OREGON WORKPLACE SAFETY INITIATIVE

Stop Violence in Health Care

Workplace Violence in Hospitals:

A Toolkit for Prevention and Management

2nd Edition, 2020

In collaboration with Washington State Hospital Association

Developed under the direction of the Oregon Association of Hospitals Research & Education Foundation

Acknowledgements

This toolkit was written by:

Lynda Enos, RN, BSN, MS, COHN-S, CPE, Ergonomics/Human Factors Consultant, HumanFit, LLC.

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Background

The Workplace Safety Initiative

In 2014, the Oregon Association for Hospitals and Health Systems (OAHHS) convened the Workplace Safety Initiative (WSI) Work Group to find ways to collaboratively address two of the leading causes of health care worker injury in Oregon - manual patient handling and workplace violence.

Work group members included representatives from SEIU 49, Oregon Nurses Association, and representatives from various OAHHS member hospitals in Oregon.

The Triple Aim group, which is comprised of Legacy Health, Providence Health & Services, Oregon Health & Sciences University, Kaiser Permanente NW, the Oregon Nurses Association, and SEIU, also supported this project.

Tool(s) that support content in this Section

i. Violence Prevention in Health Care: Sharing Lessons Learned from the OAHHS Worker Safety Initiative

A presentation that describes the Workplace Safety Initiative project; an overview of the process hospitals used to develop their Workplace Violence (WPV) Programs; and a summary of lessons learned.

The presentation was made in March 2017 at the Governors' Occupational Safety and Health Conference (GOSH), Portland, Oregon.

The goals of the WSI project were to:

- Identify and implement evidence-based programs to reduce injuries from patient handling and workplace violence and foster sustainable cultural change.
- Strengthen relationships with partner organizations around health care worker and patient safety issues.
- Disseminate lessons learned and tools developed to all hospitals in Oregon to assist implementation of sustainable effective workplace safety programs.

To reach these goals, a pilot project working with Oregon hospitals was developed. Eight volunteer hospitals of varying sizes from across the state participated in a total of 10 projects. Five hospitals participated in the Workplace Violence (WPV) project and five in the Safe Patient Handling and Mobility (SPHM) project. Hospitals participiping in the projects either had no established WPV or SPHM program or the program was unsustainable and did not achieve the intended results; or had an established WPV or SPHM program that needed strengthening.

Participating hospitals were in urban and rural areas of the state and included three hospitals with 50 beds or less; three hospitals with 50-150 beds and two with over 300 beds.

A project consultant with expertise in occuptional safety, health and ergonomics provided customized project facilitation to meet the level of assistance each needed by each facility.

The overall goals for each participating hospital were to:

- Reduce incidence, risk, and cost of staff injury related to patient handling and mobility and/or workplace violence.
- Implement evidence-based best practices that will assist to sustain SPH and/or WPV efforts at each facility.
- Enhance the culture of safety and empower health care employees to create safe working environments.
- Address patient handling and related ergonomics/safety issues and/or workplace violence proactively.

From June 2015 through May 2017, each facility worked with the WSI consultant to assess and develop a *new or enhance* an existing WPV program or SPHM program.

Each hospital designated a project leader and formed or engaged an existing interdisciplinary committee to manage the project. These committees will also facilitate and provide future oversight of the WPV or SPHM programs.

Implementation of all program elements and evaluation of the WPV programs is in process and a “continuous improvement” approach will be used to sustain and enhance the programs at each facility.

More information about the WSI project and lessons learned is provided in **Tool i.**

Acknowledgements

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Coos Bay, OR

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Burns, OR

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La Grande, OR

Mid-Columbia Medical Center
The Dalles, OR

Providence Portland Medical
Portland, OR

WSI project facilitation and consultation was provided by Lynda Enos, RN, BSN, MS, COHN-S, CPE, HumanFit, LLC.

WSI Work Group Committee Members

Chair
Cheryl Nester Wolfe, RN
President and Chief Executive Officer
Salem Health

Members
Jenn Baker
Director of Health Policy and Government Relations
Oregon Nurses Association

Brian Bennett
Security Manager
Bay Area Hospital

Cheryl Cosgrove, RN
Direct Care
Grande Ronde Hospital

Larlene Dunsmuir
Advanced Practice Consultant
Oregon Nurses Association

Andrea Easton
Associate Vice President of Advocacy and Government Affairs
Oregon Association of Hospitals & Health Systems

Felisa Hagins
Political Director
SEIU 49

Angela Heckathorn
Manager, Environment of Care, Security Administration
Legacy Health

Katie Harris
Director of Program Management
Oregon Association of Hospitals & Health Systems

Troy Larkin
Executive Director of Clinical Education and Development - Oregon
Providence Health & Services

Elaine LaRochelle
Director of Facilities
Grande Ronde Hospital

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Questions or Feedback

Contact: Katie Harris, MPH, Director of Rural Health & Federal Policy

Oregon Association of Hospitals and Health Systems

Email: kharris@oahhs.org

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Introduction

Toolkit Development

Each participating hospital in the WSI WPV project followed the same sequential step-by-step process when assessing and developing or strengthening their WPV programs.

Program development was designed to be participatory in nature to engage all stakeholders who are impacted by the WPV program, and to support culture change.

Tool(s) that support content in this Section

ii. The Workplace Violence (WPV) Program Development, Implementation & Evaluation: *Suggested Sequence of Activities*

The WPV programs are structured to incorporate the evidence-based core elements that are recommended for development and management of effective and sustainable occupational safety programs, and mitigation of workplace hazards by the Occupational Safety and Health Administration (OSHA) and other professional safety entities. These program elements incorporate program requirements described in the Oregon workplace violence law i.e., Oregon Revised Statutes (ORS) 654.412 to 654.423, "Safety of Health Care Employees".

Other elements that support ongoing program management and communication or social marketing of the WPV program are also included. Program elements are interrelated and provide the foundation for a systematic approach to implementing an effective program to address workplace violence in health care.

Workplace Violence Program Elements

A. Management Leadership B. Employee Participation C. Written Violence Prevention Policy D. Program Management E. Communications Structure F. Hazard Identification & Assessment	G. Hazard Control and Prevention a. *Engineering Controls* b. *Administrative and Work Practice Controls* H. Education & Training I. Ongoing Program Evaluation & Improvement WPV program elements are described further in Section 1 - Understanding Workplace Violence (WPV)

The participating hospitals reported that the most frequent *type* of violence observed at each facility is that perpetrated by patients and visitors towards staff. This conclusion is also supported in workplace violence related literature.

Therefore, **the focus** of the WPV project at each facility was prevention and management of violence by **patients and visitors** towards staff within the hospital environment.

However, the participating hospitals have also reviewed or are in the process of reviewing, and developing or strengthening, policies and processes to manage other causes of violence such as, lateral violence or bullying between employees and domestic violence.

Tools and approaches offered in this toolkit are based on extensive review of existing violence prevention literature, evidence-based best practices, relevant standards, and regulations such as, Safety of Health Care Employees ORS 654.412 to 654.423.

Tools were developed in collaboration with the WPV committees at each hospital, and were evaluated and enhanced throughout the project. Lessons learned from implementation of WPV program activities are incorporated in this toolkit.

Purpose and Structure of the Toolkit

The purpose of this toolkit is to provide practical tools, resources and information that can be used by hospitals, and adapted for a range of other health care settings, to develop and sustain effective violence prevention programs. The toolkit is organized into sections and follows the WPV program elements listed above. The contents aim to provide a step-by-step approach to developing or assessing and enhancing a violence prevention program.

Tool ii. 'Workplace Violence (WPV) Program Development, Implementation & Evaluation: Suggested Sequence of Activities Chart' provides an overview of the program steps.
The focus of the toolkit is prevention and management of violence by *patients and visitors* towards staff however, references and resources related to other forms of violence in health care can be found in ***Section 10*** - ***Additional Resources.***

The toolkit will assist health care leadership and violence prevention committees and other stakeholders to:

- Evaluate the WPV program and individual violence prevention practices at their facility or within their organization, against current best practices in violence prevention.
- Identify and engage stakeholders and enhance the culture of worker and patient safety.

- Develop or strengthen the WPV program and policy by identifying processes that can be implemented to manage or control violence, and can address the risk of violence proactively.

A suggested framework and strategies to aid program implementation, evaluation and sustainability are also offered.

Tools and strategies provided should be customized to an organization's culture and physical environment, and should take into account factors such as, the complexity of the patient population, facility size, resources available, and the barriers and gaps identified in that setting.

Tools are provided in several formats (e.g., Microsoft Word, Excel and/or Adobe PDF) so that they can be used, and/or customized as needed.

Reference articles that have been published within the last 10 years, and links to website resources relevant to program activities discussed in each section of the toolkit, are provided.

It is important to note that in the case of WPV programs, there is *insufficient evidence base* to support what type of program design, or combination of program elements, or approaches, are effective and sustainable in reducing incidence of violence in health care.

Therefore, it is intended that the approach to program development, the tools created, resources provided, and the lessons learned during the WSI WPV project, offer health care facilities a comprehensive resource to *facilitate* the development of WPV programs, and enhance an organization's culture of safety for their employees and patients.

> Although this toolkit offers a step-by-step approach to organize your WPV program implementation efforts program steps are not always sequential and are often interdependent. When using a *continuous improvement approach* to program management you may need to develop, implement, evaluate, and enhance some solutions and processes concurrently.
>
> It is recommended that you (together with your WPV committee), read through the entire toolkit before starting to plan your approach to implementing a WPV program. This allows you to determine which sections of the toolkit are more relevant to your efforts, depending on what WPV program elements may already exist, and are effective at your facility.
>
> Consider all phases of WPV program planning and implementation collectively within the context of a systems approach.

What's New in the 2nd Edition of the Toolkit?

- **Over 200 articles** related to health care WPV that have been published in peer-reviewed journals since the release of the original toolkit have been reviewed for inclusion in this 2nd edition of the toolkit.
- WPV resource materials published by health care related professional organizations, associations, and regulatory bodies since 2017 have been reviewed for inclusion.
- **Over 150 new references and resources** have been added to various Sections in the Toolkit and are noted as New 2020
- References to the **Washington State WPV Regulations** have been added throughout the toolkit.
- All **website links** have been updated.
- **Changes to Sections and Tools**
  - **Section 1** – *Understanding WPV*, has been updated to include new statistics about the prevalence of WPV in health care and to specific health care professions; the cost of WPV to health care organizations and relationship to patient safety; and updated information about WPV regulations and Joint Commission recommendations for addressing WPV.
  - **Section 4** – Zero Tolerance WPV Policies, Duty to Care and CMS and OSHA regulations
  - **Section 5** – *Hazard Abatement.* Over 100 new references and resources have been added to this Section. New topic sections with supporting reference materials include: De-escalation; Trauma-Informed Care; Management of the Agitated Patient; and Behavioral Health Rapid Response Teams.

    A summary of the current 'Evidence Based for WPV Programs and Interventions in Health Care' is also included
  - **Section 10**. *Additional Resources*, includes additional resources about Lateral Violence/Bullying; WPV in Home Health and Long-Term Care, and Domestic Violence
  - **New Tools**
    - 1a. Risk factors that increase the risk of Type II WPV
    - 1b. Comparison of Workplace Violence Laws for Health Care in Oregon and Washington States
    - 5g. Behavioral Health Rapid Response Teams (BHRRTs). A summary of best practices
    - 5h. An overview of de-escalation approaches to prevent and manage WPV
  - **Tools that have been updated**
    - Tool 3a. Gap Analysis which is updated to include requirements of the Washington State WPV law
    - 6a. Education and Training Plan
    - 8a. Program Measurement Plan

Compliance

The following **Oregon** regulations and rules apply specifically to workplace violence programs in hospitals, ambulatory care centers, and home health services that are owed by hospitals:

- Oregon Revised Statutes (ORS) 654.412 to 654.423, "Safety of Health Care Employees"
- Oregon Administrative Rules (OAR) 437-001-0706, "Recordkeeping for Health Care Assaults"

The following applies if a health care facility has security services that are staffed by employees or by contract personnel:

- OAR Division 60 (OAR 259-060:0005-0600) **'**Private security Services Providers Rules'

The following **Washington State** regulations and rules apply specifically to workplace violence programs in hospitals (private and public), ambulatory surgical facilities, home health, hospice, and home care agencies, evaluation and treatment facilities, and behavioral health programs.

- Revised Code of Washington (RCW). Chapter 49.19 RCW-SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070.
- RCW Chapter 72.23 Public and Private Facilities for the Mentally Ill
    - RCW 72.23.400 Workplace safety plan – State hospitals
    - RCW 72.23.410 Violence prevention training – State hospitals
    - RCW 72.23.420 Record of violent acts – State hospitals
- RCW Chapter 18.170 RCW: Security guards
- WACs Chapter 308-18 WAC: Private security guard companies and private security guards

Links to all relevant state laws are provided in the Reference and Resources

When developing and implementing the violence prevention program in addition to complying with the above state regulations and rules, it is essential to ensure compliance with:

- Specific hospital policies and procedures;
- The Joint Commission or DNV GL Health care accreditation requirements; and
- Center for Medicare & Medicaid Services (CMS) rules (e.g. rules that are applicable to

the use of restraints and seclusion of patients);

- Any other related Occupational Safety and Health Administration (OSHA) standards such as the 'General Duty Clause' where 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."; and
- The rules and requirements of other state and federal agencies.

References and Resources

2013 OSHA publications
https://www.osha.gov/dsg/hospitals/mgmt_tools_resources.html

- **Safety and Health Management Systems (OSHA) and Joint Commission Standards**
- **Safety and Health Management Systems: A Road Map for Hospitals**

Can it happen here? Oregon OSHA http://www.cbs.state.or.us/osha/pdf/pubs/2857.pdf

Center for Medicare & Medicaid Services (CMS) https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html

Department of Public Safety Standards and Training (DPSST).
https://www.oregon.gov/dpsst/PS/Pages/Executive-Managers.aspx

DNV GL Healthcare. http://dnvglhealthcare.com/standards

Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents. (2017). Directive Number: CPL 02-01-058**,** OSHA.
https://www.osha.gov/OshDoc/Directive_pdf/CPL_02-01-058.pdf

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers (2015). U.S. Department of Labor Occupational Safety and Health Administration (OSHA). Publication 3148-04R 2015 https://www.osha.gov/Publications/osha3148.pdf

Joint Commission standards - *for purchase only*
https://www.jointcommission.org/standards_information/standards.aspx

NFPA 3000 (PS), Standard for an Active Shooter/Hostile Event Response (ASHER) Program (2018) New 2020 https://catalog.nfpa.org/NFPA-3000-PS-Standard-for-an-Active-ShooterHostile-Event-Response-ASHER-Program-P18697.aspx

OSH Act of 1970. General Duty Clause. The Occupational Safety and Health Administration (OSHA). https://www.osha.gov/pls/oshaweb/owasrch.search_form?p_doc_type=oshact

Physical and verbal violence against health care workers. (April 16, 2018). Sentinel Event Alert Issue, (59). Joint Commission. New 2020
https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-59-physical-and-verbal-violence-against-health-care-workers/

Recommended Practices for Safety and Health Programs (2016). The Occupational Safety and Health Administration (OSHA).
https://www.osha.gov/shpguidelines/management-leadership.html

Workplace Violence Incidents – Enforcement Procedures for Investigating or Inspecting. Program Directive: A-283. Issue: December 1, 2011. Revised: May 31, 2017. Oregon-OSHA.
http://osha.oregon.gov/OSHARules/pd/pd-283.pdf

Healthcare facility inspection decision-making flowchart. Oregon-OSHA.
http://osha.oregon.gov/OSHARules/div1/hal-flowchart.pdf

WPV State Legislation: Oregon and Washington New 2020

Oregon
ORS 654.412 to 654.423, 'Safety of Health Care Employees'.
https://www.oregonlaws.org/ors/654.412 **2019 revision to this law as recorded in** Senate Bill 823 (SB 823-A) New 2020

OAR 437-001-0706, 'Recordkeeping for Health Care Assaults'.
http://osha.oregon.gov/Pages/re/healthcare-assault-log.aspx

OAR Division 60 259-060-0005:0600 'Private security Services Providers Rules'.
http://arcweb.sos.state.or.us/pages/rules/oars_200/oar_259/259_060.html

Questions about OSHA regulations in Oregon?

Oregon OSHA:

- **Consultation services.** http://osha.oregon.gov/consult/Pages/index.aspx

- **Employer essentials.** http://osha.oregon.gov/essentials/Pages/default.aspx
- **Worker rights and responsibilities.** http://osha.oregon.gov/workers/Pages/Worker-rights-and-responsibilities.aspx

State of Oregon - Ombudsman for Injured Workers.
http://www.oregon.gov/DCBS/OIW/Pages/index.aspx

SAIF Cooperation – Workers compensation insurer.
https://www.saif.com/employer.html

Washington New 2020

Revised Code of Washington (RCW). Chapter 49.19 RCW-SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070. https://app.leg.wa.gov/RCW/default.aspx?cite=49.19

RCW Chapter 72.23 Public and Private Facilities for the Mentally Ill
https://app.leg.wa.gov/RCW/default.aspx?cite=72.23

- **RCW 72.23.400 Workplace safety plan – State hospitals**
- **RCW 72.23.410 Violence prevention training – State hospitals**
- **RCW 72.23.420 Record of violent acts – State hospitals**

Questions about OSHA regulations in Washington? **New 2020**

Washington State Department of Labor and Industries (L&I). https://lni.wa.gov/

The Office of the Ombuds Injured Workers of Self-Insured Employers
http://ombuds.selfinsured.wa.gov/

Felony Assault Laws related to health care workers– Oregon, Washington and Alaska **New 2020**

Oregon
ORS 163.165: Assault in the third degree for intentionally assaulting EMS workers
https://www.oregonlaws.org/ors/163.165

Washington
RCW 9A.36.031: Assault in the third degree for assault of a nurse, physician, or health care provider who was performing his or her nursing or health care duties at the time of the assault. https://app.leg.wa.gov/RCW/default.aspx?cite=9A.36.031

Alaska
HB312 (2018). http://www.akleg.gov/PDF/30/Bills/HB0312Z.PDF and

AS 12.55.135. Sentences of Imprisonment For Misdemeanors. provides definition of a medical professional.
https://touchngo.com/lglcntr/akstats/Statutes/Title12/Chapter55/Section135.htm

Security Guards: Current laws and rules for Oregon and Washington New 2020

Oregon
OAR Division 60 (OAR 259-060:0005-0600) Private security Services Providers Rules.
Department of Public Safety Standards and Training Chapter 259
https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=834

Washington
RCW Chapter 18.170 RCW: Security guards
https://app.leg.wa.gov/RCW/default.aspx?cite=18.170

WACs Chapter 308-18 WAC: Private security guard companies and private security guards
https://app.leg.wa.gov/WAC/default.aspx?cite=308-18

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Understanding Workplace Violence (WPV)

What is Workplace Violence (WPV)?

The Occupational Health and Safety Agency (OSHA) defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior, that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide, and can involve employees, clients, customers and visitors. (OSHA, 2015).

Terms and definitions used to define WPV in occupational safety and violence literature can vary for example, violence that occurs between coworkers may be defined as bullying, lateral or horizontal violence or incivility. The definition of assault as related to criminal law also varies by state and federal judicial systems.

Workplace violence in health care can also be defined as intentional e.g., where there is intent by a patient to cause physiological, emotional and bodily harm to an employee, or 'non -

Definitions of Violence

Harassment – any behavior (*verbal or physical*) that demeans, embarrasses, humiliates, annoys, alarms, or verbally abuses a person, and that is known or would be expected to be unwelcome. This includes use of offensive language, sexual innuendos, name calling, swearing, insults, use of condescending language etc., arguments, gestures, pranks, rumors, intimidation, bullying, or other inappropriate activities.

Verbal or written threats – any expression of an intent to inflict personal pain, harm, damage, and/or psychological harm, either through spoken word or in writing.

Threatening behavior – such as shaking fists, intentionally slamming doors, punching walls, destroying property, vandalism, sabotage, theft, or throwing objects.

Physical attacks or assaults – hitting, shoving, biting, pushing or kicking. Extremes include rape, arson, and murder. Note: ORS 654.412 to 654.423 defines assault as *'intentionally, knowingly or recklessly causing physical injury'*.

Aggravated Assault - An unlawful attack by one person upon another for the purpose of inflicting severe or aggravated bodily injury. This type of assault usually is accompanied by the use of a weapon or by means likely to produce death or great bodily harm.

Source: IAHHS 2016, Boyle, 2016, OSHA 2015, EEOC 2016, Fell-Carlson. 2008

intentional' e.g., violence by individuals with cognitive impairment associated with dementia, brain injury, or a physiological reaction to anesthesia or medication. The perception of a patient's intent to cause harm and how 'intent' is defined greatly influences reporting of violence by health care workers, as discussed later in this section.

WPV incidents generally fall into four categories:

Tools that support content in this Section

1a. Risk factors that increase the risk of Type II WPV

1b. Comparison of Workplace Violence Laws for Health Care in Oregon and Washington States

- Type I (Criminal Intent): Results while a criminal activity (e.g., robbery or property damage) is being committed and the perpetrator has no legitimate relationship to the workplace.
- Type II (Customer/client): The perpetrator is a customer or client at the workplace (and becomes violent while being served by the worker e.g., patient, family or visitor assault towards the health care worker.
- Type III (Worker-on-Worker): Employees or past employees of the workplace are the perpetrators e.g., bullying/lateral violence or physical assault from a co-worker.
- Type IV (Personal Relationship): The perpetrator usually has a personal relationship with an employee e.g., domestic violence in the workplace.

(OSHA, 2015)

The focus of this toolkit is prevention and control of Type II (customer/client) violence, where violence is perpetrated by patients and visitors toward employees, contract personnel, and volunteers, who work within a hospital and/or clinic setting. However, any WPV prevention program should also incorporate policies and procedures to address risk of violence of any type and cause such as, bullying, domestic, and criminal activity including active shooter preparedness, that could in occur within a health care organization.

Research indicates that there is a relationship between poor organizational climate of safety and increase prevalence of Type II and Type III violence. Health care workers who are exposed to Type II and Type III violence suffer long-term negative health in organizations where there is lack of post exposure support (Friis et al. , 2019; Vrablik et al., 2019; Arnetz et al., 2018; Yragui, N, et.al., 2017; Phillips, 2016;).

There is new and early stage research that indicates that there is a greater prevalence of patient physical aggression to injury in behavioral health facilities where coworker bullying is prevalent and tolerated as part of the work culture. (Yragui, N, 2019).

The prevalence of Type II and Type III violence in a health care environment is also associated with poorer patient outcomes as discussed later in this section.

Therefore, it essential that health care organizations address all types of violence.

Refer to ***Section 10 of*** this Toolkit for information related to ***Bullying and Domestic Violence***

- In two studies of Emergency Department nurses 50-100% of respondents reported experiencing verbal or physical violence at work (ENA 2011, Phillips, 2016).
- In another study, of 762 nurses in one large hospital system, 76.0% reported experiencing verbal violence and 54.2% reported experiencing physical violence. (Speroni et al., 2014)
- In a Health Risk Appraisal survey of 3,765 registered nurses and nursing students conducted by the American Nurses Association in 2014, ***21 percent*** of registered nurses and nursing students reported being physically assaulted, and ***over 50 percent*** reported being verbally abused in a 12-month period (OSHA, 2015).
- In a more recent survey conducted by American Nurses Association as part of the Healthy Nurse, Healthy Nation™ Enterprise, more than 29% of respondents have been verbally and/or physically *threatened* by a patient or a patient's family member in the past year and **10%** have been assaulted by a patient or family member while at work (ANA, 2019).

Occurrence of WPV in Health Care

In the US, workers in health care experience substantially higher estimated rates of nonfatal injury due to workplace violence compared to workers in all other industries. Health care and social assistance workers are nearly four times more likely to be injured and require time away from work as a result of WPV (OSHA, 2015).

Within health care settings, approximately 24,000 workplace assaults occurred between 2010 and 2013, with most threats and assaults occurring between noon and midnight (Wyatt et. al, 2016).

The Bureau of Labor Statistics reports that while less than 20% of workplace injuries involve health care workers, 50% of workplace related assaults involve health care workers.

Data collected by the National Institute for Occupational Safety and Health (NIOSH) for 2012 through 2014, shows that injuries resulting from workplace violence appears to be *increasing* among all health care personnel and particularly among nursing assistants and nurses. The majority of these injuries result from physical assaults on nursing staff (NIOSH, 2016).

Type II violence is the most common in health care settings that is, verbal or physical abuse and assaults perpetrated by patients, their family members, and visitors, toward health care workers. Examples include, intentional and non-intentional verbal threats or physical attacks by patients, a distraught family member who may be abusive or even become an active shooter, or gang violence in the emergency department.

In one 2014 survey on hospital crime, Type II violence accounted for 75% of aggravated assaults and 93% of all assaults against employees (Phillips, 2016).

The most common causes of violent injuries resulting in days away from work across several health care occupations were hitting, kicking, beating, and/or shoving (GAO, 2016).

Quick Tip: Use the data provided in this section when educating senior leadership, the WPV committee, and other employees about the scope and impact of workplace violence in health care.

The highest rates of violence occur in emergency rooms and inpatient psychiatric or behavioral health departments or facilities, geriatric long-term care settings, and residential and day social services (OSHA, 2015).

A 2017-18 Cal-OSHA *Report on Workplace Violence Incidents,* indicated that 40 percent of workplace violence incidents occur in inpatient units, while 27 percent occur in the emergency department and 16 percent occur in behavioral health units (Cal-OSHA, 2019)

Some health care professions are more at risk for exposure to WPV than others. In 2013, Psychiatric Aides experienced more than 10 times the rate of violent injuries that resulted in days away from work than Nursing Assistants (NAs). NAs experienced more than 3 times the rate of violence than Registered Nurses (RNs) (OSHA, 2015).

In a 2018 poll of over 3,500 emergency physicians conducted by the American College of Emergency Physicians (ACEP), 47 percent of physicians reported having been physically assaulted at work and 71 percent said they had witnessed another assault. Nearly 80 percent reported that patient care is being affected, with 51 percent of those saying that patients also have been physically harmed. Ninety-six percent of the female emergency physician respondents reported that a patient or visitor made inappropriate comments or unwanted advances toward them, and 80 percent of male physicians reported the same (ACEP, 2018).

