restraining order, or a former patient or family member distraught over perceived misdiagnosis or mistreatment of a relative.

Although active shooter situations are rare, they can have a huge impact on a healthcare organization and the broader community. Because these situations are often over quickly before law enforcement arrives, healthcare organizations must prepare and train their staff to respond appropriately. The Joint Commission identifies the following steps that healthcare organizations can take to prepare for active shooter incidents:¹⁵

- Involve local law enforcement in your plans
- Develop a communication plan
- Assess and prepare your building
- Establish processes and procedures to ensure patient and employee safety
- Train and drill employees
- Plan for post-event activities

Some hospitals have obtained funding for active shooter exercises through grants from the Department of Homeland Security. See “Resources” on page 33 for more information about active shooter preparedness.



CheapNursingEUS.com

¹⁵ The Joint Commission. 2014. Preparing for active shooter situations. *Quick Safety*. Issue Four (July). http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_Four_July_2014_Final.pdf.

Examples

Veterans Health Administration: standardizing training nationwide

The VHA has been a leader in the training and education in prevention and management of disruptive behaviors. VHA workplace violence training comprises four modules:

- Overview and introduction
- Verbal de-escalation
- Personal safety skills (including physical “break-away” or self-defense skills)
- Therapeutic containment

All employees complete mandatory introductory training, and facilities assign additional modules to each employee based on the type and severity of risk for exposure to disruptive and unsafe behaviors. Each VHA facility has certified trainers on staff, and they track all training in a national training database. Employees assigned to additional levels of training undergo biennial skills assessments by certified trainers. If unable to pass these assessments, they must repeat the training. Employees can request additional training above their assigned level.

Saint Agnes Hospital: “train the trainer” and creative approaches

Training for associates at Saint Agnes Hospital addresses de-escalation, personal protection, bullying, domestic violence, and active shooter scenarios. In addition to introductory training for most associates, security staff and workers in high-risk areas—the ED, a “co-attending” unit for patients being treated for a medical diagnosis who also have behavioral challenges—receive six-hour nonviolent crisis intervention (de-escalation) training. Patient sitters also receive six-hour training; they are certified nursing assistants who are assigned to stay with a patient at all times, based on the patient’s needs (for example, suicidal patients and right-sided stroke victims). Instruction is delivered by a group of Saint Agnes staff who have been certified as trainers. Managers purposely selected a diverse group of trainers—bedside nurses, team leaders, nursing supervisors, human resources staff, critical care personnel, medical/surgical staff, and security workers—with the aim of providing mentors, coaches, and “champions” throughout the hospital.

Saint Agnes has made efforts to extend training to support staff and affiliates (e.g., contractors), and they use a variety of methods to keep the message fresh. For example, ED staff go through a panic button scavenger hunt as part of their orientation, and the staff newsletter includes information about a “code of the month.”

New Hampshire Hospital: de-escalation, trauma-informed care, and mental health training for security officers

As part of its “Staying Safe” program, New Hampshire Hospital places a strong emphasis on de-escalation training to minimize the need for physical intervention. This behavioral health hospital offers nonviolent crisis intervention and de-escalation training, along with custom modules based on best practices and research. All staff receive some form of training, including administrators. Trauma-informed care training has become mandatory for nursing staff, and all staff receive training on cultural diversity and boundaries. All campus police officers must go through five weeks of mental health worker education in addition to their state police training.

Providence Behavioral Health Hospital: training for all staff

Providence Behavioral Health Hospital provides all medical and nursing staff, mental health workers, and security personnel with nonviolent de-escalation training. They also use a Massachusetts Department of Mental Health–sponsored training program called the Collaboration, Assessment, Recovery Environment (CARE) curriculum. CARE is a four-hour training focused on restraints and seclusion. The hospital makes de-escalation training available to workers in support services, such as dietary and housekeeping. The hospital has in-house trainers who are certified by an outside training provider, which allows for more flexibility in scheduling. Sessions are offered three or four times per month, and staff take an annual refresher.

The hospital pays for hands-on self-defense training for everyone whose work takes them out into the community, and it also offers “community awareness” training that focuses on situational awareness. Managers get specialized training on workplace violence too, including information about the investigation process and other legal matters related to filing workplace violence reports.

Citizens Memorial Health Care: de-escalation training in long-term care

Citizens Memorial Hospital/Citizens Memorial Health Care Foundation (CMH) operates six skilled nursing homes, a hospital, and several other healthcare services in southwest Missouri. Nursing homes can pose risks for workplace violence, particularly when caring for patients with Alzheimer’s disease and/or dementia, which can lead to confusion and combativeness. As part of its comprehensive safety and health management system, CMH provides nonviolent crisis intervention and de-escalation training to all workers in its Alzheimer’s and dementia special care units, as well as to security staff and workers in certain other areas. As a result of these efforts and others, CMH has kept its injury rates and turnover rates below the national average. CMH’s continuous improvement shows how many of the same techniques that can be used to prevent violence in hospitals can also be applied to long-term care.