Sixty-one percent of home care workers report workplace violence each year (The Joint Commission, 2018).

In a survey of EMS workers primarily from the US, Canada, Europe, and Australia, 65 percent of 1172 respondents reported being physically attacked while on duty. Approximately 90 percent of the perpetrators were patients and around 5 percent were patient family members. The influence of alcohol and drugs was the most prevalent causative factor associated with violence (Maguire et al., 2018).

Injury and staff survey data collected during the WSI indicated that:

- A majority of violence is perpetrated by patients.
- Employees reported that verbal abuse is the most common type of violence that they had experienced in the last year.
- Incidence of violence mostly occurred in the ED, Behavioral health, Intensive Care units, and Medical/Surgical units. In one hospital, violence was reported as increased in family birth and in home health units, and 2 hospitals reported an increase in violence in outpatient clinics.

There are very few studies that report the rate of violence to hospital security workers however, those available report that these workers have some of the highest rates of violence-related injuries within the hospital setting, with anywhere from 2 to 5 times as many injuries as nurses. In one study, security staff had a violence-related injury rate approximately 13 times higher than the violence-related injury rate for ED nursing staff in the same facility (Gramling, 2017).

Overall, there is little data to indicate occurrence of violence in other health care units such as intensive care; and in other health care settings such as, outpatient clinics or within many job categories such as emergency medical service workers or diagnostic technologists.

Active Shooter Scenarios

The WPV related event that occurs in health care and receives the greatest media and public attention involves *active shootings* however, these events are *uncommon*.

FBI Investigations indicate an increasing trend in workplace active shooter incidents for all industries including health care, from an average of 6.4 incidents per year between 2000 and 2006, to 16.4 incidents per year between 2007 and 2013.

A study conducted by researchers at Brown University found that there were 241 incidents of hospital shootings from 2000 to 2015, with 170 occurring inside hospitals and 71 outside hospitals.

The emergency department was identified as the most common site of gun violence within a hospital (29 percent), patients' rooms (24 percent) and other locations (47%).

Reported motivation for these events include holding a grudge (33%), a result of social violence (15%), attempting to escape the facility (14%), and suicide (11%). An overwhelming majority of perpetrators are male (Gao, & Adashi, 2015).

In other studies, the most common victim of shootings in hospitals or other health care facilities is the perpetrator (45%) and about 20% of the victims were hospital staff.

In nearly 20% of the incidents, the perpetrators did not bring their own firearm to the hospital, and in 8% of all events the perpetrator took the gun from a police or security officer. In 28% of events involving firearms, a law enforcement officer shot a perpetrator in the hospital (Phillips, 2016, Aumack, 2017).

According to data from the U.S. Bureau of Labor and Statistics from

WPV in Oregon

Between 2013-2018 on average 3% (3160) work related accepted disabling claims (ADCs) were attributed to non-fatal assaults that occurred in all industries in Oregon. Of these ADCS, 10% were reported to have occurred in hospitals and 17% in nursing and residential care facilities.

Health Care and Social Assistance in the private sector accounted for 33% of these claims, which is more than any other industry. 84% of these injuries occurred as a result of health care workers being hit, kicked, bitten, or shoved. One WPV related homicide occurred between 2012-2016 in Oregon in a nursing and residential care facility (Oregon OSHA; DCBS 2019).

WPV in Washington State

In a 2018 Washington State Nurses Association survey, 86**%** of nurses in a said they've experienced or witnessed workplace violence (WSNA, 2019) https://www.wsna.org/nursing-practice/workplace-violence

For the fiscal years 2015-2019, registered nurses experienced an average of 115 accepted workers' compensation claims that were classified as *assault and violence acts by persons* per year, with an average total incurred cost of $1,111,509. Nursing Aides and orderlies experienced an average of 321 accepted claims, with an average total incurred cost of $1,547,144 for the same time period. Note this data excludes claims filed with self-insured employers. Between 2015-2018 there were no fatalities from workplace violence in health care facilities (WA L&I, 2019).

2014-2015 there were 4 homicides that occurred in hospitals, that were committed intentionally by gun violence. There have been ‘0’ reported for 2016-2018.

In terms of *fatal* workplace violence, the Centers for Disease Control (CDC) report a *decreasing* trend over the past ten years in all non-health care industries, while the numbers of homicides in health care have remained relatively stable (NIOSH, 2015).

Why is WPV Underreported in Health Care?

Studies indicate that violence in health care is hugely underreported. In one report, only 30% of nurses and 26% of physicians reported incidents (Philips, 2016).

Bullying and other forms of verbal abuse are more frequently underreported. In these cases, reasons for underreporting include lack of a reporting policy, lack of faith in the reporting system, and fear of retaliation (Blando, 2013).

Table 1.1 lists the factors that influence whether staff report a WPV episode or event in health care.

Employees at hospitals participating in the WSI project reported similar factors or barriers to reporting WPV incidents.

In addition to underreporting of WPV, inconsistencies in data collection and definitions of violence contributes to a lack of knowledge about the frequency and severity of WPV in health care.

Without accurate incident data, development and implementation of effective violence prevention programs and control strategies can be challenging.

Causes of WPV in Health Care

The cause of WPV in health care is often multifactorial and can be summarized in four broad categories. **Tool 1a. Risk factors that increase the risk of Type II WPV** provides more information.

1. **Clinical** related risk factors are the most common cause or contributor of violence e.g., patients with poorly managed mental illness, dementia, delirium, developmental impairment, and drug and alcohol intoxication and abuse.

Factors that influence reporting of WPV incidents	
Incident type and patient condition ▪ The severity of the incident i.e. whether the employee suffered physical injury requiring medical treatment ▪ The condition of the patient – for example when violence is perceived as unintentional due to the patient's clinical condition or diagnosis e.g. dementia ▪ Perception of what is 'violence' by employees ***Organizational Culture*** ▪ Concerns that assaults by patients and visitors may be viewed as a result of poor performance or negligence of the employee ▪ The intense focus on customer service in health care where the "the customer is always" right or the impact of money and profit driven management models Normalizing of WPV – 'it's just part of the job'	***Reporting process*** ▪ Whether someone else reported the incident ▪ No clear reporting policy ▪ Complicated reporting process e.g. forms take too long to complete ***Response to Reporting*** ▪ Fear of retaliation e.g., from patient and/or their family in smaller communities where everyone knows each other, stigmatization or bullying from co-workers for reporting ▪ Lack of action resulting from reporting e.g. informal report to a supervisor goes no further or there is no response to a formal report or preventative action is not taken ▪ The complexity of the legal system and response from law enforcement when reporting and/or pressing charges Source: ENA 2011, Blando 2015, Arnetz, 2015, OSHA 2015, Philips 2016

Table 1.1

2. **Social and economic** risk factors that contribute to violence include financial stress, domestic violence that extends into the workplace, ethnic conflict, access to weapons; neighborhoods with high crime rates and the increasing presence of gang members. The availability of drugs or money at hospitals, clinics, and pharmacies, makes them likely robbery targets. The increasing use of prescription opioids and related addiction in the general population is a newer concern for clinics and physician offices.

3. **Environmental** related risk factors include noise, crowded waiting areas, open access of the public in clinics and hospitals; poorly lit spaces and visibility.

4. **Organizational** factors include design of financial/billing services, long wait times, dehumanizing, and inhospitable environments, poor communications, staff shortages, lack of or inadequate training, lack of or inconsistent process to identify and respond to undesirable behavior, working alone, working with cash and/or narcotics, use of seclusion/restraints, lack of situational awareness, and inadequate presence of security and mental health personnel on site.

(ENA, 2010, Design Council, 2011, NIOSH 2013, OSHA 2015, Philips 2016)

There is also a vicious cycle or "Revolving Door" Syndrome that sometimes links workplace violence, psychiatric treatment, and the "revolving door" (NIOSH, 2013). This occurs when patients with mental health or substance abuse issues are treated in an emergency room (ER) and released back into the community without follow-up care, so they return to the ER when another mental health or substance abuse crisis occurs.

Community based mental health care is often not available due to lack of funding. This issue also contributes to the increasing use of hospitals by police and the criminal justice system, for criminal holds and the care of acutely disturbed, violent individuals.

The Joint Commission analyzed 33 homicides, 38 assaults and 74 rapes in health care workplaces from 2013 to 2015, and reported that the most common "root causes of these events were:

- Failures in communication
- Inadequate patient observation
- Lack of or noncompliance with policies addressing workplace violence prevention
- Lack of or inadequate behavioral health assessment to identify aggressive tendencies in patients

Source: Wyatt, 2016

The Cost of WPV to Health Care Organizations and Workers

Direct costs of workplace violence injuries include cost of medical treatment for physical injuries sustained and time loss from work.

Speroni, K.G., et al., report that in one study the annual workplace violence costs for the 2.1% of nurses who reported injuries were $94,156 ($78,924 for treatment and $15,232 for indemnity).

Workplace injuries and stress are common factors that contribute to employee turnover which can be costly for a health care organization. For example, the estimated cost of replacing a nurse is $27,000 to $103,000.

Studies have shown that there is an *increase* in the rate of missed workdays, burnout, and job dissatisfaction, along with decreased productivity, and deterioration in staff health by employees involved in episodes of WPV (Philips, 2016, Pestka et. al, 2012).

There can be a short and/or long-term psychological impact to employees who are the victims of WPV. Some employees especially when exposed to Type III violence or bullying, may develop post-traumatic stress disorder (PTSD). The psychological impact of WPV is sometimes harder to quantify in terms of cost to the organization and to the affected employees.

One study estimated that incivility in health care costs more than $4 billion dollars annually due to turnover of staff, lost time, and productivity (Morphet et al., 2018).

According to the American Hospital Association, the estimated cost of community violence for U.S. hospitals and health systems was approximately $2.7 billion in 2016. $1.5 billion of that is directly related to security and medical care for injured employees (AHA, 2017)

Other organizational costs related to addressing WPV include increased security needs in terms of equipment and personnel, litigation, increased insurance costs, and property damage.

There is also an indirect relationship between WPV and patient safety. Caregiver fatigue, presenteeism, injury, and stress, are tied to a higher risk of medication errors and patient infections. In hospitals where *fewer* nurses are dissatisfied or burned out, there is *higher levels of patient satisfaction* (OSHA, 2015). Type III violence or bullying is more strongly associated with increased staff turnover, and cognitive deficits associated with PTSD than Type II violence. Both factors are contributing factors to incidence of medical errors (Morphet et al., 2018; JC 2019 and 2016; OSHA 2015).

Thus, it can be challenging for health care organizations to calculate the true cost of WPV and this is complicated by the high rate of underreporting of WPV by health care workers.

There is consensus that improving the culture of safety within health care is an essential component of preventing or reducing errors and improving overall health care quality (AHRQ, 2019.)

Creating a safety climate that embraces a culture of respect and safety for patients and health care workers is associated with improved patient outcomes and health care worker safety (TJC, 2017 & 2010).

Safety climate is a strong mitigating factor related to the prevalence and impact on worker health and safety of both Type II and III WPV (Blando et al., 2015; Arnetz, et al., 2018).

Recent research indicates that supervisory support when addressing conflict in the workplace and employee stress related to work and non-work life balance plays a role in reduce the negative effects of exposure to WPV for workers (Zaheer et al., 2019; Yragui, N, et.al., 2017).

The relationship of worker safety and morale to safe delivery of care and achievement of organizational goals cannot be overstated.

In 2014, the National Patient Safety Foundation published the white paper "Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care", which highlights the importance of creating a culture in health care organizations that embraces worker and patient safety as equally important. The paper and subsequent related publications highlight the importance of creating a work environment where there is a goal of zero harm (physical and psychological) to the workforce; where there is a commitment to respect and safe behaviors; an effective system to measure, and a multidisciplinary, reliable process for responding to physical and psychological harm (NPSF, 2013, 2014).

Unfortunately, because WPV is vastly underreported in health care the full extent of the problem and its associated costs are unknown.

Solutions to Prevent and Manage WPV

When developing and implementing a WPV program, it's important to note that individual health care organizations have no or little 'control' of the social and economic factors that contribute to WPV. Nor can they prevent all the clinical factors that contribute to WPV. The goal of a comprehensive WPV program should be to minimize and eliminate where possible the organizational and environmental factors that contribute to WPV and to expedite early and accurate identification and management of clinically related and external risk factors.

Through collaboration with community stakeholders such as public health departments, law enforcement agencies, schools and social service organizations, hospitals may be able to assist in developing healthier social and safer physical environments that contribute to preventing violence in their communities (AHA, 2015).

WPV Legislation and Compliance

Oregon is one of several states that have passed legislation and has program requirements that address workplace violence.

The Oregon WPV law ORS 654.412 to 654.423, "Safety of Health Care Employees" and related (OAR) 437-001-0706, "Recordkeeping for Health Care Assaults" is only applicable to hospitals, ambulatory surgical centers, and home health care services operated by hospitals, and is aimed at preventing violence to employees from ***intentional*** assault. This law was revised in 2019 as recorded in Senate Bill 823 (SB 823-A).

The Oregon WPV law requires specific program components to be implemented.

The program components required in the Oregon law are incorporated into the recommendations for a comprehensive WPV program that addresses intentional and non-intentional Type II violence as described in this toolkit.

The Washington WPV law

Revised Code of Washington (RCW). Chapter 49.19 RCW-SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070 (revised in 2019), is applicable to hospitals, Home health, hospice, and home care agencies, Evaluation and treatment facilities and Ambulatory surgical facilities, and is aimed at preventing any physical assault or verbal threat of physical assault with or without use of a firearm or other weapon against an employee of a health care setting on the property of the health care setting.

The program components required in the Washington law are incorporated into the recommendations for a comprehensive WPV program that addresses intentional and non-intentional Type II violence as described in this toolkit.

Both Oregon and Washington WPV laws outline a programmatic approach to addressing WPV

Refer to **Tool 1b. Comparison of Workplace Violence Laws for Health Care in Oregon and Washington** for more information about the state laws

Felony Laws related to assaulting of health care workers

Thirty-eight states have enacted laws that make it a felony to assault a health care worker. However, each state law differs, and they don't all apply to all health care workers. Oregon for example, Intentionally, knowingly or recklessly causes physical injury to an emergency medical

services provider they are performing official duties is a third-degree felony. However, the law does not apply to any other health care professional such as nurses

Washington state's Felony Assaults law does apply to licensed nurses, physicians, or health care providers who was performing his or her nursing or health care duties at the time of the assault, but not to nursing aides and emergency room technicians.

There is also little data to support that states with these laws have seen them as an effective deterrent in decreasing assault of health care workers.

Federal OSHA is currently considering a standard to protect health care and social assistance workers from violence. Until such a standard is enacted the General Duty Clause of *Occupational Safety and Health Act of 1970* (OSH Act or Act) applies as related to protection of workers against violence in the workplace. The General Duty clause *also* applies to WPV circumstances where the OR WPV law may not be applicable e.g., in cases of non-intentional assault by patients or in cases of lateral violence or bullying.

The General Duty Clause requires employers to provide their workers with a workplace free from recognized hazards that are causing or likely to cause death or serious physical harm; and broadly states that employees cannot be discriminated against if they file a complaint related to work safety or reporting a work-related fatality, injury or illness.

Employers also have an *ethical* responsibility to promote a non-violent work environment that fosters a climate of trust and respect.

The Joint Commission's Sentinel Event Alert, Issue 59, March 2018, expands on the Joint Commission's prior communications that require health care facilities to comply with certain criteria for the security of patients, staff and visitors (The JC, 2010, 2018). This publication recommends specific activities that health care organizations are encouraged to complete and 'address the growing problem of WPV by looking beyond solutions that only increase security' (TJC, 2018).

The Joint Commission recommendations for addressing WPV.

1. Clearly define workplace violence and put systems into place across the organization that enable staff to report workplace violence instances, including verbal abuse.
2. Recognizing that data come from several sources, capture, track and trend all reports of workplace violence – including verbal abuse and attempted assaults when no harm occurred.
3. Provide appropriate follow-up and support to victims, witnesses and others affected by workplace violence, including psychological counseling and trauma-informed care if necessary.
4. Review each case of workplace violence to determine contributing factors. Analyze data related to workplace violence, and worksite conditions, to determine priority situations for for intervention.
5. Develop quality improvement initiatives to reduce incidents of workplace violence.
6. Train all staff, including security, in de-escalation, self-defense and response to emergency codes.
7. Evaluate workplace violence reduction initiatives.

These criteria have also been incorporated into this toolkit. In addition, there are several Joint Commission 'Leadership, Environment of Care, Emergency Management and Rights and Responsibilities of the Individual' standards that directly and indirectly apply related to how a hospital should manage and control violence. These can be found in the Sentinel Event Alert, *Issue 59,* March 2018.

Links to other compliance related considerations can be found in the Toolkit ***'Introduction'***.

Other professional organizations such as, the American Nurses Association (ANA) and the American Association for Occupational Health Professionals in Health Care (AOHP), have published position statements that state that there should be a Zero Tolerance for incivility, bullying and violence in the workplace, and in 2019 the American College of Emergency Physicians and Emergency Nurses Association have launched a Stop ED Violence Campaign (ANA, 2015, AOHP, 2017, ENA, 2019).

WPV Program Components

The box on the right lists the components of a comprehensive WPV program that provide the foundation to prevent (where feasible), reduce, and control the risk of violence in the workplace.

These program components are explored further in other sections of this toolkit as they relate to prevention of Type II violence. Program recommendations are incorporated from Oregon OSHA, Federal OSHA, The Joint Commission, and other professional associations, in addition to the lessons learned from partner hospitals in the WSI project.

Studies show that occupational injury prevention programs more effective and sustainable when they are multifaceted in nature, incorporated into an organization's overall safety and health program, and into the organization's culture, and assist to meet service delivery goals.

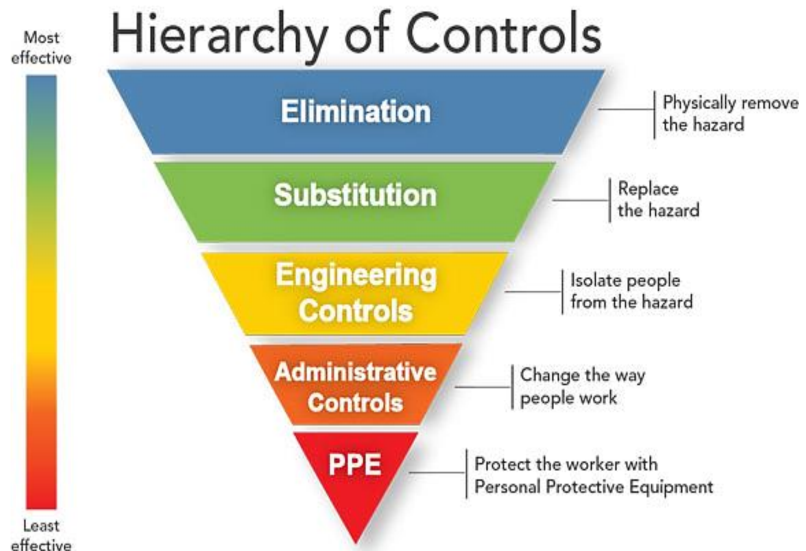
WPV Program Components

A. Management Leadership
B. Employee Participation
C. Written Violence Prevention Policy
D. Program Management Organization
E. Communications Structure
F. Hazard Identification & Assessment
G. Hazard Control and Prevention
H. Education & Training
I. Ongoing Program Evaluation and Improvement

However, there is little supporting evidence to indicate which WPV prevention program elements, or combination of program elements are more effective in preventing and managing violence in health care. This is likely because workplace violence in health care is a relatively 'new' topic which has been openly discussed for the past few years, as compared to other occupational hazards such as needlestick exposure or manual patient handling. In addition, designing experiments to test interventions is challenging in a clinical setting and risk factors for violence can vary from facility to facility.

Fortunately, there is a growing body of published case studies related to best practices for WPV prevention, and an increasing number of research activities are examining the effectiveness of WPV prevention programs.

WPV Hazard Control and Prevention



Source: NIOSH

The approach taken to prevent hazards in many occupational safety, health and ergonomics programs is to first try to eliminate or substitute or replace the hazard before turning to engineering controls that are designed to isolate or protect workers from the hazard. However, in the case of preventing workplace violence, elimination and substitution, while most effective at reducing hazards are extremely challenging. Therefore, a combination of engineering and administrative controls is primarily used within a WPV program to prevent and manage the risk of violence. An example of personal protective equipment (PPE) is the use of gowns, bite guards, gloves and face masks and shields to protect employees from blood and body fluid exposure that can occur when a patient is physically violent.

Engineering controls that are designed to isolate the worker from the hazard include:

- Improved worksite lighting
- Physical barriers at admitting/reception area
- Controlled access to buildings and units and monitored surveillance systems
- Panic alarms
- Design of waiting area to mitigate noise and overcrowding

Administrative controls which require the worker to change the way they work include:

- Procedures to:
  - Identify, assess and communicate patients/visitors at high risk for violence
  - Respond to incidents of violence and support systems for employees involved in violence

  - Facilitate employee reporting of incidents and processes for effective response management
  - Investigate incidents and correct hazards or work processes to prevent reoccurrence of a similar incident

- Security systems e.g. use of security personnel and surveillance systems
- Processes to track employees who work alone or with patients at high risk of violence
- Education & Training of all employees that is customized to their job responsibilities and role within the WPV program
- Recordkeeping and documentation

Engineering controls are preferred over administrative and PPE because they are designed to remove the hazard at the source.

Administrative controls and PPE programs may be less expensive to implement than engineering controls but over the long term, can be costly to sustain and require constant monitoring or 'supervision' to ensure desired changes to work practices and processes are maintained.

More information about specific engineering and administration controls to prevent and manager WPV can be found in ***Section 5*** of this toolkit.

A more recent approach to worker safety and health that is starting to be embraced within health care is Total Worker Health®(TWH). TWH not only incorporates traditional safety principles to prevent and reduce risk of occupational injury or illness to workers through design and organization of work, tasks performed and organizational culture, but also considers the overall well-being of the worker. TWH considers other factors such as, the impact of shift work, wages, access to benefits, interactions with coworkers, nutrition and fitness. (NIOSH, 2016).

The TWH approach that aims to protect workers and advance their health and wellbeing should be considered when addressing workplace violence concerns.

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Washington
RCW 9A.36.031: Assault in the third degree for assault of a nurse, physician, or health care provider who was performing his or her nursing or health care duties at the time of the assault. https://app.leg.wa.gov/RCW/default.aspx?cite=9A.36.031

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Information about WPV for specific healthcare worker professions or specialties

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Resources Related to this Section – Other

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Centers for Disease Control and Prevention (CDC)

- **Occupational Violence** http://www.cdc.gov/niosh/topics/violence/
- **Occupational Violence: Research on Occupational Violence and Homicide** https://www.cdc.gov/niosh/topics/violence/pubs.html

American College of Emergency Physicians and Emergency Nurses Association New 2020

- Stop ED Violence Campaign (Nov 2019) https://stopedviolence.org/

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Occupational Safety and Health Administration (OSHA)

- **Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (2015)** https://www.osha.gov/Publications/osha3148.pdf
- **Preventing Workplace Violence in Healthcare. Understanding the Challenge (2015)** https://www.osha.gov/dsg/hospitals/workplace_violence.html

- **Workplace Violence Prevention and Related Goals. The Big Picture (2015)** https://www.osha.gov/dsg/hospitals/workplace_violence.html
- **Facts About Hospital Worker Safety (September 2013). OSHA** https://www.osha.gov/dsg/hospitals/documents/1.2_Factbook_508.pdf
- **Workplace Violence – Website** https://www.osha.gov/SLTC/workplaceviolence/

The Joint Commission

- **Workplace Violence Prevention – From the Field** New 2020 https://www.jointcommission.org/wpv_healthcare_the_field'
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- **Bullying has no place in health care (2016) Quick Safety. The Joint Commission** New 2020 https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/joint-commission-online/quick_safety_issue_24_june_2016pdf.pdf?db=web&hash=84E4112AB428AD3CA1D5B9F868A1AD10
- **Questions & Answers: Hospital Accreditation Standards & Workplace Violence** November 17, 2017. https://www.jointcommission.org/questions_answers_hospital_accreditation_standards_workplace_violence/
- **Workplace Violence Resources** New 2020 https://www.jointcommission.org/workplace_violence.aspx
- **Workplace Violence Update.** Presentation on recent incidents in workplace violence. The 23rd State Hospital Association Forum 2016 https://www.jointcommission.org/assets/1/6/illinois_hospital_assoc_wpv_slides.pdf
- **Developing resilience to combat nurse burnout (2019).** The Joint Commission. Quick safety Issue 50, July 2019 New 2020 https://www.jointcommission.org/-/media/tjc/newsletters/quick_safety_nurse_resilience_final_7_19_19pdf.pdf?db=web&hash=552B3D44D99B02373F48D1FF464BFF27

<u>**Public Services Health and Safety Association (PSHSA) Ontario, Canada**</u> New 2020

- **Workplace Violence Prevention Resources – Hospital, Community Care and Long Term Care** https://www.pshsa.ca/emerging-issues/issues/workplace-violence-in-healthcare/workplace-violence-leadership-table-phase-2

<u>**World Health Organization**</u>

- **Violence against health workers**
  https://www.who.int/violence_injury_prevention/violence/workplace/en/

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Getting Started

Introduction

This section describes the steps and tools you can use to define the need for a WPV program, or the need to enhance existing WPV prevention efforts, and to develop the foundation for implementing and managing the program.

As previously discussed, the steps and activities conducted when developing and implementing a WPV program are often not sequential and may be interdependent. The steps described in this section may be performed in a different sequence, or in some cases concurrently. For example, you may feel it necessary to gather information about the frequency and severity of violence in your facility by reviewing incident data, and conducting staff surveys, and completing a gap analysis (described in ***Section 3*** of this toolkit), before you meet with leadership to establish preliminary support for the program efforts etc.

However, the sequence of program development activities described in this section are based on lessons learned during the WSI project. It is important to ensure that senior leadership support and are engaged in development or enhancement of a WPV program, before time is spent to draft a program plan, activities are conducted to engage staff in program efforts, and too many resources are used.

Tools that support content in this Section

2a. Tracking and analyzing incident and injury data.

- Version 1- contains sample data and analysis

2b. Sample injury data summary report

2c. Calculating direct and indirect injury costs

2d. Analyzing injury data and direct costs – how to

2e. Tips for effective committees

2f. Sample project charter

Health care organizations must be committed to providing ongoing financial and personnel resources, not only for the changes that may be required to improve physical security of a facility and staff education program, but to support a program that facilitates the changes in work processes and procedures required to minimize the risk of WPV. In general, successful and sustainable safety programs require ongoing organizational commitment and fiscal support.

Competing business and service demands together with changing health care reimbursement rules and the impact of health care reform can make ongoing support of comprehensive safety programs such as WPV challenging.

Therefore, it is also critical to assess the organizational culture and readiness for change, so that WPV program activities are prioritized to meet high risk needs, and that barriers to program implementation are anticipated and addressed. Implementing a WPV program that is manageable within an organization's current *business* capabilities, is designed to have a positive impact or contribution to the organization's business goals, and contributes to achieving the organization's mission and stakeholders' (patients, staff) satisfaction, have a greater likelihood of being sustained.

Define the Need for or Enhancing a WPV Program

STEP 1

a. Review best practices for assessing risk, control and prevention of WPV, and related regulations.

The first step in defining the need for or enhancing a WPV program, is to gain an understanding of the issue of violence in health care, why and how it can be addressed, and to start to identify the scope of WPV at your facility or within your organization.

Section 1 of this toolkit ***'Understanding Workplace Violence'*** provides information and reference material about the scope and impact of workplace violence in health care that you can use to become familiar with the topic. This information can be adapted and used to educate workplace violence committees, management and employees about WPV.

Section 6 Education and Training also contains links to other training resources that provide good background information about WPV in health care such as, the NIOSH '*Workplace Violence Prevention for Nurses'* interactive training course. This free course provides detailed information about the scope and nature of violence in the workplace and can be accessed at https://www.cdc.gov/niosh/topics/violence/

Review this toolkit and resources provided in its entirety to gain an understanding of best practices for assessing risk, prevention and management of WPV in health care.

Make sure you understand your organization's responsibilities as they relate to protecting workers from WPV under the Oregon workplace violence law ORS 654.412 to 654.423, "Safety of Health Care Employees" and OAR 437-001-0706, "Recordkeeping for Health Care Assaults".

In addition, it is important to understand other applicable legislation such as, the OSHA General Duty Clause, Joint Commission or other accreditation standards, and applicable CMS regulations, so that you can educate senior leadership and the workplace violence committee about regulatory and accreditation responsibilities.

Review any collective bargaining agreement(s) in your workplace for any provisions about WPV.

Refer to the ***Introduction*** and to ***Section 1*** of this Toolkit for more information about relevant laws and standards.

b. Collect baseline incident/injury and cost data related to WPV

Collecting baseline WPV incident and injury data will help you identify the scope of WPV at your facility or within your organization. For example, where and how often does violence occur; what types of violence occur e.g., physical assaults; the nature of assaults such as, biting, kicking etc.; who is the perpetrator of violence; and what are the associated workers compensation costs related to staff injuries?

To be able to examine and predict injury and other data trends, review at least *3 years* of data from OSHA logs, workers compensation reports, and other relevant sources of data as listed in ***Table 2.1***. For privacy considerations data provided should not include employee identifiers such as, name and date of birth, or information that is considered confidential under the Health Insurance Portability and Accountability Act (HIPPA).

STEP 2

Analyze data collected to identify units, departments and employee groups, with higher risk of exposure to WPV; and the nature, severity and cost of injuries associated with WPV. Begin to identify hazards/risks & program elements that need to be addressed.

Using the data collected in *Step 1*, identify the following:

- Units and departments or locations where incidents of WPV occur.
- Job tasks and employee groups with higher risk of exposure to and/or with incidents related to WPV.

- The types of violence reported e.g., verbal or physical, and nature of physical violence e.g. kicking, biting, grabbing.
- The perpetrator or status of assailant e.g., patient, behavioral health patient, visitor, employee.
- The nature of employee injuries reported e.g., mild soreness, cuts, large bruises, lacerations, fractures etc.
- The severity of employee injuries related to the number of cases with lost work days, the number of days away from work, and restricted or modified duty days.
- Calculate incident and severity rates of WPV related injuries per 100 employees.
- Calculate the direct costs of injuries and estimate the indirect costs as feasible.

As you evaluate your injury and cost data, determine if definitions and injury related variables and descriptions are *standardized*. For example, is there consistent use of standard terminology to describe WPV related incidents so that they can be accurately measured at the start of your program (baseline), and after the program is implemented and sustained? The ***Master Data*** spreadsheet in **Tool 2a**, provides an example of how injury data can be standardized to ensure accuracy of data measurement and management.

Sources of employee injury data and departments where the data is usually located	
OSHA 300 log and 300A Summary of Work-Related Injuries and Illnesses)	Human Resources or Employee Health
The Health Care Assault log (Oregon only)	Human Resources; Employee Health or Security Services
DCBS 801 Report to file for workers compensation (Oregon)	Human Resources; Employee Health
Workers compensation loss run reports (includes information about individual injury costs)	Human Resources; Employee Health or directly from the organization's Workers Compensation Carrier or Third-Party Administrator (if self-insured)
Emergency response reports such as Code Gray and Silver reports	Human Resources; Employee Health; Security Services; Quality/Risk Management
Security logs	Security Services

Table 2.1

Tools that can assist you to track, analyze and report workplace injury data

- Tool 2a. Version 1, Tracking and analyzing incident and injury data shows you how injury data can be collected, coded, and analyzed from one master spreadsheet.
- Tool 2b. Sample injury data summary. This tool provides an example of how injury data can be reported and the type of graphs you can create to demonstrate WPV illustrate the scope and nature of WPV at your facility.
- Tool 2c. Calculating direct and indirect injury costs. This tool allows you to capture and calculate costs associated with WPV related incidents.
- Tool 2d. Analyzing injury data and direct costs explains how to evaluate your WPV injury and cost data.

Calculating the direct costs of injuries and estimating the indirect costs

The full costs and impact of WPV to a health care organization can be summarized using the Iceberg Model shown in ***Figure 2.1.***

To make an effective and ongoing business case that will result in a fully funded and sustainable WPV program, it is often necessary to identify all the costs and benefits of implementing such programs. This allows you to demonstrate a positive return on investment for the organization in terms of financial benefits and contribution to strategic organizational goals and clinical programs.

Figure 2.1 Full Costs of Workplace Injuries

Direct and indirect costs related to employee injuries can be calculated more easily than the impact of WPV on operations.

Measuring operational losses and gains when developing a business case for WPV programs will be described further in ***Section 4*** of this Toolkit.

Other data such as, date and time of incidents and information about the response to incidents, can be collected at this time if convenient and analyzed later for use during development of the WPV program plan in ***Section 3.***

Analyzing the data listed above can:

- Identify the broad scope of violence at your facility.
- Help prioritize which units or departments should be the recipient of initial WPV program efforts or be a pilot unit(s) when initiating a program.
- Provide an initial indication about the general causes of WPV incidents or scenarios that maybe a priority to address e.g. patients in the ED who are in withdrawal from alcohol or drugs.
- Provide the foundation for building a business case for your WPV program and solutions you want to implement.

Direct injury costs include for money paid for medical bills, out of pocket expenses and compensation for time away from work, litigation, and settlement costs, and vocational rehabilitation if required.

Direct cost information including the productive hours needed to calculate injury incident and cost rates, can be gathered from Human Resources, Finance or Payroll, and Risk Management or Legal departments.

Indirect costs are the costs associated with investigation and management of injury claims, and the cost of temporarily replacing an injured employee such as, a nurse who is away from work or performing modified duty. Safety literature indicates that indirect or ‘hidden’ injury costs that occur as a result of worker injury absence vary between 0.5 and 10 times the direct costs of an injury.

However, rather than estimate these costs, it is better to determine what ‘hidden’ costs can be measured or captured within an organization for each injury claim.

Indirect cost information about investigation and management of injury claims, wages, benefit burden, and staff replacement costs, can be obtained from Human Resources, Worker Safety and Employee Health departments and Accounting or Payroll Departments.

Gathering incident data also provides an opportunity for you to ***build alliances and collaborate*** with Human Resources, Employee Health, Security, Finance, and other departments that will be able to assist you to gather data throughout development and evaluation of your WPV program. This includes assisting you to build the business case for justification of budget expenditures to prevent and control WPV e.g., physical changes to building, additional staffing or security personnel.

However, it should be remembered that determining true scope and cause of injuries related to WPV cannot be established from a review of OSHA and workers compensation data alone because of ***underreporting***, fraudulent reporting, and misclassification of injuries. In addition, there are other variables that can impact injury claims with days away from work, including lack of work or programs for workers who require temporary restricted duty, and case management protocols used to manage injury claims.

If you determine that analysis of the WPV injury and incident and related cost data ***is not sufficient*** to identify the initial need and solicit preliminary leadership approval to develop or enhance a WPV program at your facility, then review and incorporate information from other sources such as:

- Facility security or safety inspections
- Existing employee survey data e.g. satisfaction surveys
- Feedback from employee suggestion programs
- Minutes from safety meetings
- Employee assistance program usage reports (summary reports which do not identify individuals)
- Oregon OSHA consultation or enforcement reports related to WPV
- Grievances (harassment, discrimination)
- Patient and visitor reports or quality surveys e.g. Press Ganey

Summarize the employee injury data and any information collected for presentation to senior management. **Tool 2b** provides an example of how the injury data can be presented.

WPV Program Foundation & Management

STEP 3

Enlist support of senior leadership to develop or enhance a WPV program plan

The goal of meeting with senior leadership at this stage of WPV program planning is to gain approval and support to:

1. Further determine the scope of WPV at your facility or within your organization and to develop a draft plan to address WPV.

2. Approve resources to assist you achieve (1) above that is to,
   - Form a WPV committee to steer the project
   - Appoint a WPV project or program coordinator
   - Select a WPV program champion or sponsor from senior leadership

In addition, meeting with leadership allows you to understand:

- The overall level of support for the program
- How WPV may support organizational goals
- Potential barriers to implementation of the WPV program such as, other new or potential program initiatives related to patient and/or employee safety that compete for financial and personnel resources etc.
- What are the resources available to support program implementation and management strategies and activities

Overall, meeting with leadership reduces the risk of *wasting* resources, and time to plan and implement WPV program related activities, that may not be fully funded or supported by the organization.

The senior leadership group you meet with will vary depending on the size and structure of your organization. However, it is recommended that the group include decision makers such as, the chief executive, operating and financial officers, chief nursing and medical officers, leaders from human resources, quality and/or risk and patient safety, employee safety and security departments. In some cases, the leadership group includes the Board of Directors for a health care organization.

Preparing for the meeting

Have enough time allocated for the presentation. Leaders may not be familiar with the scope of WPV in health care, and/or with the organization's injury data and statistics that you will present, or the format they are presented in.

Sending a summary of the purpose for the meeting and organization's injury data reports to the leadership group ahead of the meeting can help facilitate discussion. **Tool ii**. **'The Workplace Violence (WPV) Program Development, Implementation & Evaluation: Suggested Sequence of Activities Chart'** is another useful document that can be shared as it provides a summary of program planning, implementation, and evaluation. ***Section 6 Education and Training*** also contain links to other training resources that provide good background information about WPV for facility leaders.

Personnel in the departments who provided WPV data to you (as described in Steps 1 and 2 above), may be able help you to determine the best way to present data and information, so that it meets the format normally used in your organization.

During the meeting

Communicate clearly and if you cannot answer specific questions during the meeting make sure you follow up with a response afterwards.

Emphasize that a *performance improvement* approach will be used to develop a WPV program, and that there are many resources freely available including this toolkit to help facilitate program efforts.

The following questions and suggested responses can assist you to plan and deliver your presentation (***Table 2.2***):

What do senior management want to know?

Question	Response
1. The purpose of the meeting	▪ To gain support to determine the scope of the issue, and to develop a plan to address, prevent, and control, WPV at your facility or within your organization (see above).

Question	Response
2. What is WPV?	▪ Define WPV with examples of each category or classification of WPV, and the scope of the issue within health care, and specifically within hospitals *(Refer to **Section 1** of this toolkit).*
3. Why is WPV so important?	▪ The cost of WPV in terms the impact on the workforce and health care organizations. Approaches to preventing and controlling WPV in health care *(Refer to **Section 1** of this toolkit).*
4. Do I & should I have to do anything about WPV?	▪ What you know about the scope of WPV at your facility in terms of injuries and associated monetary costs, and any other data you have collected to this point *(**Steps 1 & 2**).* ▪ What has the organization done to address WPV to date for example, hiring or security personnel, employee training, or changes to the physical design of the facility to enhance controlled access etc. Include where feasible, information about the impact of these efforts to reduce and/or control WPV. ▪ Legislative and accreditation related requirements i.e., Oregon OSHA, WA L&I, the JC, etc. *(Refer to **Section 1** of this toolkit).*
5. How much will it cost?	▪ Explain that until you have evaluated the full scope of the issue at your facility and developed your program plan you won't be able to answer this question. However, it may be important to highlight resources likely needed for program elements that you know should be implemented or enhanced e.g., implementation of a robust employee training program.
6. What will the results be?	▪ Provide the high-level, broad strategic objectives of the WPV program efforts, and how they can enhance or work in synergy with other programs at the facility, and support the organization's mission and goals e.g., reduce injuries and costs related to WPV, improve employee morale and reduce turnover.
7. What is our strategy?	▪ Identify a WPV program champion or sponsor from senior leadership and

Question	Response
	▪ A WPV project or program coordinator. ▪ Form an interdisciplinary WPV committee or team to determine the scope of the issue at your facility. Describe how the scope of the issue will be determined (for example, as suggested in ***Section 3*** of this toolkit). ▪ Develop a draft WPV program plan that will include the recommended scope of the program, how and who will implement and manage the program, the cost and return on investment of program activities, implementation timeline, and how the program will be measured and sustained. ▪ Present the draft plan to the senior leadership group for approval.

Question
8. What do I need to do? ***(or what do you need from senior management?)***

Response
a) That senior management understand that they are responsible for providing visible commitment, accountability, and resources, to ensure a culture of staff *and* patient safety. That is, a management climate where there is clear commitment that WPV will not be tolerated, and that supports *all facets* of implementation, ongoing evaluation, and maintenance of the WPV program. Thus, support is given to investigate the scope of WPV at the facility and to recommendations to develop or enhance an existing WPV program plan.
b) Identify a WPV program champion or sponsor from senior management who supports the position that WPV in any form will not be tolerated e.g., the chief nurse executive or nursing officer or vice president of quality services. Having a program champion or sponsor from a department such as nursing versus employee safety and health, can assist to aid the integration of WPV efforts within an organization, and promote WPV as an employee *and* patient safety initiative.

Response
Therefore, this person should be able to facilitate communication and partnership across all departments within a facility or organization, and to senior management. They should be able to remain engaged and effective in their role such as, being able to assist in leading the change management process throughout the organization. The program champion or sponsor assists the WPV committee and program coordinator to be effective by providing resources and visible support to facilitate successful implementation and sustainability of the WPV program. This includes engaging nursing management and staff in program activities, and communicating WPV program needs, progress, and outcomes with executive leadership. In addition, they should be easily accessible to the WPV program coordinator and committee and be able to engage with them on a regular basis.
c) **Identify a WPV program coordinator** for this initial planning phase, who can organize and manage the WPV committee and facilitate activities. If the program plan is approved a WPV program coordinator will be needed to oversee implementation and management of the program. The program coordinator should ideally have expert knowledge about the topic of WPV, or at least a knowledge of risk management as related to occupational health and safety. Alternatively, ensure that there is at least one person on the WPV committee with expertise in violence prevention and management. The program coordinator should also have proven project management skills. Provide the program coordinator opportunity for the further education about effective WPV programs and project management, etc., as needed. The program coordinator must have the authority and knowledge to convene the committee and require participation; enough time and resources to coordinate and lead the program; and the authority to make decisions when planning and implementing the program and ensure its effectiveness. However, it is important that management understand that *one person* cannot be responsible for implementing and managing the WPV program. All employees or stakeholders must be engaged so that WPV processes such as, patient assessment for risk of violence becomes institutionalized within the organization.
d) **Approval and resources to form an interdisciplinary WPV committee and investigate the issue further**. This includes allocation of appropriate time for WPV committee members

Response
to attend meetings, scheduling meetings, taking and distributing minutes and action plans etc., and resources to conduct activities such as, surveying employees and analyzing data. Highlight that the benefits of a well-structured and managed interdisciplinary WPV committee can**:** ▪ Solidify program support ▪ Contribute to program compliance ▪ Provides more human resources in developing and implementing the program ▪ Capitalize and engage a broad base of skills and expertise to ensure consideration of best-practice outcomes (OSACH, 2006) Discuss the tentative structure of the team, how long they may be working together, and specific responsibilities *(refer to **Step 4** in this Sectio*n).
e) Who do they want to see involved on the committee and with program efforts in general? Make sure that leadership approve connecting with community stakeholders such as, local law enforcement and EMS, behavioral health organizations and professionals in the planning phase.
f) How should mid-level management be engaged at this preliminary stage of program planning? For example, how will unit/department directors and manager be notified about initial program efforts such as staff surveys and walkthrough safety and security assessments?
g) Are there upcoming changes within the organization that may compete with resources you are requesting such as, budget for additional security staff; physical changes to a building; commitment to a comprehensive staff training program etc.? For example: – Changes within senior leadership – Addition or change within a service line – Patient safety initiatives or new work processes and or technology that are going to be introduced on a house-wide scale – New building or remodeling projects

Response
– More opportunity in use of capital budgets or in operating budgets – Revenue focus for the current year on controlling costs versus growth You should request that leadership set the criteria for solutions development in advance, and state what resources are available.
h) What is the timeline for development of a draft WPV plan to be presented to senior management?

Table 2.2

STEP 4

Identify a program champion or sponsor, and a program coordinator, and form an interdisciplinary WPV committee

Identify a program champion or sponsor and a program coordinator - Refer to Table 2.2. 8b. above.

WPV committee structure

Identifying key stakeholders to be part of the WPV program planning committee is important for success. The Joint Commission call for a collaborative and structured approach to address WPV that includes departments such as employee health, quality and security, whose functions and goals may not typically overlap or are sometimes 'siloed'.

Stakeholders are individuals, groups or organizations can affect or be affected by WPV and the WPV program overall or specific program activities.

Ensuring that staff from areas impacted or at risk for WPV are part of the committee can help to define the full scope of the issue at the facility. This can include managers from key departments such as, the emergency room, intensive care and behavioral health units. However, direct care staff such as staff nurses, aides, technicians, and other staff who have contact with patients and visitors, ***must*** be involved as they bring important knowledge and perspective about day to day experiences related to WPV to the planning process. Involving these staff facilitates employee buy-in as the WPV program is implemented and supports the culture change that will be needed. In addition, this collaborative approach to

problem solving helps ensure the solutions and strategies chosen are user-centered and applicable to specific work environments.

Figure 2.2 shows the stakeholders (i.e., disciplines, expertise and departments), that may be represented in a WPV committee at this stage of program planning stage.

Figure 2.2 Example of WPV Committee Membership

Although having key stakeholders involved in the planning phase of a WPV is critical, it is important that the committee is not so large that it is a challenge to organize and manage during this 'fact finding' investigation stage of program planning.

To address this, a smaller group of individuals with expertise in employee safety and health, security, behavioral health, human resources, risk management or quality or environment of care, and nursing management, and staff from key areas where violence occurs such as the emergency room, may form the core WPV planning committee. Membership should also include representation from existing WPV threat assessment and response teams.

Other stakeholders can be engaged on an 'ad hoc' basis during this investigation stage. Once detailed program planning, and implementation begins following approval of the WPV program plan by senior management, committee membership can be expanded as needed.

To facilitate communication during the program planning, implementation, and evaluation process, include stakeholders on the committee (in an 'ad hoc' role), that can provide linkage to other patient and employee safety committees.

In smaller organizations, one person may be responsible for multiple services and cover several areas of expertise on the committee.

At least one committee member should have subject matter expertise in violence prevention and/or is willing to attend additional training/education (e.g., de-escalation techniques, behavioral management).

Other 'ad hoc' members of the committee should include external stakeholders such as local law enforcement, behavioral health professionals, and the organization's insurance carriers. Developing a relationship with these stakeholders can assist you when completing WPV risk assessments such as, walkthrough security reviews, and developing WPV prevention processes such as, threat or violence response plans including active shooter protocols, and assistance to develop and conduct employee training.

WPV Committee 'Ad Hoc' membership – examples of departments/stakeholders

- Legal and regulatory systems
- Patient/customer services
- Finance
- Pharmacy
- Information technology
- Facilities maintenance
- Admissions
- Patient billing
- Dietary
- Laboratory services
- Transportation
- Environmental services (housekeeping)
- Marketing, communications and public relations support
- Facilities designers & architects
- Purchasing/procurement/material management
- Social work
- Clinical specialty departments: such as physical therapy, respiratory therapy, imaging
- Volunteer services

WPV reporting structure

Typically, a WPV committee reports to, or is a subcommittee of the facility employee safety and health committee. If this is not the case, make sure there is representation/communication between both committees

WPV committee roles and responsibilities

Overall Purpose

To provide interdisciplinary insight and assistance to the WPV program champion, the WPV program coordinator, and other groups of stakeholders in the design, implementation and evaluation of the WPV program.

Table 2.3, lists examples of the roles and responsibilities of a WPV committee.

Specific roles and responsibilities of the committee may be further defined after the WPV program plan is drafted and approved by senior management.

Once the program is implemented and evaluated, the committee structure and function should be reevaluated and membership, role, and activities, defined in relation to maintenance of the WPV program.

WPV committee roles and responsibilities can include:
▪ Identifying, consulting, and engaging key stakeholders through the activities outlined in this toolkit ▪ Identifying immediate and future goals and objectives for the WPV program ▪ Assessing current WPV policies and procedures, job tasks and work processes, and physical work environment, to identify and prioritize areas for improvement ▪ Identifying solutions to prevent and control WPV ▪ Assessing organizational readiness for the WPV program and associated changes ▪ Identifying barriers and facilitators to program implementation and maintenance ▪ Establishing timelines and deliverables ▪ Developing a draft WPV program plan

WPV committee roles and responsibilities can include:
▪ Assisting the WPV program champion and the program coordinator: – To solicit appropriate allocation of resources (time, staff and finance) – To develop and implement a communication plan – With implementation of WPV polices and processes and other interventions – To report and address barriers in program implementation and maintenance – With ongoing program evaluation, revision and communication (to management and employees) of process and outcome measures – To sustain and spread improvements ▪ Providing guidance, direction and support to the teams such as a threat response team, or managers and employees in departments or jobs with higher risk for violence

Table 2.3

Meeting structure

It may be necessary to meet frequently at this stage of program planning e.g., every 1-2 weeks, to get the committee established and educated about WPV, and to collect and analyze data before drafting a WPV program plan. Meeting frequency will also be dependent on direction given by senior management. Meetings could be monthly as the program is implemented and evaluated.

In smaller health care facilities, it may be feasible to have the employee safety and health committee provide WPV program oversight once the program is implemented and evaluated.

Effective teams

Borrill et. al, describes a team as a group of individuals who work together to produce products or deliver services for which they are mutually accountable. Team members share goals and are mutually held accountable for meeting them, they are interdependent in their accomplishment, and they affect the results through their interactions with one another. Because the team is

held collectively accountable, the work of integrating with one another is included among the responsibilities of each member.

The following factors tend to enhance teams in health care:

- Clear and shared goals and vision
- Strong leadership
- Members understand their role and responsibilities
- Effective communication and decision-making processes
- Mutual respect
- Individual accountability for specific actions
- Shared accountability for team outcomes

Individual members of the WPV committee will vary in their experiences and approaches to working as part of a team. There will be perceived differences in hierarchy and status for example between front-line employees and managers or leaders on the committee and between members from non-clinical and clinical disciplines.

Tool 2e, provides some tips for effective meetings and to assist committees in their work together

The following resources provide more information about developing and managing effective committees:

- **Working with Task Groups. Working Efficiently with Committees and Teams (2010). The Benchmark Institute.** http://www.benchmarkinstitute.org/t_by_t/free_stuff/working_with_task_groups.pdf
- **Team Working and Effectiveness in Health Care (2002). Findings from the Health Care Team Effectiveness Project.** Borrill et al. http://homepages.inf.ed.ac.uk/jeanc/DOH-glossy-brochure.pdf

STEP 5

Educate the team about WPV in health care, the components of successful WPV programs, the proposed approach to addressing WPV at your facility and function of the team

Once the WPV committee is formed provide them with information about the:

1. Scope and impact of workplace violence in health care, and elements of programs to prevent and control WPV. Use information provided in this toolkit including free web-based videos such as the NIOSH '*Workplace Violence Prevention for Nurses'* interactive training course listed in ***Section 6 Education and Training***.

2. Steps taken to start WPV program development at the facility

3. Purpose of the WPV program and proposed strategy to develop a draft program plan – Use information developed in ***Step 3*** and an understanding of requirements by senior management as identified in ***Step 3.***

4. Understanding of how a WPV program can support the organization's strategic goals and mission.

5. Roles and responsibilities among the members of the WPV committee; of the WPV program champion and the program coordinator etc.

6. Meeting schedule and communication methods between team members and the project coordinator etc.

Develop a draft project charter for the committee. Use your organization's existing project charter template (if one exists).

A project charter demonstrates the commitment of the organization and senior management to the WPV program and committee activities and provides formal agreement about the project details. A charter assists as a communication tool to employees about this commitment and goals, scope and high-level deliverables of the WPV program overall.

It also assists the WPV committee to *stay on course* during program development and implementation.

Typically, a project charter summarizes the:

- Need for a WPV program
- Program objectives

- Role of the program champion
- Authority of the WPV manager
- Main stakeholders
- Committee function and roles etc.