CMH incorporates role-play into its nonviolent crisis intervention and de-escalation training.

Sheppard-Pratt Health System: training in real time

Sheppard-Pratt has offered de-escalation training and annual refreshers to workers for many years, but its trainers have found that they can achieve even stronger results by offering training directly at the unit level throughout the year. This large behavioral health system has a team of trained trainers embedded in units throughout its facilities. These trainers, known as the “Green Team” because they wear lanyards with green beads, are available to coach and mentor their colleagues in real time. For example, a trainer might step in to help a colleague who is having difficulty with charting or with de-escalating a patient. They also provide monthly refresher training to their colleagues regarding holds. Real-time, in-unit training offers the benefit of realistic demonstration, an immediate opportunity to apply a skill, and the relevance that comes with learning in one’s actual work environment.

Active shooter training at Mercy Medical Center

In 2015, Mercy Medical Center in Springfield, Massachusetts, conducted a full-scale active shooter exercise with three scenarios: gang violence in the ED, a behavioral health escalation incident, and an estranged ex-boyfriend in the maternity unit. Staff from many units participated in the drill, including managers and staff from the ED, the Family Life Center, Providence

Behavioral Health Hospital, the security team, and human resources. The hospital coordinated the drill with the Massachusetts State Police and Springfield city police (including their Special Weapons and Tactics [SWAT] team), local tactical EMTs, and affiliated private security companies. Observers included other regional hospitals, school and college security, the Massachusetts Emergency Management Agency, the Homeland Security Council, long-term care facility representatives, and the Air Force Reserves, all seeking to learn and apply information to their own exercises. Evaluators noted participants' situational awareness, law enforcement response, communication, emergency operations, and treatment and triage. The exercise was followed by an open and blame-free evaluation that identified opportunities for improvement.



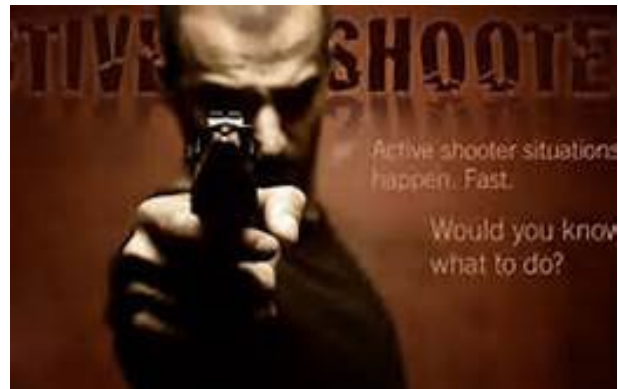
Mercy Medical Center's active shooter drill involved a large number of people in realistic scenarios—fake blood and all.

Active shooter training at Centennial Hills Hospital

At Centennial Hills Hospital Medical Center in Las Vegas, Nevada, the Emergency Preparedness and Trauma Coordinator designed and developed an active shooter exercise in collaboration with the Las Vegas Metro Police MACTAC (Multi Assault Counter Terrorism Action Capabilities) initiative and experts from the Nevada National Security Site. The exercise was called Operation Wilcox, in memory of a victim of a 2014 Las Vegas–area active shooter incident, and it received national attention. The exercise was part of Centennial Hills's innovative LIVE Project, which provides training, education, resources, and options for healthcare workers on how to handle an active shooter. "LIVE" is an acronym that stands for:

- **L—Leave (or Lockdown).** Have an escape route and plan in mind. Leave your belongings behind. Lock down in your area.
- **I—Invisible.** Hide in an area out of the shooter's view. Block entry to your hiding place.
- **V—Violence.** As a last resort and if your life is in danger, use violence to stop the shooter.
- **E—Evade.** Evading detection from the shooter is the best option.

The LIVE Project was presented at The Joint Commission's 2015 Emergency Preparedness Conference, and it includes a video that the hospital produced.



Centennial Hills Hospital Medical Center's LIVE Project trains healthcare workers on how to deal with an active shooter. The training includes a video, from which this screenshot was taken.

8. Recordkeeping and Program Evaluation

Recordkeeping and evaluation are vital to assessing the effectiveness of workplace violence prevention programs, identifying overlooked hazards, and determining what additional preventive measures could be adopted to ensure continual improvement. Regular review and reevaluation of policies and procedures, as well as additional review and evaluation when new violent incidents occur, can help a workplace violence prevention committee keep its program current and responsive to changing circumstances and needs.