Once the WPV program draft planned is completed, the project charter can be updated to include the:

- Performance improvement approach to problem solving
- Potential barriers to a successful WPV program
- Anticipated resources
- Project milestones
- Specific performance measures and improvement goals
- **Tool 2f,** provides an example of a project charter for a WPV committee.

The charter should be amended as needed and approved by senior leadership as part of the process to finalize your WPV program plan **(Refer to Section 4).**

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Workplace violence: Planning for prevention and response (2010). Kerr, K. Butterworth-Heinemann.

Resources Related to this Section – Other

The Agency for Healthcare Research and Quality (AHRQ)

- **AHRQ Webinar: Reducing Workplace Violence with TeamSTEPPS® (2016)**
  https://www.ahrq.gov/teamstepps/events/webinars/dec-2016.html
- **The Comprehensive Unit-based Safety Program (**CUSP**)** toolkit– *Tools for Engaging Senior Executives*
  https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/index.html

The American Hospital Association (AHA)

- **"Hospitals Against Violence" Resources from the AHA.**
  http://www.aha.org/advocacy-issues/violence/index.shtml

The American Organization of Nurse Executives (AONE)

- **Mitigating Violence in the Workplace (2014).** The American Organization of Nurse Executives Guiding Principles, AONE with the Emergency Nurses Association. http://www.aone.org/resources/PDFs/Mitigating_Violence_GP_final.pdf

Emergency Nurses Association (ENA)

- **Workplace Violence Resources** https://www.ena.org/practice-resources/workplace-violence
- **Workplace Violence Toolkit (members only)** https://www.ena.org/practice-resources/resource-library/-in-category/categories/ena/resources/practice-resources/toolkit

Health Employers Association of British Columbia (HEABC)

- **Violence Prevention Resources** http://www.heabc.bc.ca/Page4270.aspx#.VS1r8qN0w6Y
- **Health Authority & Providence Health Care Employees - E-Learning Modules** http://www.heabc.bc.ca/Page4272.aspx#.WUwTe2ciz8o
- **Provincial Violence Prevention Initiative Final Report – July 2012.** http://www.heabc.bc.ca/public/HSIA/HSIA_Initiative4_FinalReport.pdf

The Joint Commission

- **The Essential Role of Leadership in Developing a Safety Culture. Sentinel Alert Issue 57, March 1, 2017.** https://www.jointcommission.org/sentinel_event.aspx
- **Preventing violence in the health care setting (2010).** http://www.jointcommission.org/assets/1/18/SEA_45.PDF
- **Emerging Health Care Concern: Preventing Workplace Violence** Presentation on Workplace Violence https://www.jointcommission.org/assets/1/6/PreventingWPV_081816.pdf

Minnesota Department of Health

- **Prevention of Violence in Health Care Toolkit** https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html
- **St. Cloud - Committee Structure and Purpose** https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/docs/stcloudcommitteestructurepurpose.pdf
- **HealthEast - Violence Prevention and Intervention Presentation (PDF)** https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/docs/healtheastviolprevinterventionpresentation.pdf

Minnesota Department of Labor and Industry

- **Workplace Violence Resources** http://www.dli.mn.gov/business/workplace-safety-and-health/mnosha-wsc-workplace-violence-prevention
- **Workplace violence prevention A comprehensive guide for employers and employees** https://www.dli.mn.gov/sites/default/files/pdf/WorkplaceViolencePreventionGuide.pdf

U.S. Department of Labor Occupational Safety and Health Administration (OSHA)

- **Hospital Safety and Health Management System Self-Assessment Questionnaire (2013)** https://www.osha.gov/dsg/hospitals/mgmt_tools_resources.html
- **Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers. 2015**. https://www.osha.gov/Publications/osha3148.pdf
- **Caring for Our Caregivers. Preventing Workplace Violence: A Road Map for Healthcare Facilities (December 2015).** https://www.osha.gov/Publications/OSHA3827.pdf
- **OSHA Hospital Safety e-Tool, Workplace Violence Module** https://www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/viol.html
- **OSHA's Safety and Health Management Systems and Joint Commission Standards - Comparison** https://www.osha.gov/dsg/hospitals/documents/2.2_SHMS-JCAHO_comparison_508.pdf

Washington State Department of Labor and Industries

- Workplace Violence Prevention in Health Care Settings http://lni.wa.gov/Safety/Topics/AtoZ/WPV/wpvhealthcare.asp

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Step 6

Hazard Identification and Assessment

Introduction

Initial and ongoing identification and assessment of hazards for WPV provides the foundation of a comprehensive violence prevention program by:

1. Identifying risk factors that increase the likelihood that violence will occur. Although no one specific diagnosis or type of patient is a predictor of future violence, a thorough hazard assessment can identify combinations of risk factors that increase the risk for employee exposure to WPV. For example, working in an emergency room with patients who are withdrawing from drugs or alcohol abuse. (OSHA 2015).

2. Providing a basis for prioritizing problems by risk and severity or likely outcome, and informs decision making when choosing and implementing controls to prevent and manage WPV.

3. Identifying barriers to removing the risk factors and formulating approaches to address barriers (McPhaul et. al., 2013).

4. Allowing comparison of the current state of WPV prevention activities in your facility and within individual units and departments and comparing them to recommended best practices in violence prevention.

5. Providing an opportunity to engage employees in the development and ongoing management of a WPV program, and allow the WPV committee with leadership support, to tailor a program that will serve the needs of your facility.

Tools that support content in this Section

3a. Gap analysis tool

3b. Employee WPV survey sample

3c. Employee WPV survey report contents and sample format

3d. Employee WPV survey summary report sample

3e. Employee WPV survey marketing flier

3f. Safety and security assessment checklist

3g. Prioritizing level of risk for WPV and solutions

3h. Tips for choosing solutions

3i. Project template

As discussed in ***Sections 1 and 2,*** evidence shows that using a multidisciplinary approach that engages employees and is supported by management, can facilitate the success of occupational safety and health programs.

Hazard identification and assessment is an ongoing process within a WPV program. Continuous program evaluation is discussed further ***Section 8.***

WPV hazard identification and assessment activities

This section of the toolkit focuses on the primary hazard identification and assessment activities that hospitals in the WSI project conducted in addition to analysis of WPV injury and incident data as described in ***Section 2.*** The following assessment activities are highly recommended because they capture a broad range of critical information and facilitate evaluation of current WPV prevention activities and determination of future desired activities from a systems perspective.

- Comprehensive Gap Analysis of existing WPV program efforts and related policies (this includes assessment of an organization's culture and readiness for change)
- Employee survey to engage employees and determine their perception of WPV
- Safety and Security Assessment of the Physical Work Environment to identify hazards that may increase the likelihood of violence occurring

The following are examples of additional data sources that can also be used to assess the risk of WPV in your facility. What data source you choose to evaluate will depend on availability and quality of data, and resources available to evaluate the data.

- Formal employee focus groups
- Existing employee survey data e.g. satisfaction surveys
- Feedback from employee suggestion programs
- Minutes from safety meetings
- Employee assistance program usage reports (summary reports which do not identify individuals)
- Patient focus groups and/or surveys to elicit information about what triggers may contribute to violence and what would make them feel the most comfortable and safe
- Patient and visitor reports or quality surveys e.g. Press Ganey
- Oregon OSHA consultation or enforcement reports related to WPV

- Security and safety rounding and inspection reports (conducted by facility staff and/or external agencies e.g. law enforcement, insurance carriers etc.)
- Police reports if available
- Grievances (harassment, discrimination)

Once completed, information collected from **the Gap Analysis together with data from the employee survey and walkthrough hazard assessment** and the earlier review of **WPV injury and incident data** etc., will provide a framework to develop or a violence program or enhance an existing program. *Refer to Step 7 for more information.*

Gap Analysis

Why conduct a Gap Analysis?

The purpose of a gap analysis is to determine current state or *what's actually happening* and desired future state or *vision* of a WPV program**.** The Gap Analysis tool provided includes details of published recommended elements and current best practices of effective WPV programs, including the elements of a WPV program that are required by Oregon law.

Conducting a gap analysis allows the WPV committee and other stakeholders to determine:

- What violence prevention best practices exist
- Completeness and effectiveness of existing WPV policy and procedures
- Which WPV program elements and practices should be developed and implemented.

Conducting a Gap Analysis also provides an opportunity to **assess organization culture and readiness for change.** Determining culture and assessing readiness for the implementation or enhancement of a WPV program and associated processes, is important to help the WPV committee determine and prioritize implementation strategies.

The organization's culture and readiness for change should be evaluated and discussed throughout the WPV program planning process, so that the WPV committee can develop strategies to address potential barriers that can then be discussed when presenting the draft WPV program plan to senior leadership.

Change in a health care organization's leadership and/or delivery of business services necessitates that an organization's culture and readiness for change is evaluated on an ongoing basis after WPV program implementation.

Refer to ***Figure 3.1****,* for more information on assessing your organization's culture. Determining how **ready a health care facility** is to implement a WPV program is discussed at the end of this section.

The first section of the Gap Analysis tool provided i.e., 'Violence Prevention Program Foundation and Management', identifies behaviors and practices that help determine if a culture of patient and employee safety exists, and the potential barriers to implementation of a successful program and associated procedures.

It is recommended that a gap analysis is also completed periodically as a part of an ongoing program evaluation, and as a tool to facilitate program sustainability as discussed in ***Section 8*** of this toolkit.

Completing the Gap Analysis

Have each member of the Workplace Violence committee (WPV committee) and any other key stakeholders complete the entire gap analysis or assign program section(s) to individuals for completion. This allows you to gather different perspectives on current violence prevention practices within your facility before establishing program priorities.

Once individual responses are collected use a brainstorming approach to review responses to each question as a committee and discuss overall 'gaps' identified in each program component section to arrive at consensus to determine what program elements and activities:

- Exist and are functioning well
- Are only partially implemented
- Need to be developed
- Will not be implemented or are not applicable

Once complete, rank items in each program component section by:

1. Need to be developed
2. Are only partially implemented

3. Exist and are functioning well

4. Will not be implemented or are not applicable (note you may want to review these items again in the future to determine if they are applicable or should be addressed)

Assessing an organization's culture

Assessing the organization's culture and readiness for change involves reviewing the organization's approach to a 'culture of safety'. OSHA summarizes an organization's culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to objectives such as quality and safety. Healthcare organizations that foster a "culture of safety" characterized by an atmosphere of mutual trust, shared perceptions of the importance of safety, confidence in the efficacy of preventive measures, and a no-blame environment are more successful at implementing programs that reduce injuries to both patients and workers.

Typical attributes of a culture of safety include:

- Staff and leaders who value transparency, accountability, and mutual respect
- Safety as everyone's first priority
- Not accepting behaviors that undermine the culture of safety
- A focus on finding hazardous conditions or "close calls" at early stages before injuries occur
- An emphasis on reporting errors and learning from mistakes
- Careful language to facilitate conversation and communicate concern
- Principles of High Reliability Organization (HRO) and Just Culture are embraced

The following provides a good review about HROs and Just Culture and the relationship to a culture of safety and will assist you to review the culture of safety at your facility.

- **The essential role of leadership in developing a safety culture**. Sentinel Event Alert. The Joint Commission. Issue 57, March 1, 2017 https://www.jointcommission.org/sea_issue_57/

- **Workplace Violence Prevention and Related Goals. The Big Picture.** OSHA 2015. https://www.osha.gov/Publications/OSHA3828.pdf

Figure 3.1 Assessing an organization's culture

The next step is to determine as a committee what you think must be done to move from the current state to desired future state of the violence prevention program at your facility or within your organization. *This is discussed in Step 8 on page 16.*

The Gap Analysis Tool

The WPV Gap Analysis tool provided, highlights the important components of a violence prevention program to *address violence from patients and visitors.* You can use the checklist to help identify those components of your violence prevention program that are well developed, as well as those that need further development.

The *Gap Analysis* tool was developed from several resources (provided as references) and includes all elements of the assault prevention program required by Oregon State law ORS 654.412 to 654.423 'Safety of Health Care Employees' and the Washington state WPV law Revised Code of Washington (RCW). Chapter 49.19 RCW-SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070.

The tool is provided in several formats however, the MS Excel version allows you to prioritize responses to individual questions and then offers a project planning format to identify specific strategies to address identified gaps; potential barriers and how anticipated problems will be averted or minimized?); those responsible to carry out the strategies; timeline for implementation and resources needed.

The *Gap Analysis* tool can be customized by adding or deleting components specific to your facility for example, smaller hospitals may not have resources to hire security staff, etc.

This tool focuses primarily on violence prevention programs in hospitals. Additional information may be needed if reviewing a violence prevention program for a home health services as defined in ORS 654.412 to 654.423.

Conducting WPV Employee Surveys

The goal of conducting WPV employee surveys

The goal of conducting employee surveys is to gain further insight about the type and frequency of violence in the facility, and employee perceptions of violence and of prevention efforts. This activity will further help to identify potential hazards that may lead to violent incidents and related 'gaps' in WPV prevention processes and procedures. Surveying employees can also provide insight into changes they deal with on a daily basis related to WPV and solicit feedback from employees about the ways they think WPV can be addressed in their work area.

Conducting employee surveys is one method to engage employees in the WPV program and prepare employees for changes in work practices that is, a culture change.

When to conduct employee surveys

Employee surveys can be used as part of WPV program planning and during periodic evaluation of the WPV program **(*Refer to Section 8*).**

Developing an WPV employee survey

The **Employee Survey tool (3b)** provided, was developed using information from current WPV literature and input from the hospitals in the WSI project. It is a comprehensive survey; in that it aims to solicit employee responses about all major elements of a WPV program. Additionally, the survey was designed to be completed by employees in any department in a hospital.

Your WPV committee should review the survey and adapt it to your program needs. Consider how the data will be used and frame questions in a way that will elicit the most helpful information. Consider the stakeholder audience and departments you are targeting in your program efforts. Ensure language and terminology used can be understood by the employees you are surveying.

Once drafted, senior management, and in some facilities the legal department, will need to approve the survey content before launching the survey.

Note: The sample survey provided takes about 20-25 minutes to complete if conducted as a computer-based survey.

WPV employee survey – topics included	
▪ Demographics ▪ Employees overall experience related to WPV at the facility ▪ Types of violence employees have experienced and their perception of cause ▪ The perpetrators of WPV ▪ Frequency of exposure to violence ▪ Management support and employee awareness of WPV program efforts	▪ Risk assessment ▪ Education & training ▪ Incident response ▪ Knowledge about how to report and respond to WPV ▪ Response post incident ▪ WPV prevention ▪ Additional questions for Home Health Employees related to Oregon WPV law if applicable

Conducting WPV employee surveys

In addition to designing a survey that is meaningful and readily understood by employees, marketing the survey well is critical to gaining a good response rate from employees.

Tool 3e is a **sample flier** that can be adapted to help market your survey. Find out the most effective method(s) used in your facility to communicate with employees in various departments e.g., bulletin boards, newsletters, email and management and employee meetings, etc.

Make sure all department/unit managers have been notified about the survey launch and rationale. **Employees** should have a clear understanding of why the survey is being conducted; the importance of their participation; and how data collected will be used. Communicate that you will provide a summary report of survey findings (see below), and the projected timeline for publication of that report.

Timing the launch of a survey is also critical. If your facility is already conducting or planning to conduct other surveys that impact your target audience such as, Press Ganey surveys, then these activities may negatively impact the response rate to the WPV survey. Health care employees are often surveyed regularly on a broad range of topics leading to 'survey fatigue'.

Offering the survey via web-based applications such 'Survey Monkey® can facilitate response rate and assist to expedite data analysis. Check with the Information Technology (IT) department at your facility to find out what is application is available to help conduct the survey.

It is recommended that surveys are conducted on a **voluntary basis,** and are confidential and anonymously so that employees feel comfortable sharing their responses and experiences etc. You can add the option of allowing employees to provide their name and contact information if they choose to so that you can find out more about their responses as needed.

Include the contact information of the WPV program coordinator or other member of the WPV committee on the survey as a resource for employees that may have questions about contents of the survey or survey process etc.

Allowing employees to **complete surveys on work time** can also increase participation.

It's suggested that the survey is conducted for 2-4 weeks and then demographic data reviewed, to determine if more responses are desired from specific departments or units, shifts and/or job categories. Consider marketing the survey again and allowing another 2 weeks to increase response rate as needed.

Who should complete a WPV survey?

When planning a new, or enhancing an existing WPV program, it can be beneficial to survey all staff within a facility, versus just those who provide direct care to patients or have direct contact with patients and families etc.

This allows you to gain information about the prevalence and scope of *all* types of violence that employees may be experiencing i.e., violence from patients, visitors, coworkers and domestic relationships.

Although patient/visitor to employee violence was the focus of the WSI project, participating hospitals found that conducting a WPV survey of all staff was helpful in highlighting the need for violence prevention efforts related to lateral violence or bullying in specific work areas.

If conducting periodic survey of all employees is not feasible as part of WPV program evaluation e.g., due to lack of available resources, then target surveys to groups of employees who are impacted by program interventions. For example, conducting follow up surveys of employees in departments where the presence of security staff and surveillance equipment was enhanced and/or a WPV patient assessment tool was implemented.

Analyzing and reporting the WPV survey data

An important facet of planning to conduct the survey is to **identify who and how data will be analyzed, and a report(s) developed.** Some survey tools such as Survey Monkey will provide analysis of data and supporting graphs, but often additional analysis is needed especially when analyzing data for specific units. Find out if your IT department or departments who survey employees regular such as, Quality or Human Resources, can assist you with data analysis and report development.

Contents of the comprehensive WPV survey reports developed for hospitals in the WSI project is provided **(Tool 3c)** together with a sample survey summary **(Tool 3d)**.

The comprehensive written report is typically shared with the WPV committee and senior management (as requested), and the written survey summary is designed to be shared with all employees. In addition, meeting with management and employee groups to share survey findings helps to engage leadership and employees in program development efforts.

A summary of staff survey data from participating hospitals in the WSI project can be found in *Tool i.* 'Violence Prevention in Health Care: Sharing Lessons Learned from the OAHHS Worker Safety Initiative'.

Safety and Security Assessment of the Physical Work Environment

The goal of conducting a walkthrough safety and security assessment

To assess the physical design and layout of the hospital or work environment, and identify existing or potential conditions or hazards, that may increase the likelihood of violence occurring in a specific location.

Work environment assessments can also assist the WPV committee to ‘fill gaps’ or expand their understanding about information collected from the review of injury data and existing WPV related polices, the employee survey, and the gap analysis. For example, to further identify patient characteristics that might be a risk factor for violence, and work tasks, point of-care work, clinical or nursing practices and procedures, that may put employees at a higher risk of exposure to violence.

Employees have knowledge and familiarity with facility operations, process activities and potential threats for WPV. Therefore, interviewing employees during a walkthrough assessment provides invaluable insight about hazards and procedural activities that they feel can increase their risk for violence in their workspace. They can also provide suggestions for changes to the physical environment and procedural changes, that may reduce the risk of violence and/or improve response when managing violence. Thus, work environment assessments also provide another opportunity to engage employees in the WPV program and prepare them for change.

When to conduct a walkthrough safety and security assessment

A walkthrough safety and security assessment should be conducted at the start of the WPV program during the planning phase, and then periodically as part of a proactive approach to hazard prevention.

Safety and security assessments can also be used as part of the investigation process following a workplace violence related incident to help determine if the physical design or maintenance of the work environment and/or procedural issues contributed to the event and can be changed to prevent further incidents etc.

Conducting a walkthrough safety and security assessment

The 'Walkthrough Safety and Security Assessment' tool provided was developed from multiple resources (See *References* at the end of this section) and is focused on acute care facilities. The tool can be customized for other health care environments as needed such as outpatient clinics and/or additional security related measures can be added as needed.

WPV Walkthrough Assessment Tool – Work Areas Included	
A. Exterior Building Areas **B.** Parking Areas **C.** Interior Building (Non-Patient Care Units/Treatment Areas) **D.** In Patient Care Units (use only as a basic list for behavioral health) **E.** Emergency Room **F.** Pharmacy	**G.** Other treatment areas/offices where patients are interviewed etc. **H.** Other Rooms and Storage Areas **I.** Individual Offices **J.** Files/Records in non-patient unit areas. **K.** Cafeterias **L.** Other areas as identified during the walkthrough

Tips for conducting a WPV walkthrough assessment

- Before conducting an assessment, have the WPV committee (or at least the members who will be involved in the walkthrough), review the assessment tool to become familiar with it, and to make any relevant additions. They should also be familiar with the work areas, tasks, and patient populations, you have identified as a 'risk' during the review of incident data etc., in ***Section 2.***
- Communicate the purpose of the assessment with unit and department managers and determine when the assessment is to be scheduled. When scheduling the assessments consider when it will be the best time to gain access to all areas of the unit or department and to interview employees.
- Have a small group or several small groups from your WPV committee conduct the assessment. Small groups are least disruptive when assessing busy work areas such as the emergency department.
- Conducting the assessment during all shifts also helps to engage employees and will highlight variations in work tasks and demands, and procedures.

- In a larger facility it can be helpful to divide assessment activities by units or areas of a facility e.g., the exterior of the facility; interior building non-patient care/treatment areas and patient care units and assign a group to review a specific work area.
- Having committee members with differing professional expertise involved in the assessment process can provide a broad insight about the work area being reviewed. In addition, committee members can become familiar with the worksite from a safety perspective and gain insight into employee's perspectives about WPV. Information gathered from the employee survey (if completed) can also be clarified or investigated further during the walkthrough.
- Ideally employee safety and security staff should be involved in assessment of all work areas, and at least one person should have experience of, or be familiar with work environment audits for safety and security purposes.
- It's helpful to have at least one person in each group be familiar with the work area being reviewed to expedite the assessment process, share insight into procedural activities, and ensure the complete workspace is reviewed. The unit or department manager can assist in this role.
- Members of local law enforcement and the organization's workers compensation or general business insurance carrier, may also be able to assist the walkthrough assessment process. This is particularly helpful if a hospital doesn't have internal security expertise.
- Note potential solutions while completing the assessment. If there are any issues that need to be addressed immediately make sure that this occurs.
- The assessment should be conducted without assigning fault or blame for deficiencies that may be found. The process should be considered as an opportunity to improve the environment (ASIS, 2010).

Analyzing and prioritizing data collected during a WPV walkthrough safety and security assessment

After completing the walkthrough assessment:

- List the items that are identified as needing to be addressed.
- As a committee (or a subgroup of the WPV committee) discuss the items you identified as needing to be corrected.

- Rank or prioritize the risks identified to determine the most serious safety hazards or issues that could contribute to or facilitate WPV and that should be addressed first. That is, prioritize these items based on risk level considering the *consequence* if an item is not addressed i.e., the likelihood of that item contributing to or facilitating a negative event (WPV related event), and the *seriousness* of the outcome if this event occurred.

The walkthrough safety and security assessment form (Tool 3f) is provided in document and spreadsheet format. The spreadsheet version of this tool allows you to sort checklist responses, so you can easily list and prioritize items that may need to be addressed. The tool also offers a project planning format to identify corrective action to be taken and the associated fiscal impact, those responsible for the corrective action, and deadline for completion.

For example, employees such as ED staff who work with patients with poorly managed mental illness or drug and alcohol intoxication and abuse, may be a higher risk of physical WPV that may result in a serious injury, is typically a high priority when developing solutions, than medical billing specialists who are exposed to frequent verbal abuse by patients via telephone or written correspondence.

Tool 3g provides examples of how to categorize risk.

Step 7

Analyze all data collected and prioritize hazards and needs

Once injury/incident and cost data; completion of the Gap Analysis, employee surveys, walkthrough safety and security assessment, and any other data, is collected and analyzed, the WPV committee will need to summarize findings to describe areas of concern/risk and program gaps, and where WPV prevention efforts are to be directed overall.

An example of the work or task related characteristics, culture and program elements that may be included in a **risk assessment summary** is shown below.

Risk Assessment Summary **Work or Task Related Characteristics, Culture and Program Related**	
▪ Department(s) ▪ Work area(s) within each department ▪ Job categories/titles of employees at risk ▪ Job tasks/activities/point of-care work practices where violence occurs ▪ Time of shift/day ▪ Characteristics of high-risk patients ▪ How often violence occurs ▪ Type of violence reported; perpetrator; the nature and severity of employee injuries reported and associated incident rates ▪ Direct costs of injuries and estimate the indirect costs were feasible ▪ Management leadership i.e., organizational/safety culture – Within senior leadership and within units identified. Consider unit level work organization: job demands, overtime, staffing, supervisor support for safety, teamwork, employee training competence ▪ Employees participation -employee perception of WPV and knowledge of prevention processes etc. ▪ Written WPV policy ▪ Program management organization	▪ Communications structure *(Addressed in Section 4)* ▪ Hazard identification/assessment processes ▪ Hazard control and prevention - *Engineering Controls*: Physical environment ▪ Hazard control and prevention *Administrative and Work Practice Controls:* – Incident reporting – Identifying and tracking Patients/visitors at high risk for violence – Tracking employees working alone or in secure areas – Entry procedures – Employee dress code – Transportation procedures – Security rounding – Incident response/post incident procedures – Incident investigation – Other controls as identified – For Home Care employees if applicable ▪ Education & training *(Addressed in **Section 6)*** ▪ Ongoing program evaluation and improvement

Step 8

Developing solutions to address and control hazards

Developing Solutions

WPV committee will then need to:

1. Determine what WPV program elements, processes and environmental changes (i.e. program activities) need to be developed and implemented to reduce hazards and risk factors and achieve a comprehensive and successful WPV program. You will have likely started to discuss and note which program activities need to be addressed during completion of the Gap Analysis and Safety and Security Assessment.

   Determine goals and develop measurable outcome(s) for each program activity identified. These will be important when conducting ongoing program evaluating and continuous improvement.

   More information about measuring program activities can be found in ***Section 8*** of this toolkit.

2. Prioritize the program activities identified above with consideration to addressing any high hazard or risk issue that creates an immediate and/or emergent threat to employee safety. When prioritizing risk consider:

   - How often an employee is exposed to the situation or conditions i.e., frequency of exposure
   - The probability or likelihood that the situation will occur
   - The degree (severity) of harm likely to result from the exposure
   - How many or percentage of employees that are exposed to the situation or risk

   The risk assessment methods offered in **Tools 3g and 3h** can be used to assist you to prioritize activities.

3. Determine potential strategies/solutions (and supporting rationale) for each of the program activities identified.

   Consider the following:

   - Are there some solutions/strategies that must be implemented before other recommendations? *For example,* in work areas where a higher incident of violence is

identified through a review of incident and injury data, the WPV employee survey, and from feedback from employees during a walkthrough hazard assessment.

- Solutions or program elements that should be implemented to meet Oregon WPV law ORS 654.412 to 654.423 'Safety of Health Care Employees' or Washington state WPV law RCW Chapter 49.19 SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070, can be found in **Tool 1b** *Comparison of Workplace Violence Laws for Health Care in Oregon and Washington States*, and **Tool 3a** *the Gap Analysis tool*.

- Are there solutions/strategies that are based on a higher level of evidence than others? *For example,* research indicates that the program foundation components as outlined in the gap analysis tool, and patient assessment for violence processes, are evidenced based program elements that contribute to program sustainability, culture change and violence prevention.

- Will some solutions/strategies take longer to implement? *For example,* hiring security personnel, training all employees, and/or developing a patient assessment alert system in an electronic health record.

- Are there hazards or risks that can be easily corrected? Effective solutions to highly visible safety issues that are implemented early in program adoption can assist to gain employee and/or management "buy in" to program efforts.

Tool 3h provides Tips for Solution Development. ***Section 5*** provides information about specific solutions and processes to control and prevent WPV.

Note the rationale or evidence that supports your decision to identify specific hazards as high hazard and the interventions chosen e.g., prior WPV incidents that could have been avoided or outcomes less severe if specific WPV controls had been in place, or an intervention that is strongly supported

Quick Tip: Refer to the following resources to assist with developing solutions:

- Tool 3g. for ways to prioritize program needs and
- Tool 3i Project template to summarize project plan
- Tool 3h. for tips on choosing solutions
- Tool 3a the Gap Analysis and the
- Tool 3f the Safety and security assessment checklist tool and
- Section 5 Solutions to Address and Controls Hazards for details about recommended program elements and design of the physical environment etc.

by published evidence or required by law. Noting the rationale will help gain support for the intervention that may be needed when requesting and justifying budget and resources from senior leadership.

4. Identify potential barriers to implementation of solutions/strategies identified and how they will be addressed. Barriers can be related to budget, skills, leadership, workload and staff resources, competing projects, cultural or attitudinal issues. Refer to *'Assessing Readiness for Change'* at the end of this Section for more information to assist you with identifying potential barriers to program implementation.
5. Identify the person(s) willing and able to carry out the strategies.
6. Identify strategies and resources that will be needed to implement, evaluate, and maintain strategies/solutions. Consider budget, staff, sample documents & templates, external assistance etc. Refer to ***Sections 7 and 8*** for more information about implementing and evaluating the WPV program.
7. Draft a proposed timeline for implementation and completion; how the strategies/solutions will be monitored, evaluated and revised as needed.

Quick Tip: When identifying barriers to developing and implementation WPV solutions, use the diverse expertise within your committee and have members share their experience and lessons learned related to implementation and maintenance of other employee and patient safety initiatives or programs.

The above activities provide the framework for your draft WPV program plan that you will present to senior leadership (refer to ***Section 4***).

Solicit assistance from appropriate stakeholders on your team to address issues e.g., from security, human resources, safety, nursing and leadership, to determine and implement solution(s).

You will likely find that 1 or 2 specific strategies/solutions identified may address several individual program elements.

Don't wait until the WPV program plan is approved by leadership to address serious WPV related issues.

It may be necessary to continue development of some solutions and/or implementation strategies, resources required and timelines as the committee finalizes the draft WPV program plan and starts program implementation. More research may be needed related to feasibility of some solutions, and stakeholder feedback during program implementation may require you to adapt plans and timelines etc.

A sample project management form is provided in **Tool 3i.**

Assessing Readiness for Change

As the WPV committee is prioritizing needs and developing solutions, they should evaluate the organization's readiness for change i.e., to implement and sustain a WPV program. Solicit input as needed from non-committee members who are or will be impacted by the WPV program including senior leaders.

Ensuring readiness prior to beginning the finalization and implementation of the WPV program plan, eliminates potential time and resources wasted, and further identifies gaps in the safety culture and organizational structure that may need to be addressed.

The following is a summary of key questions to consider when assessing readiness for change (Adapted from various AHRQ Toolkits – refer to References at the end of this Section).

Quick Tip: ***Appendix 3.1 – Facilitators and Barriers: Questions to Guide You*** in the Registered Nurses' Association of Ontario (RNAO) guide to **Implementation of Best Practice Guidelines (2nd ed.),** provides a good review of how to address barriers to change when implementing new programs and practices.

http://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

The WPV committee should have addressed some of the questions below as they completed the program planning activities described in ***Sections 2 and 3***.

- Does senior administrative leadership support this initiative?
- Who will take ownership of this effort?
- What is your current state, what do you want to accomplish, and why?
- Which WPV prevention and management practices do you want to use?
- What resources are needed?
- How will you measure WPV program practices implemented and program management strategies?
- How do you sustain an effective WPV program?
- What are the challenges and opportunities that you are facing?

- Is the organization ready for change?
- How will you prepare the organization for and manage change?
- Does your organization have the right infrastructure to begin the intended change process?
- Does your organization have the right culture to embrace the work?
- What if you are not ready and unable to implement some of the program elements recommended?

When reviewing the above questions consider how your organization has implemented new patient and employee safety programs and associated best practices in the past.

Determine as a team which element of a WPV program are most important for success, and which elements may be harder to implement at the current time and in the future, due to resource or cultural related challenges. This will increase the likelihood of approval of the WPV program plan by senior leadership and successful implementation of program elements.

Quick Tip: The Agency for Health Care Research and Quality Indicators (AHRQ) have published several *toolkits* related to patient safety initiatives that provide good information about how to assess and health care organization's culture and readiness for change that can be adapted for use with any patient or employee safety program or initiative. Refer to 'Reference' for links to AHRQ resources and guides from other organizations that provide further information about approached to project management in health care. www.ahrq.org

The Institute for Healthcare Improvement (IHI) have published a *Quality Improvement Essentials Toolkit* that contains many freely available tools to facilitate project management http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx

The American College of Healthcare Executives and Institute for Healthcare Improvement also provide information on Leading a Culture of Safety: A Blueprint for Success. **New 2020** http://www.ihi.org/resources/Pages/Publications/Leading-a-Culture-of-Safety-A-Blueprint-for-Success.aspx

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Developing the WPV Program Plan

Step 9

Develop communications plan, education and training plan, and zero tolerance WPV policy

Section 3 described how to identify and assess hazards and risks for WPV in your facility, and a process for determining solutions to address hazards and identify WPV program elements that require implementation.

This Section (4) discusses how to finalize your WPV program plan by developing the plans and policy that provide a critical foundation for your WPV program efforts.

- Developing a Communications plan provides you with a key tool that will help to facilitate culture change (e.g., required changes in practices and procedures), and guide efforts to implement and sustain the program.
- Developing an education and training plan at this stage allows you to determine resources (budget, personnel etc.) needed, that you will request from leadership to implement an ongoing employee/stakeholder WPV training program.
- Developing or updating an existing zero tolerance WPV policy allows the organization to clearly state to all employees that prevention of WPV is paramount for employee and patient/visitor safety. It defines how the organization will respond to WPV in any form and roles and responsibilities of employees in the prevention and control of WPV.

Tools that support content in this Section

4a. Communications plan

4b. WPV policy sample that includes a summary of program elements

4c. WPV Program plan summary template

Refer to Section 6 for the Education and Training Plan

Communications Plan

Why develop a Communications Plan for a WPV program?

Effective ongoing communications or social marketing to all employees in a health care facility is essential to facilitate and manage change within an organization.

There are many people who are interested in and affected by the WPV program and outcomes.

WPV program management is as much about ***organizational culture change*** as it is about implementing and/or enhancing violence prevention strategies. Therefore, to aid in facilitation of culture (or behavior) change, it is essential that all stakeholders of the program are informed of their role within the program, and about program progress and accomplishments. Developing and implementing a communications or social marketing plan helps to achieve that goal.

The message should be tailored to fit the audience. Examples of success stories related to WPV efforts within the organization, on a unit, and the progress of the WPV Committee, should be disseminated regularly. Positive reinforcement of good work practices and behaviors is encouraged. Recognition is given to employees that develop solutions to improve employee and patient safety. Communication efforts to groups outside of the hospital or organization are also important and can strengthen the relationship between the facility and local community.

Developing a ***communications plan*** provides the WPV project coordinator and the committee with a road map for getting your message to your audience or stakeholders i.e., those affected by the WPV program plan and related activities. Sharing well developed and meaningful information with managers and employees about what is happening within their departments and units, as well as across the organization, helps them align with and participate in achieving WPV program goals.

A WPV program communications plan:

- Gives you a structure to determine whom you need to reach and how
- Helps to ensure that all stakeholder groups are identified and included in the plan
- Helps to determine what each target group needs to know
- Makes your communication efforts more efficient, effective, and lasting

Creating the plan at this stage of program planning, facilitates project management during the implementation and management stages of the WPV program. The plan also provides a

foundation for developing the WPV program education and training plan.

As with management of a WPV program, the communications plan and your communication efforts should be evaluated periodically and revised as needed.

Developing the Communications Plan

Tool 4a, the sample WPV Program Communication Plan can be used as a template when developing your communications plan.

1. **As a committee, determine how is information is communicated within your facility currently and if there are methods of communication that are more effective than others?** Does effectiveness vary by stakeholder group e.g., senior leadership vs. direct care staff? All employees may have access to work email but are some stakeholder groups (or target audience) more likely to read their email and in a timely manner than others? This would be important to consider before implementing a broad email-based communication effort.

   It can be helpful to identify methods of communication as listed in ***Table 4.1.***

2. **Determine what the objectives of communications related activities are.** What are the results you want to achieve through your communications about the program, program goals and WPV in general?

3. **Identify your audience** i.e., the WPV program stakeholders *(see **Table 4.2**):* All employee groups, contractors, students, patients, families, other visitors, volunteers, community agencies, etc., who may be impacted by the WPV program policies and procedures. You should have identified your primary stakeholders when building the WPV committee, however, additional stakeholders may be identified as a result of hazard assessment activities.

4. **What do you want to communicate (the message)?**

   a. What do they need to know? For example:

      i. The scope of WPV in health care and current trends in preventing WPV.

      ii. Why a WPV program is being developed or enhanced at your facility (i.e., the rationale for why a change is needed). This may include a summary of WPV incident and injury data, the staff survey, and the information gathered from the analysis and assessment of the physical environment.

iii. The goal of the WPV program or vision of future outcomes after the initiative is completed.

iv. An overview of the WPV program plan and activities that is, what, how, and when will the program will be implemented and sustained.

v. Where they can get more information, assistance as needed, and provide feedback about the program activities during and after the program is implemented etc.

vi. Updates on the status of program implementation and management, including success stories.

Methods of communication		
On a unit/dept.	**Within the hospital**	**External**
▪ Face to face ▪ Staff meetings ▪ Shift change handoff ▪ Safety huddles ▪ Email ▪ Intranet ▪ Notice boards/posters in staff restrooms ▪ FAQs ▪ Executive rounding	▪ Employee safety and/or Environment of Care Committee ▪ WPV resource/training intranet page ▪ Newsletters ▪ Hallway information boards ▪ Director/manager meetings ▪ Executive rounding	▪ Community newsletter ▪ Local media when program established ▪ School of nursing and/or other disciplines

Table 4.1.

b. How will the WPV program and associated practices and procedures be meaningful to each stakeholder group or audience?

i. The stakeholder's role in the initiative - what specific behaviors and activities are expected during and after implementation of the WPV program (including the organization's expectations related to behaviors and activities) in the initiative.

ii. The impact of the WPV program and related procedures on the day-to-day activities of managers and employees (what will they have to do?), and job functions, if applicable.

WPV Stakeholder Groups - Example	
▪ CEO and Administration ▪ Committee or group that the WPV committee report to (if applicable) e.g. employee safety committee ▪ WPV Program Committee and ▪ Program Coordinator ▪ Directors and Unit Managers - all ▪ Unit RNs and CNAs including Float Pool Nurses & CNAs ▪ Other direct care staff such as MAs in outpatient clinics etc., (if applicable) ▪ Home Health staff (if applicable) ▪ Physicians and other medical providers e.g. NPs, PAs etc. ▪ Contract staff e.g. traveling nurses; physician; support services; building contractors etc. ▪ Other staff groups e.g., rehab/therapy; imaging staff, respiratory therapy; lab, transportation, etc., who may have direct contact with patients and perform care related tasks	▪ Support service staff – environmental services, maintenance, food services, information technology, biomed, administrative personnel, etc. ▪ Security (if applicable) ▪ Clinical Education/Professional development staff ▪ Union/Labor representatives ▪ Patient population and families (community) ▪ Nursing Students (and/or other student groups) ▪ Emergency Medical Services ▪ Volunteers ▪ Law Enforcement ▪ External behavioral health treatment facilities or clinics (not operated by this hospital) in the community, other community agencies

Table 4.2

iii. Identify 'what's in it for them' or how will it benefit them. Will the benefits of the program and how it will impact the stakeholder outweigh the costs?

Consider that some benefits of the WPV program may not be tangible or have a direct impact on some groups of individuals. For example, loss of comfortable or preferred behaviors, time to learn new practices, or the emotional investment

inherent in learning and behavior change. When the costs outweigh the perceived benefits, unacceptable trade-offs can prevent new practice. Planning attractive and motivating exchanges that are customized to each stakeholder group can assist to solicit stakeholder 'buy-in' and understanding that the benefits outweigh the cost of changes required that impact practice or work procedures etc. (RNAO, 2012).

5. The best method(s) to communicate to each customer group

a. Identify direct and indirect methods of communications using multiple media as appropriate. Customize the content to each stakeholder group as needed.

b. Consider developing a theme or brand for the program with a logo and 'eye-catching' promotions if feasible to help distinguish the program from other safety efforts and promote communication. When creating your message, consider content, mood, language, and design.

c. Use multiple media to disseminated information than a single delivery method e.g., showing positive program trends on visibly displayed large wall charts together with conducting brief updates at staff meetings and program information in newsletters.

Using multiple methods to deliver information about WPV program activities and processes etc., will help facilitate engagement in the program, and help ensure that employees on all shifts will receive the information you are sharing.

6. When does the communication need to be conducted/sent and how often?

For example, at the beginning of WPV initiative, then frequently and consistently throughout the entire implementation process and then periodically after implementation in an ongoing basis.

Frequency of communication depends on progress of program implementation and questions or concerns of stakeholders. The important thing is to maintain regular two-way dialogue with all stakeholders about the WPV program and related activities especially those that impact them directly to ensure all stakeholder questions are addressed.

7. Who will develop the communication?

a. Do you need assistance from other departments e.g. marketing or communications department?

8. **Who will conduct and distribute the communications?**

    a. Do you need assistance from other departments e.g. education, information technology (IT) etc.

    A study by Prosci Inc., a company that conducts periodic research on change management, examined the success factors associated with change initiatives in 288 organizations located in 51 countries. It was found that employees perceived the most effective sources of communication about change were as follows:

    i. Their immediate supervisor (most effective)

    ii. The organization's President/CEO

    iii. Other organizational executives (i.e., COO, CNO, CFO)

    iv. Senior managers (i.e., Vice-Presidents, Directors)

    v. Department heads and charge nurses

    vi. Change implementation team member (i.e., change team member)

    vii. Change implementation team leader (i.e., change team leader) (least effective)

    Therefore, communicating and training leaders and managers about WPV and the program plan etc., should occur before other employee stakeholder groups so that they understand why the WPV program is necessary, and the related benefits, and their role in the implementation of the program. This assists to enlist leader and manager support for the change during the employee rollout, including delivering communications to their employees.

9. **Is follow up needed to review if the communication/message and delivery method was effective** i.e., were your objectives achieved? If 'yes' how and who will perform this task?

    Implementation of the WPV Communications Plan will be discussed in ***Section 7***

Education and Training Plan

Why develop an Education and Training Plan for the WPV program?

Education and training are critical elements of a successful WPV program. The goal of education in a WPV program is to facilitate employee understanding of the scope, and principles of WPV prevention as related to their work environment and the organization as a whole. Education reinforces that violence is not an acceptable part of health care work and the scope of the organization's WPV policy.

Hospitals participating in the WSI project learned that it is important to follow-up communication efforts and don't assume that staff on all shifts are aware of the WPV program and implementation progress. For example, at one facility information about WPV program planning efforts was disseminated through the staff survey process, newsletters, email, and department staff meetings.

However, it was found that not all staff who worked nightshifts and weekends in the Emergency department (ED) were aware of the WPV program goals and plans etc. Some staff had been away on vacation or personal leave, or away from work due to occupational injury, or were just were not aware of the communications sent.

To address this issue, one of the ED staff nurses adapted information from a PowerPoint presentation about the WPV program that the facility WPV committee had shared with other staff groups. She then shared the information with her colleagues in the ED during staff meetings and huddles and had her colleagues disseminated the information to their coworkers on each shift etc.

Training provides employees with the skills to identify and report potential hazards and risks for WPV, and to learn how to protect themselves, their coworkers, and their patients.

Overall, an ongoing WPV education and training program engages employees in development, implementation and sustainability of the WPV program.

Developing a draft education and training plan allows you to identify resources (budget, personnel, time for development of training materials, and scheduling of training, etc.), that will be needed to implement an ongoing WPV training program. Developing a plan allows you to identify what training resources are available, and where there are gaps in resources in needed. For example, can you develop and conduct WPV training required for all stakeholder groups (as

identified in your Communications Plan) using internal resources, or do you need find an external provider etc.?

After developing your plan, you can draft an education and training budget that will be presented to leadership as part of the WPV program proposal.

Development and implementation of an education and training program plan for a WPV Program is discussed in detail in ***Section 6*** of this toolkit. **Tool 6a**, provides a sample education and training program plan together with links to training materials that are available in the public domain.

Workplace Violence Policy

Purpose

The foundation of an effective WPV program is the creation and implementation of a well written zero-tolerance WPV policy and supporting procedures, that is actively enforced, followed, and maintained.

A WPV policy should:

- Provide a clear statement of the organization's position on workplace violence i.e., violence in any form is not acceptable in the workplace and that all threats or incidents of violence will be taken seriously.
- Clearly define the scope of WPV i.e., acts of physical violence, harassment, intimidation, and other disruptive behavior.
- Explicitly state the consequences of violation of the WPV policy by employees i.e., the consequences of making threats or committing acts of violence in the workplace.
- Inform patients, visitors, and others of their responsibilities and the conduct that is expected of them.
- Encourage employees to report incidents or related concerns and explain the reporting process.
- Demonstrate senior management's commitment to dealing with potential violence, response to reported threats or violent events, and providing constructive support procedures after the event, without fear of reprisal for reporting incidents.

- Reference specific WPV regulations e.g., Oregon WPV law, ORS 654.412 to 654.423 - Safety of Health Care Employees or Washington WPV law Chapter 49.19 RCW-SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070.
- Instruct all employees that they are responsible for complying with the policy.

The policy also provides an opportunity to communicate to staff that employee safety and security are as important as patient safety.

Many professional health care organizations and associations such as the American Nurses Association, the Association of Nurse Executives and the Emergency Nurses Association promote the development of a "Zero Tolerance" WPV policy**.**

Instituting a zero-tolerance workplace violence policy sends a clear message to everyone working in the organization, that all threats or incidents of violence will be taken seriously, and the consequences of WPV.

However, when determining if, and how your organization will use the term "zero tolerance" in your WPV policy, consider the language that is used to clarify the consequences or penalties of violating the WPV policy and specific violence related behaviors. For example, the consequence for violating the policy will lead to penalties "up to and including termination". This allows for flexibility in dealing with a variety of violence incidents and circumstances. In addition, the appearance of inflexibility can discourage employees from reporting incidents because they do not want to get their coworker fired in the case of lateral violence or bullying i.e., they just want the behavior stopped. The appearance of inflexibility also may discourage early intervention in potentially violent situations involving patients who are unintentionally verbally or physically violent towards employees e.g., patients with dementia or severe brain injury (FBI 2004, Farrell, 2014).

Lastly, as discussed in ***Section 1 'Understanding WPV',*** you cannot always prevent violent incidents, but you can reduce the risk by planning and being prepared to act swiftly to deal with threats, intimidation, and other disruptive behavior at an early stage.

Consult with your organization's human resources and legal departments when drafting your WPV policy and reviewing potential legal implications.

Developing the WPV Policy

- Use committee resources to gather existing policies and procedures related to WPV and facility/environmental security. You may find that there are policies that overlap or are related and reside in different departments such as Human Resources, Quality/Risk Management, Security and Employee Health.

WPV policies can vary greatly in scope and content. **Tool 4b,** provides an example of a WPV policy template chosen and developed by some of the hospitals in the WSI project.

Other examples are provided in the ***References*** at the end of this Section.

If you have policies that overlap or are redundant, consider combining, simplifying them, and storing them in a location that is easily accessible for employees.

- Determine the structure of the policy. For example, do you want to develop a brief and simple policy statement and provide information about related procedures in supporting operating manuals, or keep program and procedural details within the policy document?

- Use a policy template that is approved by the organization if applicable. As you develop your draft policy determine what information will be included in the policy appendices, or referred to via cross reference (e.g., via intranet link) to another policy document that exists.

- Other written procedures that should be reviewed and enhanced, or developed to address WPV, may have been identified during the *Gap Analysis* review described in ***Section 3*** of this toolkit. For example:

  i. Procedures specific to clinical areas such as critical care, emergency room, behavioral health, mother and baby, outpatient clinics, transportation and home health

  ii. Procedures for specific patient populations such as behavioral health patients; patients in withdrawal; and patients with dementia/Alzheimer's

  iii. Procedures to address for violence perpetrated by visitors/family

A list of other related safety and security policies and procedures that should be reviewed can be found in **Tool 3a - the Gap Analysis checklist.**

As you review and develop your WPV policy, ensure that procedures for managing aggressive behavior/violence meet current law and regulations such as, OAR 259-060-0130 'use of force' rules and CMS, Joint Commission and DNV rules for Restraint and Seclusion of patients.

Elements that can be included in a WPV policy are listed in ***Table 4.3.***

Example of the elements that can be included in a WPV policy	
▪ Objectives or Purpose ▪ Policy Statement about intent of the violence prevention program and organizations' executive management commitment to support the program etc. ▪ Scope of the policy ▪ Definitions of violence (well defined with examples) ▪ Reference to state law or regulation for addressing WPV in health care and other applicable regulations such as those for security personnel if applicable. ▪ Non-retaliation policy ▪ Information about violence in health care e.g., the prevalence of violence, where violence can occur, and the perpetrator (i.e., patients, visitors etc., types of violence) ▪ Roles and responsibilities of specific groups within the program e.g., executives and management, clinical and non-clinical employees, violence prevention committee, threat assessment and response team, security personnel, etc. ▪ Risk assessment protocols*	▪ Investigation considerations ▪ Post incident review including protection of employee of health care employer after assault by patient* ▪ Employee support resources* ▪ Education plan* ▪ Program evaluation ▪ Record keeping/data analysis* ▪ Policy review timeline ▪ Appendices, checklists, tools etc. This may include detailed information about: – Code silver and code gray protocols – Criteria for restraint/seclusion application – Other security related policies as applicable – Links to other related information/resources for employees e.g., state WPV laws; employee assistance programs; incident reporting access; WPV program webpage. **Program elements that must be addressed per Oregon ORS 654.412 to 654.423 Safety of Health Care Employees or Washington state*

Example of the elements that can be included in a WPV policy	
▪ A summary of technology/processes used or hazard control (e.g., personal alarms, lock down ability etc.) * ▪ Reporting and response procedures including code grey, code silver, use of force etc.*	*Chapter 49.19 RCW-SAFETY—HEALTH CARE SETTINGS RCW 49.19.005 to 49.19.070.*

Table 4.3

The WPV policy is typically reviewed with employees and implemented at the start of program.

Implementation and evaluation of the policy and associated procedures will be discussed further in ***Sections 7 and 8.***

Zero-Tolerance Workplace Violence Policies New 2020

WPV policies that state that there is zero tolerance of violence within a health care organization can create conflict when balancing the 'duty to care' for patients versus duty to create a safe work environment for employees. (Morphet et al., ,2018; Copeland & Henry, 2017)
It may be feasible to enforce a 'zero tolerance' policy for violence that is perpetrated by employees, contractors and visitors, but it is challenging to do so when the perpetrator is the patient and a hospital that receives federal assistance, maintains charitable nonprofit tax status, or participates in Medicare, has a duty to provide emergency care under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) and other applicable state laws.

Thus, it can be challenging for hospitals to meet both the patient safety focus of the Centers for Medicare & Medicaid Services (CMS) and the worker safety focus of Occupational Safety and Health Administration (OSHA) when addressing WPV.

However, in August 2019 in an effort to identify and resolve contradictory regulatory expectations of hospitals created by the agencies' differing perspectives, CMS and Federal OSHA issued a report that was mandated by Congress on regulatory standards governing workplace violence in health care settings.

Zero-Tolerance Workplace Violence Policies *continued*

The Department of Health and Human Services, Centers for Medicare & Medicaid. '*Senate Appropriations Committee Report to Congress on: Safety in Healthcare Facilities*' report reiterates the agencies' perspectives on the protection of patients and health care workers from WPV. (MHA Today, August 23, 2019)

In summary, CMS states in the report that 'In order to provide care in a safe setting, hospitals should identify patients at risk for intentional harm to self or others, identify environmental safety risks for such patients, and provide education and training for staff and volunteers.' And 'CMS believes that, in general, healthcare workers should have a right to provide care in a safe setting. CMS health and safety requirements do not preclude healthcare workers from taking appropriate action to protect themselves from workplace violence'.