Managers can improve program performance by sharing data with all employees. Discussion of safety trend data involves employees in safety awareness, creates opportunities for improvement, and provides motivation to achieve continuous improvement. Staff can help to identify deficiencies and offer suggestions to improve the program. Changes to the program can be discussed at regular meetings of the workplace violence prevention committee, with union representatives, and with other employee stakeholder groups.

Reporting

Accurate records of incidents, assaults, hazards, corrective actions, patient histories, and training can help employers to:

- Determine the severity of their workplace violence problems
- Identify any trends or patterns in particular locations, job categories, or departments
- Evaluate methods of hazard control
- Determine whether programs are working
- Identify training needs

Accurate tracking of workplace violence depends on the ease with which employees can report a wide range of incidents or “near-misses”—and the extent to which employees perceive that reporting will lead to positive results.

Clearly defined policies and procedures that encourage workers to report violent incidents or present their other concerns to management are one key to effective reporting. Examples include procedures to ensure that, pursuant to the OSH Act, employees are not retaliated against for voicing concerns or reporting injuries (Section 11c, 29 U.S.C. 660(c)). Section 11(c) of the OSH Act and implementing regulations at 29 CFR 1904.36 prohibit discrimination against an employee for reporting a work-related fatality, injury, or illness. Additionally, reporting procedures must protect employee and patient confidentiality, either by presenting only aggregate data or

by removing personal identifiers if individual data are used, so that individual data are only available to those staff who need to follow up on the incident. Prompt follow-up can also encourage more reporting because it shows employees that their reports are taken seriously.

A variety of different report forms are used in different healthcare settings—some electronic, some paper-based—and the content and format of the incident report can be tailored according to the facility needs. Some facilities use the same reporting system for all types of safety and health-related incidents. See the “Resources” table at the end of this section for samples of violent incident report forms that can be customized to suit a facility’s needs.

Recordkeeping

OSHA’s regulation at 29 CFR 1904 requires private sector employers and many public sector employers, including many healthcare establishments, to record and report work-related injuries or illnesses. First, employers with 10 or fewer employees at all times during the calendar year are partially exempt from keeping records. Second, establishments in certain lower-hazard industries, including medical offices, are also partially exempt.

Employers covered by Part 1904 must record work-related injuries and illnesses that result in:

- Death
- Days away from work
- Restricted work
- Transfer to another job
- Medical treatment beyond first aid
- Loss of consciousness
- Significant injury or illness (e.g., cancer, chronic irreversible disease, fractured or broken bones, or a punctured eardrum) diagnosed by a physician or other licensed healthcare professional

Injuries and illnesses that are caused, contributed to, or significantly aggravated by events or exposures in the work environment are considered work-related for OSHA recordkeeping purposes. Work-relatedness is presumed for injuries and illnesses resulting from events or exposures in the work environment, unless an exception in Section 1904.5(b)(2) specifically applies.

Employers keep records using the following forms:

- **OSHA Form 300: Log of Work-Related Injuries and Illnesses.** Employers covered by this regulation must record each recordable injury or illness on the OSHA 300 Log.
- **OSHA Form 301: Injury and Illness Incident Report.** For each case recorded on the 300 Log, employers must also prepare a 301 Incident Report. This form provides additional detailed information about each case entered on the 300 Log.
- **OSHA Form 300A: Summary of Work-Related Injuries and Illnesses.** At the end of each year, employers are required to prepare a summary report of all injuries and illnesses on the 300 Log. Employers must post this form from February 1 through April 30 of the following year.

OSHA makes these forms available on its public website at www.osha.gov/recordkeeping and provides guidance on how to record cases. Employers may use alternate forms to record injuries and illnesses, provided such forms include the same information as the OSHA forms. Many healthcare facilities use their workers' compensation forms as equivalent forms. All OSHA recordkeeping forms, or equivalent forms, must be maintained by the employer for five years. The recordkeeping regulation also gives employees the right to review their injury and illness records, and employers must provide copies to employees within one business day of a request.

In accordance with Section 18 of the *Occupational Safety and Health Act of 1970*, 21 states and Puerto Rico have elected

to develop and operate State Plans for occupational safety and health programs, which must be at least as effective as federal standards and must cover public sector workers (see the map below). Healthcare facilities in these states should consult their state programs for additional recordkeeping guidance. Five other states and the U.S. Virgin Islands have State Plans that only cover public sector employment.