The full report can be accessed from the Missouri Hospital Association https://www.mhanet.com/mhaimages/mhatodaylinks/CMS.OSHA.Blunt_hospital.report_8.2019.pdf

Although WPV zero-tolerance policies are widely advocated by professional organizations and in discussed in the literature, there is little evidence to show that zero tolerance policies alone reduce the incidence of violence in health care.

Therefore, when developing WPV policy, careful consideration should be given to the balance between protecting staff and quality of care and following CMS and OSHA requirements to protect patients and staff respectively.

Copeland and Henry suggest it is also 'worthwhile to reevaluate what is meant by the term "zero tolerance." Especially for staff who work with patients with delirium, dementia, traumatic brain injury, psychotic disorders, or drug/alcohol intoxication, where exposure to violence is not beyond the realm of possibility; in fact, it occurs and it is tolerated, perhaps because it is understandable if not expected.

Step 10

Complete the draft WPV program plan

By this stage of program development, you have already identified and prioritized hazards and risks for WPV ***(Step 7);*** drafted solutions to address and control hazards; and determined potential barriers to implementing the program plan and specific solutions ***(Step 8).***

If you have not done so already you should have organized the above information in a project planning format (**Tool 3i**, provides a sample format).

The communications, education and training plans, and the WPV policy, should be kept with the plan and integrated as needed to guide program implementation.

The WPV committee should then determine how the project plan and draft zero tolerance WPV policy will be communicated to senior leadership for approval. Use approved protocols that already exist in your organization for presenting and gaining project approval by senior leaders.

Tool 4c provides a sample of how the WPV program can be summarized for presentation to leadership. **Tool 4b** - the sample WPV policy with program elements could also be adapted for this purpose. Your project charter (if developed) could also be expanded to provide a summary of the overall program etc. **(Tool 2f)**

Some recommendations to address hazards may need to be supported by formal cost justification and demonstration of return on investment e.g., hiring additional security personnel, or installing comprehensive security surveillance systems or structural changes to the physical environment. Factors to consider when identifying benefits versus costs of solutions are shown in ***Table 4.4.***

It is worth reminding leadership that because WPV is vastly underreported in health care, the full extent of the problem and its associated costs at your organization cannot likely be fully calculated.

If you are presenting your plan during a regularly scheduled leadership meeting or during a stand-alone meeting, make sure to schedule your presentation well in advance and request enough time for the presentation and discussion etc., to avoid delay of program implementation.

<table>
<tr><th colspan="2">Factors to consider when demonstrating the financial value of WPV related solutions
Benefits vs. Costs</th></tr>
<tr><td>Financial Benefits of Solution(s) i.e., Reduced:
▪ Direct costs of workplace violence related injuries e.g., workers compensation costs
▪ Indirect injury costs e.g., associated with employee temporary replacement, incident investigation and management etc.
▪ Operational Losses:
o Staff turnover and associated costs
o Decreased productivity associated with burnout and job dissatisfaction
o Costs related to short and/or long-term psychological impact post-traumatic stress disorder(PTSD).
o Impact on patient safety associated with error, and omission or delay in care, due to caregiver fatigue, presenteeism, injury, and stress.
o Negative impact on quality of service/care provide leading to decreased patient satisfaction.
o Health care worker fatigue contributing to other occupational injuries such as, accidents from slips, trips and falls due inattentiveness, and/or musculoskeletal disorders.
o Regulatory & Legal consequences e.g. citations and fines by Oregon OSHA.
o Other - include increased security needs in terms of equipment and personnel, litigation, increased insurance costs, and property damage.
Refer to Tool 2c for more information on calculating costs of WPV incidents and Tool 3h for determining effectiveness of a solution to eliminate or reduce the risk factors versus cost effectiveness of a solution.</td><td>Cost of the Program & Solution(s)
▪ Direct Equipment costs
▪ Facility Design - Workplace adaptations and upgrades/equipment installation
▪ Structural expense/Storage
▪ Maintenance (preventative and as needed)
▪ Cost of replacement parts for equipment due to breakage, loss or theft, or ‘life’ of equipment and/or components
▪ Cost of borrowing money if financed
▪ Employee training time, supplies, staff backfill, etc. (Refer to your Education and Training plan)
▪ Initial
▪ Periodic
▪ As needed
▪ Program administration</td></tr>
</table>

Table 4.4

Step 11

Obtain approval of the WPV plan and draft policy from senior leadership

Formally presenting the WPV plan and policy to senior leadership for approval (or sign-off) provides leadership an opportunity to ask questions, clarify issues, and be fully prepared and informed about their role in implementation of the WPV program. Presenting the draft plan to leadership allows the WPV committee to adapt or adjust the plan as needed based on additional input.

A formal presentation may also assist to increase commitment and leadership buy-in and enables a means for them to actively demonstrate their commitment to implementing the WPV program and preventing WPV.

Leadership should be familiar with the WPV initiative if they have been engaged as described in ***Section 2, Step 3***, and have received updates about development of the WPV program plan and related activities from your program champion.

Ideally, any concerns from leadership about proposed project activities related to resources and timeline for implementation, will have been passed along to the WPV committee and considered when developing the draft WPV program.

Review the ***'Tips for presenting to Leadership'*** that are described in ***Section 2*** of this toolkit when planning your presentation.

Your presentation should enable leadership to have a clear understanding of the following:

- A summary of why the WPV program is needed and what leadership agreed to (in ***Step 3*** Enlist support of senior management to develop or enhance a WPV program plan) and the goal of the meeting.
- The program planning steps completed to date

Quick Tip

The Institute for Healthcare Improvement / National Patient Safety Foundation offers a free toolkit to guide collaboration among health professionals and financial leaders to demonstrate the value and return on investment for safer, quality care.

The '**Optimizing a Business Case for Safe Health Care: An Integrated Approach to Safety and Finance'** toolkit, can assist you develop business case for employee and patient safety initiatives and can be accessed at http://www.ihi.org/resources/Pages/Tools/Business-Case-for-Safe-Health-Care.aspx

- The scope of the program
- Goals (short and long term) of the WPV program and likely outcomes
- Recommendations (i.e., what program activities need to be implemented and related rationale)
- How recommendations will be implemented including resources needed and cost justification as applicable
- Any potential barriers that have been identified and how they will be addressed
- Roles and responsibilities
- How the program will be managed and sustained, and outcomes and process evaluated
- Proposed timeline

Provide the leadership group with your program summary that you developed in ***Step 10*** and have project details (electronic or printed) available upon request.

Step 12

Finalize the WPV program plan and policy

Based on recommendations received from senior leadership you should be ready to finalize the WPV program plan and zero tolerance WPV policy and communicate them to all employees as detailed in your Communications Plan as you start to implement the program.

References and Resources Related to this Section – Articles

Implementation of Best Practice Guidelines (2nd ed.). (2012). Toolkit. Registered Nurses' Association of Ontario (RNAO). Toronto, ON. http://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

Benchmarking Report: Best Practices in Change Management 2003 and **Prosci's 2018 Benchmarking Report: Best Practices in Change Management - Highlights and Trends, April 2018.** Prosci Inc. CO, USA https://www.prosci.com/ **New 2020**

Do zero tolerance policies deskill nurses? (2014). Farrell G.A. & Salmon P . Nursing Times. 110(6):14-16.

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Developing Workplace Violence and Harassment Policies and Programs: A Toolbox (2010). Workplace violence prevention series. Occupational Health and Safety Council of Ontario (OHSCO). http://www.wsps.ca/Information-Resources/Topics/Violence-Harassment.aspx

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Preventing and Managing Violence in the Workplace (2009). Registered Nurses Association Ontario, Canada (RNAO). http://rnao.ca/sites/rnao-ca/files/Preventing_and_Managing_Violence_in_the_Workplace.pdf

Prevention and Management Violence and Aggression in Health Services (2017 2nd edition). Worksafe Victoria, Australia. https://content.api.worksafe.vic.gov.au/sites/default/files/2018-06/ISBN-Prevention-and-management-of-violence-and-aggression-health-services-2017-06.pdf

Violence in HealthCare (2017). ECRI Institute General information about WPV. Includes links to policies for members only. https://www.ecri.org/components/HRC/Pages/SafSec3.aspx

Workplace Violence Prevention: A Comprehensive Guide for Employers and Employees (2010). Minnesota Department of Labor and Industry https://www.dli.mn.gov/sites/default/files/pdf/WorkplaceViolencePreventionGuide.pdf

Workplace Violence Prevention Resources. California Hospital Association http://www.calhospital.org/resource/workplace-violence-prevention-resources

Workplace Violence Prevention Guidelines and Program for Health Care, Long Term Care and Social Services Workers (2012). North Carolina Department of Labor, Occupational Safety and Health Division
https://www.labor.nc.gov/documents/ig-051-workplace-violence-prevention-guidelines-and-program-health-care-long-term-care-and

Minnesota Department of Health

Workplace Violence Toolkit

https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

Examples of WPV policy

- Metro Compact - Violence Prevention Toolkit (PDF) - *Management of Violence in the Healthcare/Workplace Setting Template*
- Cloquet Hospital - Violence Prevention Policy (PDF)
- Essentia Health - Violence Prevention Policy (PDF)
- HealthEast - Workplace Violence Policy (PDF)
- High Pointe Surgery Center - Violence Prevention Policy (PDF)
- Mille Lacs - Violence Prevention Policy (PDF)
- Zero Tolerance Policy (PDF)

Policy – Specific Topics

- HealthEast - Code Silver Policy (PDF)
- Parkwest Medical Center - Staff Alert Violent Behavior (PDF)
- Policy - Support for Staff Involved in Violent Incidents (PDF)
- St. Cloud - Code Green Policy (PDF)
- St. Cloud - Metal Detection Policy (PDF)
- St. Cloud - Weapons Policy (PDF)
- Essentia Health - Weapons Policy (PDF)

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Step 8 (continued from Section 3)

Hazard Control and Prevention

Introduction

The overall approach to controlling and preventing workplace violence in health care is described in ***Section 1.***

Solutions and strategies reported in research literature and by health care organizations including, those in the WSI project, demonstrate that implementation strategies must be carefully planned and used in combination.

A combination of engineering and administrative controls is primarily used within a WPV program to control and prevent the risk of violence:

- ***Engineering controls*** *such as:*
  - Physical and environmental safety and security measures e.g., controlled access to buildings and patient care units, weapons screening, monitored surveillance systems and panic/duress alarms or systems
  - Design of the physical environment to
    - Improve visibility
    - Provide barrier protection for staff, and allow for quick access to assistance and egress
    - Reduce risk of furniture and equipment being used as weapons
    - Create a less stressful environment for patients and visitors

Tools that support content in this Section

5a. WPV Risk assessment tool

5b. WPV Incident report

5c. Management of Difficult Behavior Flow Chart

5d. Code Grey debrief form

5e. Example of hospital signage about WPV

5f. Job description contract security officer

5g. Behavioral Health Rapid Response Teams (BHRRTs). A summary of best practices

5h. An overview of de-escalation approaches to prevent and manage WPV

- **Administrative controls** such as:
    - Identifying (using a validated risk assessment tool), monitoring and managing patients/visitors at high risk for violence using interventions that are customized to address the underlying cause of the agitation or aggression and stage of violence being exhibited.
    - Violence reporting including user friendly, well communicated processes to get help during an WPV incident and when reporting/documenting incidents, and communication, reporting, and documentation protocols that inform all staff who will be in contact with a patient who is identified at risk for violence e.g., department transfer huddles; shift change huddles; flagging the patient's health record, etc.
    - Incident response protocols including use of behavioral health rapid response teams, emergency medication kit for violence, the use of safe assessment rooms, clearly defined protocls for use of restraint and seclusion as a last resort, security personnel and the use of force.
    - Post incident management and incident investigation
    - Policy and procedures for employee groups who are at higher risk for exposure to violence e.g., employees working alone or in secure areas
    - Policy and procedures to address organizational risk factors for WPV such as, improve staffing levels during busy periods to reduce crowding and wait times, provide adequate security and mental health personnel on site, etc.
    - Proactive safety and security audits and security rounding
    - Education and training for employees including protective behavior training (de-escalation)

Well written WPV policy and supporting procedures, that is actively enforced, followed, and maintained, provides the foundation and assists to facilitate the effectiveness of solutions to control and prevent WPV.

What is the Evidence Based for WPV Programs and Interventions in Health Care? New 2020

It is important to note that there is no clear evidence that defines or supports a specific intervention or combination of interventions, that will reduce the incidence and risk of WPV in hospitals or health care environments in general.

The lack of high-quality studies may be because the causes of WPV are multifactorial and varying in nature, thus making it harder to conduct well controlled research studies over a long period of time. Additionally, implementation of comprehensive WPV programs in health care is a relatively new initiative.

To date, research about the impact of multi-component WPV programs on reducing the risk and incidence of violence in health care are mixed (Morphet et.al., 2018)

However, despite the lack of evidence to support effectiveness of WPV programs, it is widely agreed by OSHA, the Joint Commission, experts in the field of WPV and other related entities, that the implementation of a comprehensive WPV prevention program is key to preventing and managing WPV. Despite the lack of research, there are numerous hospitals who have developed best practices that are successfully used to manage WPV and reduce risk to staff and patients. Examples of these are included throughout this toolkit.

Overall, it appears that the best approach to addressing all types of WPV in health care is using a customized multifaceted program approach that includes promoting a culture of safety for both patients and employees together with ongoing risk assessment, evaluation, and continuous improvement of interventions.

The following is a summary of the evidence published to date related to various interventions used in WPV programs. This information is mostly based on two large scoping reviews of peer reviewed literature by Raveel & Schoenmakers, 2019 and Morphet, et. al, 2018, and other references as noted.

Evidence to support WPV Training programs is discussed in Section 6 and WPV Polices in Section 4.

If specific interventions are *not* mentioned below e.g. panic alarms, it's because there is currently very little or no published evidence to know if they are effective or reducing the incidence or risk of WPV.

Patient assessment tools to predict the immediate risk of violence
(Tool 5a WPV Risk assessment tool)

Validated risk assessment tools that are designed to identify the risk of patient violence based on a set of observed behaviors, are a good predictor for violence in the *short term*, thus, improving patient management and reduce the incidence and severity of violence.

Two risk assessment tools with good validity and sensitivity for early identification of aggressive behavior are STAMP and the Brøset Violence Checklist (BVC). (Calow et al, 2016)

To be effective these tools must be used correctly on a consistent basis so that patients are identified at risk for violence accurately and resource allocation for response management is used appropriately.

What is the Evidence Base for WPV Programs and Interventions in Health Care continued?

Clearly communicated and practiced standardized violence response protocols are also key to success of using violence risk assessment tool.

Flagging Patient Records for Risk of Violence

A 90% reduction in assaults by high-risk patients was reported by the Veterans Health Care Administration when flagging a high-risk patient's chart was used to communicate risk of violence.

Behavioral Health Rapid Response Teams (Tool 5g)

These teams assist to intervene as early as possible when a patient's agitation is escalating and show promise in reducing the severity of the incident or situation. When implemented using evidence-based models, they reduced security calls, restraint use, and staff injuries while moderately improving staff knowledge and self-efficacy. The presence of the team alone is reported to be enough to de-escalate the situation in some cases. (Choi et. al, 2019)

Safe Assessment Rooms (SARs)

There is some evidence to support that having a space or area where patients with behavioral disturbance are assessed and de-escalated in the Emergency Room can improve patient management including success of de-escalation and create a safer environment for consumers and staff.

Crisis Stabilization Centers

This relative new concept offers a way to reduce the number of patients experiencing a behavioral health crisis in Hospital Emergency Departments. Saxon et al, report that Crisis Stabilization Centers are effective at providing suicide prevention services, addressing behavioral health treatment, diverting individuals from entering a higher level of care and addressing the distress experienced by individuals in a behavioral health crisis. Studies also show that the cost of Crisis Stabilization Centers is significantly less than psychiatric inpatient units and satisfaction among clients is greater. These centers may also be adjacent to an Emergency Departments. (Saxon et al, 2018)

Design of the Physical Environment

There is some evidence that: (1) improving visibility so that staff can see people entering and moving around the facility e.g. the use of closed-circuit video surveillance systems, adequate lighting, and treatment spaces and offices with windows. Constant monitoring of surveillance footage enables rapid identification and prompt response to escalating behavior and allows evaluation of incidents and enhancement to staff training; (2) Securing furniture or using weighted furniture to reduce risk of being used as a weapon can reduce the incident of violence

Post-incident support

Debriefing of staff, review of violence incidents and other measures to support staff involved with violence has been shown to raise staff awareness of the risks for WPV and increase reporting. Performing a root cause analysis using a team approach can identify systematic weaknesses in the WPV program and overall safety culture, and potential solutions, action plans and revision of workplace violence policy and procedures.

The following *Sections* in this toolkit, provide more information about developing and implementing strategies to control and prevent workplace violence:

- **Section 3: Step 8 Developing solutions to address and control hazards**
- **Section 4: Developing the WPV Program Plan**
- **Section 6: Education and Training**
- **Section 7: Implementing the program**

Tool 3a. Gap analysis tool and **Tool 3f. Safety and security assessment checklist,** provide more information and ideas about engineering and administrative controls that can be used to prevent and manage WPV.

Examples of tools **(5a-5f)** developed by the hospitals in the WSI project are also provided as resources.

This Section provides a list of existing resources with links to tools where possible, that will assist you to develop solutions and strategies to address WPV in your health care facility.

Physical and Environmental Safety and Security Measures

Refer to ***Section 9*** for references and resources related to Facilities Design i.e., standards and guidelines that address employee and patient security and safety needs, when designing and building behavioral health, emergency and other departments within health care facilities.

References and Resources Related to this Section – Other

Association for Healthcare Security & Safety (IAHSS). http://www.iahss.org/

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Emerging Health Care Concern: Preventing Workplace Violence
Presentation on Workplace Violence
https://www.jointcommission.org/assets/1/6/PreventingWPV_081816.pdf

Emergency Management [slug] Announcing Emergencies Hospital Executives Prefer Plain Language or a Blend of Plain and Coded Language in Emergency Alerts. The Joint Commission. December 2018 EC News. New 2020
https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/emergency-management/codedvsplainannouncementsv2-jk-10-31-18.pdf

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Prevention and management of occupational violence and aggression in healthcare: A scoping review (2018). Morphet, J., Griffiths, D., Beattie, J., Reyes, D. V., & Innes, K. Collegian, 25(6), 621-632. New 2020

Preventing patient-to-worker violence in hospitals: outcome of a randomized controlled intervention (2017). Arnetz JE, Hamblin L, Russell J, Upfal MJ, Luborsky M, Janisse J, Essenmacher L. JOEM 59(1), 18-27. New 2020

Safewards. New 2020

Mental Health Nursing Institute of Psychiatry Health Services and Population Research, London, England

- Resources for Safewards Implementation
  http://www.safewards.net/model-diagram

- Selected Articles about the Safewards Model

  Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial (2015). Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. *International journal of nursing studies*, *52*(9), 1412-1422.

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Outcomes of the Victorian Safewards trial in 13 wards: Impact on seclusion rates and fidelity measurement (2017). Fletcher, J., Spittal, M., Brophy, L., Tibble, H., Kinner, S., Elsom, S., & Hamilton, B. *International journal of mental health nursing*, *26*(5), 461-471.

The Joint Commission - Workplace Violence from the Field New 2020
https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/from-the-field/

Western Connecticut Health Network-Examples of policies related to workplace violence:

- Armed Intruder – Active Shooter Code 55
- Bomb Threats Code 10
- Code Grey – Immediate Security Assistance – Danbury Hospital
- Code Silver: Site Emergency Lockdown

Overhead Emergency Codes -Poster. The Joint Commission New 2020

- https://www.jointcommission.org/assets/1/6/EM-OVERHEAD-EMERGENCY-CODES-POSTER.pdf

Threat Assessment Strategies to Mitigate Violence in Healthcare (2019) Henkel, S. IAHSS-Foundation RS-19-02 November 11, 2019. New 2020
https://files.constantcontact.com/683345b7001/a3a98b90-3c81-4840-82d5-f1500f850639.pdf

Veterans Health Administration (VAH) New 2020

- **VHA's Workplace Violence Prevention Program (WVPP)**
  https://www.publichealth.va.gov/about/occhealth/violence-prevention.asp
- **Mental Health Resources US Department of Veterans Affairs.**
  https://www.mentalhealth.va.gov/

- **Behavioral Threat Management and Violence Prevention Program.** Veterans Health Administration (VHA). https://www.publichealth.va.gov/about/occhealth/violence-prevention.asp

Public Services Health and Safety Association (PSHSA), Ontario, Canada New 2020

- **Violence Response Toolkit and Other Resources for Hospitals (2019).** https://www.pshsa.ca/emerging-issues/issues/workplace-violence-in-healthcare/workplace-violence-leadership-table-phase-2

  Appendix E - Examples of Controls
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- **Personal Safety Response System Toolkit Resource Manual**
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  https://workplace-violence.ca/tools/personal-safety-response-system/

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Webinars *(can be accessed free of charge)*

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Identifying and Monitoring Patients/Visitors at High Risk for Violence

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Development of a data collection instrument for violent patient encounters against healthcare workers. (2012). Kowalenko, T., Hauff, S., Morden, P. et al._Western Journal of Medicine 13(5), 429-33.

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Association of Threat Assessment Professionals www.atapworldwide.org/
A non-profit membership association including mental health professionals, law enforcement, corporate safety specialists, lawyers, probation officers, and others concerned with threat and violence risk assessment. Topic areas include threats, stalking, and homeland security.

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Minnesota Department of Health
Prevention of Violence in Health Care Toolkit
https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

Risk Identification

- Broset Tool Utilization - Article (PDF)
- HealthEast Threat - Assessment Worksheet (PDF)
- St. Cloud - Environmental Checklist Screenshot (PDF)

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Information about Oregon OSHA recordkeeping requirements related to WPV related workplace injuries can be found in **Tool 2d: Analyzing Injury Data and Direct Injury Costs**

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References and Resources Related to this Section – Other

California Hospital Association

Workplace Violence Prevention Resources
https://www.calhospital.org/workplace-violence-prevention

Workplace Violence Incident Case Number Assignment Form

- Violent Incident Log
- Violent Incident Reporting

Confidential Incident Report Forms. U.S. Department of Labor Occupational Safety and Health Administration (OSHA).
https://www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/confidentialreportform.html

Johns Hopkins Safe-at-Work Program

- Johns Hopkins Continuum of Disruptive Behaviors at Work

Minnesota Department of Health
Prevention of Violence in Health Care Toolkit
https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

Accurate and Concurrent Reporting

- Development of a Data Collection Instrument Article (PDF)
- Injury Severity Levels (PDF)
- Incident Types (PDF)
- St. Cloud - Aggressive Incident Dashboard FY11-FY14 (Excel)
- St. Cloud - Aggressive Incident Dashboard Template (Excel)
- Suggested Data Collection Elements (PDF)

The Joint Commission - Workplace Violence Resources - from the Field New 2020
https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/from-the-field/

- Employee Reporting Procedure - Western Connecticut Health Network
  Incidents of Workplace Violence and Assault of Western Connecticut Health Network Employee Reporting Procedure

Workplace Violence Incident Report Form. Civil Service Employees Association, Local 1000, AFSCME, AFL-CIO https://cseany.org/wp-content/uploads/2013/02/Incident-Report.pdf

Workplace Violence Prevention Program Guidelines. New York State Department of Labor Appendix 2 contains a Workplace Violence Incident Report. http://tinyurl.com/q6x5t3s

Incident Response (includes Active Shooter Resources)

Refer to ***Section 4*** for additional WPV policy related resources.

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De-escalation New Topic Section 2020

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De-Escalation Tips. Crisis Prevention Institute. (2017). New 2020
https://www.crisisprevention.com/Blog/October-2017/CPI-s-Top-10-De-Escalation-Tips-Revisited

Effective ingredients of verbal de-escalation: validating an English modified version of the 'De-Escalating Aggressive Behaviour Scale' (2016). Mavandadi, V., Bieling, P. J., & Madsen, V. *Journal of psychiatric and mental health nursing*, *23*(6-7), 357-368. New 2020

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The Trauma Informed Project
http://www.traumainformedcareproject.org/

What is Trauma Informed Care?
https://traumainformedoregon.org/wp-content/uploads/2016/01/What-is-Trauma-Informed-Care.pdf

Trauma-Informed Care.
Substance Abuse Mental Health Administration (SAMHSA) -HRSA Center for Integrated Health Solutions (CIHS). https://www.integration.samhsa.gov/clinical-practice/trauma-informed

A Systematic Review of Physician Leadership and Emotional Intelligence (**2014**). Laura Janine Mintz and James K. Stoller. Journal of Graduate Medical Education**:** 6(1), 21-31.
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Management of the Agitated Patient New Topic Section 2020

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Behavioral Health Rapid Response Teams New Topic Section 2020

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Incident Response (includes Active Shooter Resources)

References and Resources Related to this Section – Other

<u>The Agency for Healthcare Research and Quality (AHRQ)</u>

- **AHRQ Webinar: Reducing Workplace Violence with TeamSTEPPS® (2016)**
  https://www.ahrq.gov/teamstepps/events/webinars/dec-2016.html

California Hospital Association

Workplace Violence Prevention Resources
https://www.calhospital.org/workplace-violence-prevention

- Disruptive Behavior Algorithm
- **Disruptive Behavior Guidelines – Assessment, Intervention, Documentation**
  https://www.calhospital.org/sites/main/files/file-attachments/disruptive_behavior_guidelines.pdf

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http://www.lhsc.on.ca/Research_Training/Student_Affairs/orientation/CodeWhiteLHSCDecember2015.pdf

Depression and Bipolar Support Alliance New 2020

Understanding Agitation Kit for Treatment Teams and Medical Staff

- Multiple Resources about De-escalation techniques
  https://www.dbsalliance.org/education/clinicians/understanding-agitation-kit-for-treatment-teams-and-medical-staff/
- ***Understanding Agitation Webinar***
  https://ons.confex.com/ons/2019/mediafile/ExtendedAbstract/Session2060/2060handout.pdf
- ***Video demonstration of verbal de-escalation (9 minutes)***
  https://www.youtube.com/watch?v=udRjZcRuak4

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Minnesota Department of Health

Workplace Violence Prevention Resources
https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

Treatment Plans

- St. Cloud - Unique Treatment Plan Policy (PDF)
- St. Cloud - Unique Treatment Plan Policy and Example (PDF)

Incident Response

- Assessment and Management of Violent Patient - Article (PDF)
- Enhancing Safety in Behavioral Emergency Situations - Article (PDF)
- Essentia Health - Response Policy (PDF)
- HealthEast - Behavioral Emergency Code Green Presentation (PDF)
- Metro Compact - Incident Response Team Make-Up (PDF)
- Metro Compact - Sample Incident Response Form (PDF)
- St. Cloud - Acronyms for De-escalation (PDF)
- St. Cloud - Active Threat Response Plan (PDF)
- St. Cloud - Active Threat Situation Presentation (PDF)
- St. Cloud - Lockdown Procedures (PDF)
- St. Cloud - Patient Belongings and Room Search Policy (PDF)
- Verbal De-escalation on the Agitated Patient - Article (PDF)

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U.S. Department of Veterans Affairs

- Prevention and Management of Disruptive Behavior - Training overview and basic information
- Preventing Patient Violence in VA Health Care (2.6 MB, PDF) on pages 14-15 in Vanguard magazine.