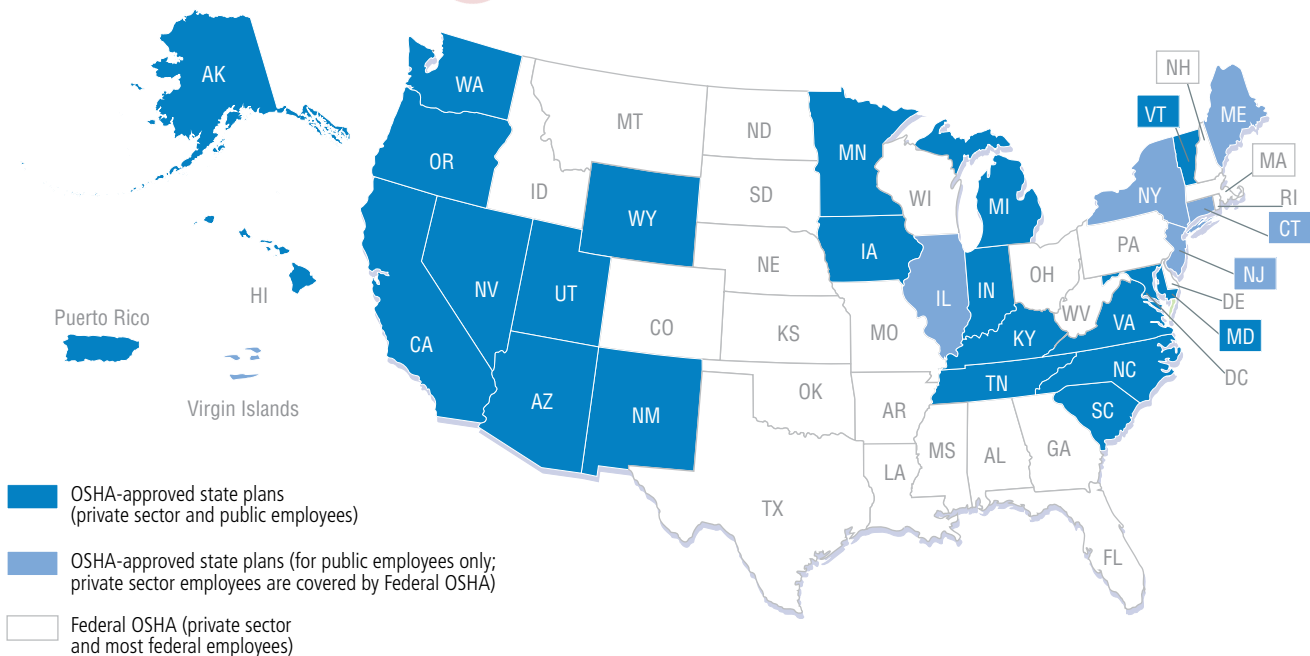
A 2014 update to OSHA's recordkeeping regulation requires all employers, including those in partially exempt industries, to report any work-related fatality to OSHA within 8 hours of learning of the incident. The revised regulation also requires all employers to report work-related inpatient hospitalizations, amputations, and losses of an eye to OSHA within 24 hours of learning of the incident. These events can be reported to OSHA in person, by phone, or by using the reporting application on OSHA's public website at www.osha.gov/recordkeeping.

Program Evaluation

According to OSHA's *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, processes involved in a comprehensive workplace violence prevention program evaluation typically include:

- Establishing a uniform definition of violence, reporting system, and regular review of reports.
- Reviewing reports and minutes from staff meetings on safety and security issues.

OSHA-Approved State Plans





Bulletin boards in staff areas can help keep employees aware of program performance. For example, this board in a behavioral health hospital shows employees how they are doing in their quest to reduce the use of restraints and seclusion.

- Analyzing trends and rates in illnesses, injuries, or fatalities caused by violence relative to initial or “baseline” rates and sharing data with management at all levels.
- 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 workers before and after making job or worksite changes or installing security measures or new systems to evaluate their effectiveness.
- Tracking recommendations through to completion.
- Keeping abreast of new strategies available to prevent and respond to violence as they develop.
- Surveying workers periodically to learn if they experience hostile situations while doing their jobs.
- Complying with OSHA and state requirements for recording and reporting injuries, illnesses, and fatalities.
- Establishing an ongoing relationship with local law enforcement and educating them about the nature and challenges of working with potentially violent patients.

- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving worker safety.