Hospital Security and Use of Weapons New 2020

- **Hospital Security Programs and Policies Related to Guns and Other Weapons. (2019).** Journal of Healthcare Management, 64(3), 157-166. Blando, J. D., Cramer, R. J., & Szklo-Coxe, M.
- **Position Statement on Weapons Use in Hospitals and Patient Safety (2018).** Janofsky, J et. al. American Psychiatric Association (APA) Position Statement New 2020 https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-2018-Weapons-Use-in-Hospitals-and-Patient-Safety.pdf
- ***Centers for Medicare and Medicaid Services***. State Operations Manual Appendix A - Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. Interpretive Guidelines §482.13(e) New 2020 https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf

Active Shooter Preparedness

Refer to Section 6 Education and Training for video resources

3 Echo: concept of operations for early care and evacuation of victims of mass violence (2014). Autrey, A., Hick, J., Bramer, K., et al. Prehospital Disaster Medicine. 29(4):421-8.

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Active Shooter Drill Materials. Hospital Association of Southern California. http://www.hasc.org/active-shooter-drill-resources

Active Shooter Planning and Response in a Healthcare Setting (2017). Healthcare and Public Health Sector Coordinating Council. https://www.fbi.gov/file-repository/active_shooter_planning_and_response_in_a_healthcare_setting.pdf

Active Shooter Response Toolkit (2015). Healthcare Staff Training. MCHC and Hillard Heintze. https://www.aha.org/system/files/content/16/2015mchcactiveshooterresource.pdf

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Department of Homeland Security

- **Active Shooter Preparedness**
  The Cybersecurity and Infrastructure Security Agency (CISA)
  https://www.dhs.gov/cisa/active-shooter-preparedness

- **Active Shooter Emergency Action Plan Guide and Template**
  https://www.dhs.gov/publication/active-shooter-emergency-action-plan-guide

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NFPA 3000™ (PS): Standard for an Active Shooter/Hostile Event Response (ASHER) Program.
New 2020 https://www.nfpa.org/codes-and-standards/all-codes-and-standards/list-of-codes-and-standards/detail?code=3000&tab=research

NFPA 3000™ fact sheets **New 2020**
https://www.nfpa.org/~/media/0E8FE5DBA73B46E0801AAFB4D8F17263.ashx

San Bernardino Mass Shooting The Loma Linda Response and Lessons Learned - PowerPoint
New 2020 https://www.jointcommission.org/-/media/tjc/documents/resources/workplace-violence/clem_san_bernardino_mass_shooting_loma_linda.pdf

A Tactical Medicine After-action Report of the San Bernardino Terrorist Incident (2018). Bobko, J. P., Sinha, M., Chen, D., Patterson, S., Baldridge, T., Eby, M., ... & Lichtman, O. Western journal of emergency medicine, 19(2), 287–293. **New 2020**
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5851501/

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The Joint Commission
Workplace Violence Resources from the Field
https://www.jointcommission.org/workplace_violence.aspx

- **Willis Towers Watson – Active Shooter/armed intruder video**
  https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/willis-towers-watson/

- **Hospitals & Healthcare Facilities Security Awareness for Soft Targets and Crowded Places**
  https://www.dhs.gov/sites/default/files/publications/19_0515_cisa_action-guide-hospitals-and-healthcare.pdf

- **Active Shooters in the Hospital Setting** – PowerPoint Presentation
  https://www.jointcommission.org/assets/1/6/wpv_Active_Shooters_Hospital_setting.pdf

- **Active Shooters in the Hospital Environment** – PowerPoint Presentation

https://www.jointcommission.org/assets/1/6/wpv_DOH_active_shooter_presentation_Mar_25.pdf

- **Emergency Management Resources - Security/Violence/Active Shooter (July 2016)** https://www.jointcommission.org/emergency_management_resources_violence_security_active_shooter/
- **Quick Safety: Preparing for Active Shooter Situations (July 2014).** The Joint Commission https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_Four_July_2014_Final.pdf

Minnesota Department of Health

Workplace Violence Resources

https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

- Mille Lacs - Active Shooter Policy

United States Active Shooter Events from 2000 to 2010: Training and Equipment Implications (2013). Blair, J.P. and Martaindale, M.H. School of Criminal Justice. Texas State University https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/flrtc/documents/ActiveShooterEvents.pdf

Policy & Procedures for Addressing Violence Risk with Specific Patient Populations

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http://www.calhospital.org/emergency-department-toolkit

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- **Dementia: Understanding Risks and Preventing Violence (2010).** https://www.worksafebc.com/en/resources/health-safety/books-guides/dementia-understanding-risks-and-preventing-violence?lang=en&direct

Working with Dementia patients

- **Search for 'Working Safely with Dementia'** -multiple resources https://www.worksafebc.com/

Post Incident Management and Incident Investigation

References and Resources Related to this Section – Articles

Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review (2007). Jackson, D., Firtko, A., & Edenborough, M. Journal of advanced nursing, 60(1), 1-9.

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References and Resources Related to this Section – Other

The Agency for Healthcare Research and Quality (AHRQ)

- **Learn from Defects Tool CUSP Toolkit** https://www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/toolkit/learndefects.html

California Hospital Association

Workplace Violence Prevention Resources
http://www.calhospital.org/resource/workplace-violence-prevention-resources

- Investigation of Workplace Violence Incidents

Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers (2015). U.S. Department of Labor Occupational Safety and Health Administration (OSHA) Publication 3148-04R https://www.osha.gov/Publications/osha3148.pdf

Worksafe BC
https://www.worksafebc.com/en

- Incident investigations in health care: Focusing on change instead of blame (2012).
- Incident investigation case example: Violence (2012)

Minnesota Department of Health

Workplace Violence Prevention Resources
https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

- Policy - Support for Staff Involved in Violent Incidents (PDF)
- Violent Incident Staff Aftercare Checklist (PDF)

The Role and Management of Security Staff

References and Resources Related to this Section – Articles

A data-driven model for estimating industry average numbers of hospital security staff (2015). Vellani, K. H., Emery, R. J., & Reingle, J. G. Journal of healthcare protection management: publication of the International Association for Hospital Security, 31(1), 51-63.

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Security customer services: the tangibles and intangibles (2014). Bailey J.O. Journal of Healthcare Protection Management. Vol. 30 (1), 73-76.

Should you outsource your hospital's security services? Some things to consider (2014). DiNapoli, David V; Journal of Healthcare Protection Management, 30(1): 46-54.

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The TASERs Are Coming, the TASERs Are Coming—Conducted Electrical Weapons: Tools to Manage and Prevent ED Violence? (2014). Lefton, C. Journal of Emergency Nursing, 40(2),174–176.

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References and Resources Related to this Section – Other

California Hospital Association
Workplace Violence Prevention Resources
http://www.calhospital.org/resource/workplace-violence-prevention-resources

- Hospital Guard Review Form

Minnesota Department of Health
Workplace Violence Prevention Resources
https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

- Essentia Health - Security Management Policy (PDF)

Membership organizations: Safety and Security That offer a variety of publications

ASIS International
https://www.asisonline.org/
Organization for security professionals worldwide.

Association for Healthcare Security & Safety (IAHSS). http://www.iahss.org/

- HealthCare Security Industry Guidelines 2018.
- Basic training manual for Healthcare Security Officers, 6th edition (USA) Canadian version also available New 2020
- Toolkit for New Healthcare Security Managers New 2020
- Journal of health care protection management

Security System Monitoring in Health Care Facilities (2016). Evidence Based Healthcare Security Research Series IAHHS Foundation IAHSS-F RS-16-01 March 23, 2016. New 2020
https://iahssf.org/assets/securitysystemmonitoring.pdf

The International Association of Professional Security Consultants (IAPSC)
https://iapsc.org/

Campus Safety magazine- Journal and other publications.
https://www.campussafetymagazine.com

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WPV Education and Training

Tool that support content in this Section

6a. Education and Training plan

As discussed briefly in ***Section 4,*** education and training are critical elements of a successful WPV program.

The goal of WPV ***education*** is to provide employees with information about the topic of WPV in health care, the organization's WPV program, and the rationale for policy and procedures that exist or are to be implemented, that prevent and control WPV. WPV ***training*** should provide employees with a specific set of skills for example, how to report incidence of WPV and how to use de-escalation techniques to manage a violent patient or visitor.

Developing a WPV education and training plan allows you to identify the stakeholder groups that should receive training, training content, and the resources, that will be needed to implement an ongoing WPV training program, and to determine other training related logistics.

Elements of effective WPV Education and Training programs

Information and evidence base related to what training content should be included in WPV education and training programs, how content should be delivered, and overall effectiveness of these programs is scarce.

Of the few studies published, evidence indicates that the following are more effective at increasing staff situational and environmental awareness as well as increased confidence and improved technical skills for preventing and managing violence or aggression (Heckemann et. al., 2016).

- Training programs should be tailored to staff groups/disciplines.
- Training programs should be tailored to stratified risk levels related to work roles within the organization.
- Training programs should have clearly defined goals with measurable outcomes.
- Training methods for the prevention of clinical aggression should, where possible, be evidence based, cost-effective and reflective of local need.
- Promotes a culture of continuous quality improvement underlies prevention of clinical aggression training and responses (Knott, J., et. al., 2014).

- A hybrid training module that is, use of computer based or on-line learning coupled with interactive classroom-based tabletop exercises. This design provides essential initial learning and foundation in the topic (on-line) and the interactive class-based activities support application and synthesis of the topic (Martindell, 2012; Gillespie et al., 2014; & Parker, 2016).
- Tabletop exercises or vignettes provide information that is directly applicable to the staff's work environment e.g. the emergency room, in-patient care unit, clinic etc.
- Discussion and collaboration with interprofessional colleagues on how to best manage the incident of workplace violence depicted in case studies or vignette.
- On-line training that staff can complete over a period of time (e.g., 2 months), and is flexible to allow staff to take modules over several sessions and start where they left off.
- Both mindfulness and communication skills training may reduce the experience of aggression reported by health care support workers (Baby et al., 2019).

Currently, there is no clear evidence that de-escalation training reduces the number of actual incidents of violence and aggression, or reduces staff injuries, however, there is some evidence that de-escalation training improves staff confidence in dealing with and managing escalating violence and in self-reporting of workplace violence incidents. (Leach, 2019).

Overall, health care facilities should adopt a method of de-escalation that works best for them and their patient population and within the context of a comprehensive WPV program as described in this toolkit. Refer to **Tool 5h** for more information on de-escalation techniques.

In contrast, Morphet et al., found that studies of evasive self-defense or break away training have found that participants were *unable* to apply the techniques learned during the training, when tested in a simulated setting In addition, there was no evidence that self-defense training reduced the incidence of WPV in health care.

Evidence also indicates that content of WPV training programs is highly variable. However, topics that are ***commonly lacking*** in programs include a facility's policies, protocols, and environment; 'costs' associated with aggression; pharmacological management of aggression; issues around the use of restraint; seclusion; management of non- intentional violence e.g. dementia; and managing the emotional impact of WPV (Peek-Asa, C. et. al., 2007; Hartley, D. et. al., 2015; Arbury et. al., 2017).

In addition, 'packaged' training programs are frequently used by health care organizations. These typically ***do not*** include information about the hospital's specific policies, procedures, and potential risk factors. In addition, some *employee* groups (e.g., physicians and contract personnel), are often excluded from training, and training length is insufficient to cover necessary material (Arbury et. al., 2017).

Chapter 4 *'Select and Tailor Implement Interventions and Strategies'* of **The Implementation of best practice guidelines (2nd ed.). (2012).** *Toolkit: by the* ON: Registered Nurses' Association of Ontario (RNAO), provides further discussion about evidence based education and training strategies that work in health care http://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-

No published evidence is found related to ***how often*** WPV training should occur so that staff can retain and refine skills etc. Nor is there any reported analysis of costs and benefits of online versus face to face training (Knott, J., et. al., 2014).

Requirements for WPV Education and Training programs in Oregon

1. **ORS 654.412 to 654.423 Safety of Health Care Employees** requires that employers (that is, hospitals and home health services if owed by a hospital, and ambulatory surgical centers), must conduct assault prevention and protection training for employees where existing or potential hazards for assaults exists. 'Assault' is defined as actions that intentionally, knowingly, or recklessly causing physical injury to an employee:

   Training must be conducted:

   1. On a regular and ongoing basis, e.g. annually. *ORS 654.414 (1) c*
   2. Within 90 days of the employee's initial hiring date. *ORS 654.414 (4) b*

   ORS *654.414* 4(A) Assault prevention and protection training, requires that the following topics are addressed:

   a. General safety and personal safety procedures, e.g. all hazard control and preventions strategies and procedures that have been implemented nature and extent of risks associated with specific jobs/location.

   b. Escalation cycles for assaultive behaviors; (including identify non-patients/visitors at risk or exhibiting at risk behaviors for violence.

c. Factors that predict assaultive behaviors.

d. Techniques for obtaining medical history from a patient with assaultive behavior.

e. Verbal and physical techniques to de-escalate and minimize assaultive behaviors.

f. Strategies for avoiding physical harm and minimizing use of restraints.

g. Restraint techniques consistent with regulatory requirements.

h. Self-defense, including:

   i. The amount of physical force that is reasonably necessary to protect the employee or a third person from assault; and

   ii. The use of least restrictive procedures necessary under the circumstances, in accordance with an approved behavior management plan, and any other methods of response approved by the health care employer.

i. Procedures for documenting and reporting incidents involving assaultive behaviors.

j. Programs for post-incident counseling and follow-up.

k. Resources available to employees for coping with assaults; and

l. The health care employer's workplace assault prevention and protection program.

Additional topics to consider:

- Possible medical and psychological effect of violence aggression on employees.
- Addressing management of patients who do not intend to assault employees e.g., confused elderly, patients recovering from anesthesia.

A health care employer may use classes, video recordings, brochures, verbal or written training, or other training that the employer determines to be appropriate, based on an employee's job duties, under the assault prevention and protection program developed by the employer per *ORS 654.414 (4c).*

2. If an employer i.e., a health care organization employs or utilizes at least one individual (including contract security services) whose primary responsibilities include providing private security services, then the employer must comply with **Oregon Administrative Rules Division 60 (OAR 259-060:0005-0600) 'Private security Services Providers Rules'**.

These rules state that the employer:

- Must designate an individual to perform the duties of an executive manager at all times as described in Division 60 Rules. An employer may obtain licensure for more than one executive manager: and
- The executive manager has met and maintains the *training and certification* requirements required in OAR Division 60 Rules and the Department of Public Safety Standards and Training (DPSST).

In addition, any security personnel have met and maintain the training and certification requirements required in OAR Division 60 Rules and the Department of Public Safety Standards and Training (DPSST).

It is important to note that goal of the training required above, is to ensure the executive manager and security personnel have knowledge of the Oregon law related to use of force when managing WPV incidents. These personnel should also receive WPV training that is specific to a health care organization's WPV policy and procedures etc.

Requirements for WPV Education and Training programs in Washington State New 2020

Training must be conducted:

1. **By July 1, 2020,** and on a regular basis, thereafter, as set forth in the WPV plan for all applicable employees, volunteers, and contracted security personnel, as determined by the plan. The frequency of training may vary according to the information and strategies identified in the WPV plan.
2. New employees - within 90 days of the employee's initial hiring date unless he or she is a temporary employee.

RCW 49.19.030 requires that the following topics are addressed:

3. Trainings must address the following topics, as appropriate to the particular setting and to the duties and responsibilities of the particular employee being trained, based upon the hazards identified in the plan:

    (a) The health care setting's workplace violence prevention plan.

    (b) General safety procedures.

    (c) Violence predicting behaviors and factors.

(d) The violence escalation cycle.

(e) De-escalation techniques to minimize violent behavior.

(f) Strategies to prevent physical harm with hands-on practice or role play.

(g) Response team processes.

(h) Proper application and use of restraints, both physical and chemical restraints.

(i) Documentation and reporting incidents.

(j) The debrief process for affected employees following violent acts; and

(k) Resources available to employees for coping with the effects of violence.

The method of training may vary according to the information and strategies identified in the plan.

Trainings may include, but are not limited to, classes that provide an opportunity for interactive questions and answers, hands on training, video training, brochures, verbal training, or other verbal or written training that is determined to be appropriate under the plan.

Developing the WPV Education and Training Plan

Tool 6a, the sample **WPV Education and Training Plan** can be used as a template when developing your plan. Your **WPV Communications Plan (Tool 4a),** can also be used to assist you build your Education and Training Plan as some of the content is related to training needs.

Determine the following:

1. **The employee and non-employee groups who should receive WPV education and training.** Use your WPV Communications plan **(refer to *Section 4*)** to assist you to identify groups of stakeholders who should receive training.

2. **The overall objectives of WPV education and training activities.** For example*, what are the results you want to achieve* such as, all employees are aware of WPV program and program goals. They know how identify risk for WPV in their work area, and how to address and report incidents of violence etc.

3. **Specific education and training objectives and content for each group (Refer to Tool 6a).** Make sure content is customized to your facility and meets regulatory requirements.

4. **How training objectives will be measured** e.g., at the end of a training session and periodically after training is conducted, to evaluate if training was effective i.e., the 'transfer of training'.

5. **The best method(s) to deliver training to each group** e.g., computer-based training, classroom with lecture, simulations and drills.

   Determine how training is conducted within your facility currently and if there are methods of delivering training content that are more effective than others?

6. **When training needs to be conducted for each group, and how often** e.g., at program implementation, and then periodically, for new hires, when violence prevention processes/procedures are changed, or new processes implemented, and when employees are transferred to a new unit that have different training requirements.

7. **If a train-the trainer model could be used to reduce costs and expedite employee training etc.**

8. **Who will develop the education and training and/or there are existing resources available?** *(Refer to* ***Tool 6a*** *and* ***Resources*** *at the end of this Section for a list of freely available WPV related training tools).*

   Consider how training materials and delivery will be developed to meet the recipient's educational, language, and cultural needs etc.

Some hospitals in the WSI project conducted employee meetings to discuss WPV in health care, introduce the WPV program, and to solicit employee feedback about program activities.

When asked how long should basic WPV training should be for employees:

- Nurses and other direct care staff said 2 hours is preferred. They thought that a computer based module that could be completed over a period, followed by classroom based training with a focus on descalation to address 'real' world WPV related scenarios would be most effective.
- More in-depth competency based training with simulation should be conducted for Threat Response Teams etc.
- Support service staff such as, EVS employees requested that they also receive training on descalation techniques that could be offered during staff meetings in addition to completing computer based training.

If you developed a 'brand' for your WPV program and communications make sure to incorporate that into your training materials and related advertising.

Quick Tip: Offering continuing credit education to nurses and other licensed professionals can help facilitate attendance to training classes. Having a variety of candy available helps too!

9. **Who will conduct the training?**
   Consider how you will ensure that trainers have appropriate knowledge base and skills to conduct training. Will you need assistance from the Clinical Education department if not already involved in program planning, etc.

10. **If training will be mandatory for each group identified.** Identify a process to address employee non-compliance with mandatory training policy.

11. **The length of training classes/sessions and capacity for each session that will facilitate maximum learning.**

12. **The budgetary cost and resources required to implement and evaluate the WPV education and training program.**

13. **The barriers to implementing the WPV education and training plan and approaches to address them.** For example, the cost of using external training programs and providers, and/or the time for employees to attend training including cost to provide extra staffing coverage.

    You should have identified some of these barriers during the Gap Analysis assessment.

14. **General logistics of implementing an education and training plan**. For example,

    - How will you communicate the WPV education and training requirements and advertise classes to employees?
    - How and who will employees register for classes and how will attendance be tracked?
    - What training space and materials including audiovisual equipment, handout materials etc., will be needed, and who will address these needs?

- Where and how will training records be kept, and for how long*?* (It is recommended that training records should include the subject matter, time, date, duration of training, instructor's name and affiliation, and competency verification).

  Note: there is no specific requirement in Oregon or Washington State to maintain WPV training records.

Periodically review and update your WPV Education and Training plan based on feedback from attendees and measurement of objectives.

Implementation of the WPV Education and Training Plan will be discussed in ***Section 7.***

Quick Tip: If you do not have the in-house resources with expertise to train employees on every aspect of your WPV program, then the following outside sources may be able to assist you:

- Local Police
- The Sheriff's department
- Community based behavioral health groups, clinics and mental health department
- Oregon OSHA consultation
- Your worker's compensation insurance carrier (they may also know of other resources)
- Private training companies Note: Private companies often have strict requirements for class length and frequency for attendees and for hospital based trainers. Make sure classes offered can be customized to incorporate an organization's WPV policy and procedure and the Oregon or Washington WPV laws.

Employee and non-employee groups who should receive WPV Education and Training

Hospitals in the WSI project identified the following employee and non-employee groups as needing some degree of WPV Education and Training.

- Hospital in-patient care
  - Staff who will respond to WPV events, such as Code Grey, and/or work in departments/units where risk of patient violence is higher. For example, Emergency and Behavioral Health departments, Intensive care and Medical-Surgical units, Security, Threat Assessment team members, Emergency Management Director.
  - Staff who provide clinical, medical or nursing care to patients, including temporary /contract personnel., e.g., nurses, aides, therapists, medical assistants, social/case workers, diagnostic technicians, medical providers, and religious/spiritual counselors.
- Support staff who work directly with patients/or the public and who may be at risk for violence. For example, patient admissions, discharge coordinators, unit clerks, volunteers, students, pharmacists, transporters, and laboratory technicians.
- Support staff who do not work directly with patients/or the public. For example, Environmental services, Dietary, Linen services, Facilities, Biomed, and information technology.
- Other Staff Groups. For example, senior leadership, directors, managers and supervisors, the WPV committee and program coordinator, patients and visitors, Emergency Medical Services, Union/Labor representatives, local law enforcement and community behavioral health treatment facilities or clinics (not operated by this hospital), and other community agencies.
- Outpatient clinics (if applicable) – all employees
- Home Health (if applicable) – all employees

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D., Gillen, M. and Harrison, R., Journal of occupational and environmental medicine, 49(7), 756-763.

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OAR Division 60 259-060-0005:0600 'Private security Services Providers Rules'. Retrieved from http://arcweb.sos.state.or.us/pages/rules/oars_200/oar_259/259_060.html

Resources Related to this Section – Articles

Active shooter training in the emergency department: A safety initiative (2018). Journal of Emergency Nursing, 44(6), 598-604. Sanchez, L., Young, V. B., & Baker, M. **New 2020**

A live threat violence simulation exercise for psychiatric outpatient departments: a valuable aid to training in violence prevention. (2018). Academic psychiatry, 42(5), 598-604. Feinstein, R. E., & Yager, J. **New 2020**

Assessing the effectiveness of clinical education to reduce the frequency and recurrence of workplace violence. (2017). Adams, J., Knowles, A., Irons, G., Roddy, A., & Ashworth, J. Australian Journal of Advanced Nursing, The, 34(3), 6 **New 2020**

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Implementing an Active Shooter Policy and Training Program (2019). Clark, K. R**.** Radiol Technol. 90(4):407-409. New 2020

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Implementing a workplace violence simulation for undergraduate nursing students: A pilot study(2017). Journal of psychosocial nursing and mental health services, 55(10), 39-44. Martinez, A. J. S. New 2020

Management of Aggressive Patients: Results of an Educational Program for Nurses in Non-Psychiatric Settings (2019). Casey, C. Medsurg Nursing, 28(1), 9-21. New 2020

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Nursing student evaluation of NIOSH workplace violence prevention for nurses online course (2017). Brann, M., & Hartley, D. Journal of safety research, 60, 85-91. New 2020

Reviewing the Evidence Base for De-escalation Training: A Rapid Evidence Assessment (2019). Leach, B et. Al. NHS Improvement, 2019. https://www.rand.org/pubs/research_reports/RR3148.html

Staff perception of interprofessional simulation for verbal de-escalation and restraint application to mitigate violent patient behaviors in the emergency department (2019). Krull, W., Gusenius, T. M., Germain, D., & Schnepper, L. Journal of emergency nursing, 45(1), 24-30. New 2020

The effect of a workplace violence training program for generalist nurses in the acute hospital setting: A quasi-experimental study. (2018). Nurse education today, 68, 45-52. Lamont, S., & Brunero, S. New 2020

Using Simulation Training to Promote Nurses' Effective Handling of Workplace Violence: A Quasi-Experimental Study (2019). Ming, J. L., Huang, H. M., Hung, S. P., Chang, C. I., Hsu, Y. S., Tzeng, Y. M., ... & Hsu, T. F. International journal of environmental research and public health, 16(19), 3648. New 2020

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Resources Related to this Section – Other

The following training resources and tools are free of charge

Section 7. Tools and Resources 4C: Assessing Staff Education and Training. Pressure Ulcer Toolkit (2011). Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/putool7b.html

2015 ASHRM Annual Conference & Exhibition.

Preventing workplace violence in health care organizations.
http://www.businessinsurance.com/article/20151020/VIDEO/151029966

Alabama Department of Public Health

Safety in the Workplace
Broadcast Date: July 17, 2013 Garrett, T.