Records that should be analyzed during program evaluation include the following:

- OSHA Log of Work-Related Injuries and Illnesses and Injury and Illness Incident Report (OSHA Forms 300 and 301).
- Medical reports of work injury, workers’ compensation reports, and supervisors’ reports for each recorded assault.
- Records of incidents of abuse, reports filed by security personnel, and records of verbal attacks or aggressive behavior that may be threatening.
- Information recorded in the charts of patients with a history of past violence, drug abuse, or criminal activity.
- Documentation of minutes of safety meetings, records of hazard analyses, and corrective actions recommended and taken.
- Records of all training programs, their attendees, and the qualifications of the trainers.

Additional evaluation tips include:

- Using the same tools for re-evaluation as for the initial worksite assessment and hazard identification process, to allow for consistent data comparison
- Working closely with the workplace violence prevention committee to learn what has worked in reducing violence or to learn about barriers that have been encountered.
- Examining only those incident reports that have been submitted since the last assessment took place, to avoid any overlap.
- Documenting all assessments as well as all changes introduced based on the results.
- Making sure to assess the quality and effectiveness of training programs rather than simply noting their presence.

It is important to evaluate all aspects of the workplace violence program systematically. Regular review is necessary to identify deficiencies and opportunities for improvement. The core elements are all interrelated, and each is necessary to the success of the overall system.

Examples

Ascension Health: standardizing reporting and definitions

Ascension Health is the nation's largest Catholic and not-for-profit health system, with more than 150,000 associates at 1,900 locations, including more than 100 hospitals. Ascension has standardized a definition of workplace violence across its locations, which has helped to ensure consistency in reporting and subsequent data analysis. The definition includes lateral (employee-on-employee) violence. Ascension defines workplace violence as:

A threat or act of violent behavior, against oneself, another person, or a group that either results in or has a high likelihood of resulting in injury, death or psychological harm. These events may involve patients or family members, visitors, volunteers, vendors, physicians or other associates. Examples include bullying, hostility, intimidation, or use of physical force, weapons or power.

All Ascension hospitals use an electronic incident reporting system for occupational injuries and illnesses called DOERS (Dynamic Online Event Reporting System), which is intended to be a point of entry resource available from any computer connected to the hospital's intranet. Every associate can enter a report using a secure login. Each report is routed to the hospital's occupational health staff, security director, and human resources. A report will also go to the associate's manager. However, in events of workplace violence the associate can check a box to exclude his or her manager if the report concerns a sensitive issue such as bullying by a supervisor. Hospital policies require managers to follow up promptly with any employee who submits a report.

By encouraging reporting, making it easy and accessible, providing confidentiality, following up on every report, and emphasizing a "no fear" environment, Ascension's hospitals have increased the number of reports they receive, even while injury rates and incident severity have decreased or remained steady. For example, at St. John Medical Center in Tulsa, Oklahoma, reporting more than doubled when components of a comprehensive workplace violence prevention initiative were adopted; Saint Agnes Hospital in Baltimore, Maryland, saw a 75 percent increase in reports of workplace violence. Many of the reports involve "near-misses" or precursor events, which Ascension encourages associates to report because they provide opportunities for learning and proactive intervention.

Veterans Health Administration: systematic annual program evaluation

Every fiscal year, each VHA facility conducts a Workplace Behavioral Risk Assessment (WBRA) to evaluate the level of risk for behavioral incidents and the mandatory training processes. An interdisciplinary team conducts the WBRA, including the DBC chair, a Veterans Affairs (VA) police officer, the patient safety officer or his/her designee, and often a labor partner or union workplace safety representative. The team reviews DBC records, VA police data, and data from the VHA's Automated Safety Incident Surveillance and Tracking System. After completing a WBRA, a facility receives guidance on continual improvement from national program staff.

9. General Resources

Author	Title	Description	URL
OSHA	Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers	Voluntary guidelines for reducing workplace violence in the healthcare and social service sectors.	www.osha.gov/Publications/osh3148.pdf
Emergency Nurses Association	Workplace Violence Toolkit	Toolkit with templates and examples designed specifically for the ED.	https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/toolkitpg1.htm
Minnesota Department of Health	Prevention of Violence in Health Care Toolkit	Website with a variety of resources and models for preventing violence in healthcare settings. Tools and examples have been developed by various hospitals and agencies and compiled by the state of Minnesota.	http://www.health.state.mn.us/patientsafety/preventionofviolence/toolkit.html
The Joint Commission	Emergency Management Resources—Violence/Security/Active Shooter	Web page with resources on violence prevention.	http://www.jointcommission.org/emergency_management_resources_violence_security_active_shooter





“This course was developed from the public domain document: Caring for Our Caregivers: Preventing Workplace Violence: A Road Map for Healthcare Facilities (2015) – U.S Department of Labor, Occupational Safety and Health Administration (OSHA).”