This webinar is geared toward healthcare professionals. The speaker discusses how to identify potential risk factors in the work setting and develop a response plan in the event of a violent situation. http://www.adph.org/ALPHTN/index.asp?id=6289

American Organization of Nurse Executives (AONE) New 2020

Hospitals Against Violence: Reducing Health Care Violence by Innovative Training and Valuable Partnerships (June 2017). *Webinar*

http://www.aone.org/resources/Reducing-Health-care-Violence-by-Innovative-Training-and-Valuable-Partnerships

California Hospital Association

Workplace Violence Prevention Resources - Workplace Violence Prevention Toolkit
http://www.calhospital.org/resource/workplace-violence-prevention-resources

- Documentation of Workplace Violence Prevention Training

Centers for Disease Control - NIOSH

Workplace Violence Prevention for Nurses CDC/NIOSH. CDC Course No. WB1865 - NIOSH Pub. No. 2013-155. http://www.cdc.gov/niosh/topics/violence/training_nurses.html

Emergency Nurses Association

Workplace Violence Prevention online course. For Emergency Room staff - Online CE course
https://www.ena.org/education#online

Health Employers Association of British Columbia (HEABC)

Violence Prevention Training Modules
http://www.heabc.bc.ca/Page4272.aspx#.VhqnkXl4emQ

Institute for Healthcare Improvement / National Patient Safety Foundation. New 2020

Workplace Violence in Health Care Can't Be the Norm (August 10, 2017). *Webinar*
http://www.ihi.org/resources/Pages/AudioandVideo/WIHI-Workplace-Violence-in-Health-Care-Can't-Be-the-Norm.aspx

International Labour Organization, International Council of Nurses, World Health Organization, & Public Services International

Framework Guidelines for Addressing Workplace Violence in the Health Sector: The Training Manual
http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_108542.pdf

Journal of the American Medical Association

Ensuring Staff Safety When Treating Potentially Violent Patients-*Article and podcast*
http://jamanetwork.com/journals/jama/fullarticle/2594721
http://jamanetwork.com/learning/audio-player/13911304

Minnesota Department of Health

- **Online Module: Workplace Violence Training Level 1**
- **HealthEast Violence Prevention Staff Education (PDF)**
- **MN Hospital Association - Resiliency Training PowerPoint (PDF)**

https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/

Minnesota Department of Labor and Industry

Violence against health care workers online training module video
This training video was created by the Minnesota Department of Health and Minnesota OSHA Workplace Safety Consultation to help workers learn how to identify, prevent and de-escalate violence as required under Minnesota's Violence Against Health Care Workers law (Minnesota Statutes § 144.566). (created January 2016).

http://www.doli.state.mn.us/wsc/Wvp.asp

Minnesota Hospital Association

- **Systems Change in Action/No Two Snowflakes are Alike**
- **Motivational Interviewing/Negotiating Skills**
- **Managing Aggressive & Violent Patients: Legal Considerations**

https://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-improvement-topics/workplace-violence-prevention#/videos/list

Occupational Safety and Health Administration (OSHA)

- **Recommended Practices for Safety and Health Programs: Education and Training**
  https://www.osha.gov/shpguidelines/education-training.html
- **Best Practices for the Development, Delivery, and Evaluation of Susan Harwood Training Grants.** OSHA 3686-09 2010. Provides a review of how to develop content for safety and health training programs. https://www.osha.gov/dte/sharwood/best-practices-booklet.pdf

- **OSHA Workplace Violence Prevention - Health Care and Social Service Workers – Power Point** https://www.osha.gov/dte/library/wp-violence/healthcare/

Public Services Health and Safety Association (PSHSA), Ontario, Canada New 2020

- **Workplace Violence in Healthcare Violence in the workplace cannot be tolerated. Webinars and more** https://www.pshsa.ca/emerging-issues/issues/workplace-violence-in-healthcare
    - A Security Toolkit for Community and Healthcare Organizations
    - Recognizing Hazards and Planning for Prevention
    - Assessing and Communicating the Risk of Workplace Violence

The Joint Commission - Workplace Violence Resources - from the Field New 2020

https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/from-the-field/

- Willis Towers Watson Active shooter/armed intruder response https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/willis-towers-watson/

- Video: Workplace Violence Prevention Implementing Strategies for Safer Healthcare Organizations webinar for Sentinel Event Alert 59: Physical and verbal violence against health care workers. https://www.jointcommission.org/en/resources/patient-safety-topics/workplace-violence-prevention/workplace-violence-prevention-implementing-strategies-for-safer-healthcare-organizations/

U.S. Department of Health & Human Services International Committee of the Red Cross.

Health Care in Danger: It's a Matter of Life and Death.

This e-learning training is broken into ten chapters (with links to videos and other resources) and designed to help health care personnel understand: the effects of violence on health care, their own rights and responsibilities, and ethical dilemmas they may face in emergencies (2014).
https://asprtracie.hhs.gov/technical-resources/resource/1920/health-care-in-danger-its-a-matter-of-life-and-death

Washington Department of Labor & Industries

- Workplace Violence Prevention: Module 1
- Workplace Violence Prevention: Module 2
- Critical Incident Stress Debriefing (CISD) Overview - (online training covering traumatic workplace events, including workplace violence incidents).

http://www.lni.wa.gov/Safety/Topics/AtoZ/WPV/training.asp

Worksafe Victoria

- **Public Education Campaign: Up to 95% of our healthcare workers have experienced verbal or physical assault: It's never OK**. https://www.worksafe.vic.gov.au/itsneverok
- Guide for Violence and Aggression Training in Victorian Health Services
- Violence Prevention and Management: Standards for Development of Training and Organisational Responses in Victorian Health Services
- Minimum Training Standards: Preventing and Managing Clinical Aggression including the use of Physical Restraint

Private training companies most commonly hired in Oregon with WPV training programs for health care (list not all inclusive).

Note: Private companies often have strict requirements for class length and frequency for attendees and for trainers re if they can teach beyond a specific organization. Classes may not be customized to incorporate an organization's WPV policy and procedure and the Oregon WPV law.

- **AVADE® Healthcare Workplace Violence Prevention Training.** New 2020 www.avadetraining.com
- **Crisis Prevention Institute (CPI)** https://www.crisisprevention.com/
- **Non-Abusive Psychological Physical Intervention (NAPPI)** http://www.nappi-training.com/
- **ALICE (Alert, Lockdown, Inform, Counter, Evacuate).** Active Shooter training for organizations https://www.alicetraining.com/

Training for Security Personnel

- **Lock-Up** http://www.policecombat.com/#
- **The International Association for Healthcare Security and Safety (IAHHS) –** Online courses http://www.iahss.org/
- **ASIS International** https://www.asisonline.org/Pages/default.aspx
- **Security trainers approved by the Oregon DPSST** http://www.oregon.gov/dpsst/ps/Pages/index.aspx

Active Shooter

- **Federal Bureau of Investigation**

  Video: Run. Hide. Fight. Surviving an Active Shooter Event
  https://www.fbi.gov/about/partnerships/office-of-partner-engagement/active-shooter-resources

- **Minnesota Department of Health**

  HealthEast Care System Active Shooter Staff Education
  https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

- **Minnesota Hospital Association**

  Hospital Active Shooter: Response & Recovery
  http://www.mnhospitals.org/quality-patient-safety/quality-patient-safety-initiatives/workplace-violence-prevention#/videos/list

- **MESH Coalition**

  Responding to an Active Shooter in a Healthcare Setting

  This video provides information on preparing for and responding to an active shooter event in a healthcare setting. Training video based on guidelines established by the Department of Homeland Security (2014). https://vimeo.com/112455575

For Home Care Workers

- **Worksafe BC**

  Leave When It's Unsafe **-** Video for home care workers
  https://www.worksafebc.com/en/resources/health-safety/videos/leave-when-its-unsafe?lang=en

- **Centers for Disease Control - NIOSH**

  Workplace Violence Prevention for Nurses CDC/NIOSH. CDC Course No. WB1865 - NIOSH Pub. No. 2013-155.
  http://www.cdc.gov/niosh/topics/violence/training_nurses.html

  Training Curriculum for Homecare Workers - Caring for Yourself While Caring for Others

  https://www.cdc.gov/niosh/docs/2015-102/default.html

- **HEABC - Health Employers Association of BC Modules**

  Violence prevention training modules
  http://www.heabc.bc.ca/Page4272.aspx#.VhqnkXl4emQ

  Module 3: Interventions in Community Care
  https://www.interiorhealth.ca/sites/Partners/WHSresources/Documents/Module_3_Community_Scorm_1.2_Final_V2/course/course26144.html

Other

Videos developed to educate the Public that violence in health care is not OK. New 2020

- **Help Us Help You – Violence and aggression are unacceptable.** Royal Melbourne Hospital, Australia https://www.youtube.com/watch?v=2nCQzC4KKWk

- **It's Never OK: Occupational violence and aggression against nurses**. WorkSafe Victoria https://www.youtube.com/watch?v=yQUkOx-PUMM

Videos that discuss the scope and show the reality of WPV in Health care New 2020

- **A&E: When Patients Attack. Jan 2018** https://www.youtube.com/watch?v=_nEgeUl7iZg

- **Shocking Videos: Hospital violence captured on camera- compilation #2. Mar 2017** https://www.youtube.com/watch?v=7hLczQkHyvg

- **Buried Trauma: PTSD Awareness Spot** Manitoba Nurses Union, Canada
  https://www.youtube.com/watch?v=_zyqPZwdhrw

- **Canadian Federation of Nurses Unions** Workplace Violence – Various nurses' stories
  https://nursesunions.ca/workplace-violence-our-stories/

- **ER Nurse Recounts Being 'Slapped, Pinched, Spat On' By Combative Patients. Nov 2015**
  https://www.youtube.com/watch?v=eEh64gjRw2U

- **News report from MA Hospital Workers Increasingly Targets of Patient Violence. July 2014**
  https://www.youtube.com/watch?v=N0TWMOcW0Vo

- **Risk eTips: Workplace Violence in Healthcare. Sept 2017** Cooperative of American Physicians, Inc. https://www.youtube.com/watch?v=w3bEt2Ogq0g

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Step13

Implementing the WPV Program

Summary of activities completed to date *(Sections 1-6)*

You should have completed the following activities by this stage of developing or enhancing your WPV program:

- Defined the need for a program or program enhancement.
- Built the foundation for the successful program implementation and maintenance including ensuring support from senior leadership and key stakeholders.
- Identified program goals, and assessed, and prioritized specific hazards and program needs.
- Identified an approach to addressing hazards and program needs based on regulatory requirements and published evidence including best practices, etc.
- Developed a 'zero-tolerance' WPV policy including mechanisms to address accountability.
- Have begun the process of changing culture as related to WPV prevention and control.

You have also developed a WPV program plan that describes in detailed strategies for each program activity that is to be implemented that include:

- Roles and responsibilities of staff i.e., committee and others implementing the plan.
- Prioritization of implementation activities based on severity and importance of the hazards and risks to be addressed.
- Resources (budget, personnel and time, etc.) needed and available for implementation, and ongoing support of solutions and new processes.
- Implementation timelines for each program activity.
- Strategies to evaluate, monitor, adapt as needed, and document solutions and processes implemented.
- Communications strategies for engaging stakeholder groups and sharing progress of program implementation and outcomes.
- Plans for sustaining the WPV program. ***(Section 9)***
- Education and training plans to help employees learn new practices.
- Strategies to address barriers and facilitators that consider the organization's culture and readiness to change and thus enable program implementation.

Tips for managing implementation of the WPV program plan and related activities

Successful implementation of any safety program takes time and can be facilitated by applying principles of project management. Find out if your organization e.g., from Quality or Safety departments, uses any specific project management tools or templates.

Use project management software if available or adapt project planning tools provided in this toolkit.

The ***Reference*** documents provided at the end of this Section provide more information and tools about project management and program implementation.

Identify any solutions and/or processes that are easy to implement (i.e. low hanging fruit), and that could produce 'quick wins' that facilitate employee and management engagement and support.

Plan implementation strategies to suit the level of resources available e.g., a large hospital may have resources to implement several activities in the same time period whereas, a smaller hospital may have to implement activities sequentially as resources are available.

Determine if you need to pilot or trial some solutions and/or processes e.g., to ensure a solution or new process does not create new issues or unintended consequences.

A plan to implement any pilot/trial activities - *Refer to **Table 7.1.***

A continuous performance improvement approach to implementing programs requires that implementation strategies should be flexible so as you review progress, you can modify or change your approach and address emerging issues based on feedback and results.

Monitor progress (including use of budgetary expenses) and respond quickly to information or data that indicates that implementation activities not going as planned.

Do not forget to communicate proposed and actual changes in program implementation etc., to stakeholders and solicit their input as appropriate.

The program coordinator and WPV committee should periodically *step back* from reviewing the details of implementing specific activities to view the big picture perspective when monitoring program progress. It is easy to get sidetracked or stuck spending a majority of committee time on a one activity.

Its important to remember that even though you have chosen solutions to address WPV that are based on the best available information, as discussed in ***Section 1*** of this Toolkit, there is insufficient evidence to indicate which WPV prevention program elements, or *combination* of program elements are more effective in preventing and managing violence in health care. Hence flexibility and careful planning and monitoring of program implementation strategies and outcomes is key.

Additional project management resources

- **Usability.gov. Project Management Basics** https://www.usability.gov/what-and-why/project-management.html
- **University of California, Davis Organizational Excellence** http://oe.ucdavis.edu/resources/index.html
- **AHRQ Project Planning and Management** https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/project

In addition, when choosing how to implement solutions that will change behaviors or practice in health care, a combination of various approaches is more effective (RNAO, 2012).

Ongoing activities conducted during WPV program implementation

In addition to implementation, and or pilot testing of solutions and new processes to prevent and control WPV as detailed in you program plan, the following activities should be conducted on an ongoing basis:

1. WPV committee and subcommittee or workgroup meetings.
   - During implementation of some WPV activities such as, a patient assessment tool, you may need to meet frequently e.g., weekly, as a committee or workgroup to be able to meet implementation timelines and stay focused on relevant activities.
2. Ensuring (with management assistance) that the WPV policy, expectations, and roles related to the WPV program is clearly communicated (and posted), to all stakeholders including employees & labor representatives, patients, and visitors.
3. Implementation of your communication and education and training activities as detailed in your WPV Communications and Education plans.
   - Typically, you will start with communication and education of directors (senior managers) and unit/department managers as discussed in ***Section 4***.
4. Evaluation of implementation activities.
5. Reporting program implementation progress.
   - Provide periodic updates as determined previously with the leadership group.
   - Provide periodic updates to all other stakeholders as identified in your WPV Program Communications Plan.
   - Document progress of program implementation and process improvements or changes you have made to the implementation plan. Note, which implementation strategies that were effective, and not effective, and overall lessons learned, to aid with future program management.
   - Communicate program goals, implementation activities and progress using visual aids such as dashboards, that are posted for easy access by stakeholders.

Tips for piloting a WPV solution/process

Conducting pilot test allows you to:

- Evaluate the feasibility of a WPV program solution or process prior to full scale implementation. Consider how the solution interfaces with existing care delivery procedures and processes, the physical environment, and work culture, etc.
- Identify if there are any unintended consequences of the intervention e.g., the solution had a negative impact on patient care or created other safety issues.
- Evaluate how well the proposed intervention will meet desired objectives e.g., to what degree is risk of WPV reduced and/or controlled.
- Prevent waste of resources such as money and time.
- Solicit employee feedback about the intervention and provides a foundation for culture change and successor of the intervention.
- Minimize disruption of work processes.

<u>Planning and conducting a pilot test</u>

Are you testing the intervention with the correct group of stakeholders and in the most appropriate work areas? Are there areas where staff are more likely to embrace the opportunity for improvement and adopt new processes more easily?

- Avoid conducting a pilot test in a work area where other new projects are being implemented that may strain resources and staff time to participate in your pilot.
- Identify steps needed to prepare for the pilot test.
- Determine how you will evaluate the intervention(s) i.e., what data will you need to really know your interventions are making a difference. **(Refer to *Section 8*)**
- Communicate your pilot testing plans to all stakeholders involved.
- Provide training/instruction as needed to stakeholders involved in the pilot testing.
- Use employee surveys and interviews and observation (if appropriate) to solicit feedback.
- Ensure solution(s) did not cause new problems.
- Evaluate the pilot outcomes and process.
- Making necessary changes to the intervention based.

Tips for piloting a WPV solution/process
▪ Implement on full scale after careful planning & obtaining leadership and stakeholder commitment. ▪ Have staff from the pilot area to share their experience and lessons learned with other units.

Table7.1

Change Management Resources

The process of implementing a WPV program involves asking stakeholders and the overall organization to change. The following resources may be helpful in understanding how change occurs, and the most appropriate strategies to choose when implementing your WPV program.

- **TeamSTEPPS® 2.0.** Agency for Health Care Research and Quality. Rockville, MD. https://www.ahrq.gov/teamstepps/instructor/index.html
- **Change Management in Healthcare: A Literature Review (2014)** Michael Antwi, M& Kale, M. Smith School of Business at Queen's University, Toronto, Ontario, Canada https://smith.queensu.ca/centres/monieson/knowledge_articles/monieson-cihr-change-management-in-healthcare-report.php
- **Psychology of Change Framework to Advance and Sustain Improvement (2018).** Hilton K, Anderson A Boston, Massachusetts: Institute for Healthcare Improvement. New 2020 http://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx
- **Implementation of Best Practice Guidelines (2nd ed.). (2012).** Toronto, ON: Registered Nurses' Association of Ontario (RNAO). http://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

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Preventing Pressure Ulcers in Hospitals. Content last reviewed October 2014. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/systems/hospital/pressureulcertoolkit/index.html

The OSSIE Toolkit for the implementation of The Australian Guidelines for the Prevention of Infection in Health Care (2010). Australian Commission on Safety and Quality in Healthcare. https://www.safetyandquality.gov.au/sites/default/files/migrated/OSSIE-Toolkit_WEB.pdf

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Step 14

Evaluating the WPV Program

Why evaluate the WPV program?

Tools that support content in this Section

8a. Program Measurement Plan

WPV programs cannot be managed and sustained without clearly defined measurement systems. Program evaluation is an ongoing process to determine the relevance, progress, efficiency, effectiveness, and impact of WPV prevention and control activities.

Effective ongoing evaluation of your WPV program will assist the WPV committee to adapt the program and be responsive to meet changing circumstances and needs.

Evaluation measures should indicate both progress with the program and should indicate success when it is reached.

Overall, evaluation of WPV solutions and the program implementation process plays an important role in changing employee behaviors and achieving program goals.

Ongoing evaluation of program outcomes and processes allows you to determine:

- The effectiveness of solutions and processes i.e., how well did they mitigate hazards and/or risk for WPV? Did they eliminate or reduce the risk of WPV to an acceptable level?
- Analysis of trends and rates in the number of incidents, illnesses, injuries or fatalities caused by violence relative to initial or “baseline” rates on a periodic basis.
- Measurement of improvement based on lowering the frequency and severity of workplace violence.
- If there are any overlooked hazards.
- Any unintended positive or negative consequences of solutions and processes implemented.
- If there is ongoing compliance with procedures.
- If solutions and processes work well in context of the organization’s culture in the present and future state.
- The relevance of solutions and processes over time with consideration to changes in delivery of patient care or to the physical environment, etc.

As a result of the evaluation process, the WPV Committee can use lessons learned to identify ways to improve ineffective program solutions or processes and thus, guide implementation of future WPV program activities as part of a performance improvement approach.

What should be evaluated?

When determining how to evaluate your WPV program consider:

- How data will be collected, analyzed and reported? Consider methods and tools needed, target population e.g., when surveying employees, patients and/or specific units/departments etc.
- How will you share the evaluation data with all stakeholders?
- How will you follow-up in response to the data collected and processes evaluated? Consider budget, staff, sample documents & templates, external assistance needed.

The same methods and tools that were used for collecting baseline data at the start of WPV program planning, can be used to collect post implementation data. This will allow comparison of pre-and post-implementation results.

When assessing newly implemented program processes and procedures such as a patient assessment for violence, or post incident response procedures, evaluate each step of the process to make sure it is necessary, functional, and is effective.

Tool 8a provides examples of outcome and process data that can be used to evaluate your WPV program**.**

Sections 2 and 3 provide descriptions of tools and methods that you can use to evaluate your WPV program.

The program evaluation methods may change depending effectiveness of data collection methods and as the program matures. If you introduce new assessment tools be sure to use the first data collection as a baseline in which to compare other data collected during re-evaluation.

When should the WPV program be evaluated?

Program efforts should be evaluated:

- At baseline i.e., the start of the program planning.
- During WPV program implementation to evaluate progress of new processes and adapt as needed.
- After initial WPV program implementation to assess solutions and program implementation processes.
- On an ongoing basis to identify and correct issues.
- Formally and in depth at least once a year.
- When changes occur in the workplace e.g. change in delivery of care, patient population, or structural modifications are made to the building or a department, etc.
- As a result of recommendations from investigation of violence related incidents.

Scheduling and frequency of evaluation activities will vary depending on:

- The type of evaluation e.g., safety and security assessments of the physical environment should be conducted more frequently than other activities such as, conducting

employee surveys, because the activity facilitates identification and prevention of hazards *before* an incident occurs.

- How long you consider it will take to enable change to occur when implementing new procedures, etc.
- Resources that are available.

Who should evaluate WPV program?

The WPV Committee and other key stakeholders including direct care staff should be involved in program evaluation. Stakeholder such as unit managers can help provide context for information being reviewed in relation to a specific unit or department.

Communicating Program Results

Regular meaningful communication with employees helps maintain their engagement with program efforts and facilitates opportunities for continuous improvement.

Ways to share outcomes, successes and program progress with all stakeholders should be included in your WPV Communications plan - Refer to ***Section 4.***

Using multiple media to disseminated information is more effective than a single delivery method e.g., showing positive program trends on visibly displayed large wall charts together with conducting brief updates at staff meetings.

Include information about how employees find out more about the program and ask questions, e.g., provide contact information for the WPV program coordinator and WPV committee members.

Having a dedicated webpage or repository on the facility intranet for all WPV program related information can be an effective vehicle for ongoing communication to employees.

It is also important to communicate to employees if, and why, a solution or process did not have the desired results, and why it may not be feasible to implement solutions that employees may have suggested. Providing this feedback to employees can assist to maintain employee involvement in the program.

Consider sharing your program efforts with your local community e.g., writing articles in local publications and working with local media to spotlight your program efforts.

Documenting and Recordkeeping

Document all program and evaluation activities and outcomes etc., is essential to effective management of the WPV program and for some activities is required by law.

OSHA recommends the following are documented:

- OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300 and 301) – mandatory for some employers with over 10 employees however, certain low-risk industries are exempt. For more information go to https://www.osha.gov/recordkeeping/
- Health Care Assault log - mandatory for Hospitals and ambulatory surgical centers in Oregon per OAR 437-001-0706, 'Recordkeeping for Health Care Assaults';
- Medical reports of work injury, workers' compensation reports and supervisors' reports for each recorded assault - e.g. DCBS Form 801 for some employers in Oregon (mandatory); Report of Accident for employers in Washington State.
- Records of incidents of abuse, reports conducted by security personnel and threat response teams, verbal attacks or aggressive behavior that may be threatening;
- Information on patients with a history of past violence, drug abuse or criminal activity recorded on the patient's chart;
- Documentation of minutes of safety meetings*, records of risk assessment/hazard analyses and corrective actions recommended and taken;
- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate how well they work;
- Tracking recommendations through to completion;
- Survey of workers before and after making job or worksite changes or installing security. Measures or new systems to determine their effectiveness;
- Records of all training programs, attendees, and qualifications of trainers.

Patient and employee confidentiality should be ensured and guaranteed.

*In Oregon, unless you are the sole owner and the only employee of a corporation, employers must have a worker safety committee (separate from a patient safety committee) or hold safety meetings, and retain and post the minutes of these meetings for employees to view. For more information go to http://osha.oregon.gov/Pages/topics/safety-committees-and-meetings.aspx

For information about employers' requirements related to safety committees in Washington State go to https://lni.wa.gov/safety-health/preventing-injuries-illnesses/create-a-safety-program/safety-meetings-and-committees

Oregon OSHA requirements for Recordkeeping related to WPV

ORS 654.412 to 654.423, 'Safety of Health Care Employees' and OAR 437-001-0706, 'Recordkeeping for Health Care Assaults' require that employers keep records of assaults against employees as described in ***Table 8.1.***

ORS 654.416 'Safety of Health Care Employees' **Section 5. Required records of assaults against employees; contents; rules**
(1) A health care employer shall maintain a record of assaults committed against employees that occur on the premises of the health care employer or in the home of a patient receiving home health care services. The record shall include, but need not be limited to, the following: (a) The name and address of the premises on which each assault occurred; (b) The date, time and specific location where the assault occurred; (c) The name, job title and department or ward assignment of the employee who was assaulted; (d) A description of the person who committed the assault as a patient, visitor, employee or other category; (e) A description of the assaultive behavior as: (A) An assault with mild soreness, surface abrasions, scratches or small bruises; (B) An assault with major soreness, cuts or large bruises; (C) An assault with severe lacerations, a bone fracture or a head injury; or (D) An assault with loss of limb or death; (f) An identification of the physical injury; (g) A description of any weapon used; (h) The number of employees, **including nursing staff** as defined in ORS 441.179 in the immediate area of the assault when it occurred; and (i) A description of actions taken by the employees and the health care employer in

ORS 654.416 'Safety of Health Care Employees' Section 5. Required records of assaults against employees; contents; rules
response to the assault. (2) A health care employer shall maintain the record of assaults described in subsection (1) of this section for no fewer than five years following a reported assault. A Record of assaults shall be kept on 'A Health Care Assault Log' which can be found together with instructions for use at http://osha.oregon.gov/Pages/re/healthcare-assault-log.aspx ***Requests for a copy of records of assaults committed against employees*** **New 2020** (3) (a) Upon the request of an employee or of a workplace safety committee conducting a review pursuant to ORS 654.414 (i.e. the WPV Program requirements) , the health care employer shall generate and make available to the requesting party a report summarizing: (A) The information in the record required under subsection (1) of this section; (B) Information regarding work-related injuries and illnesses recorded by the health care employer to comply with applicable federal health and safety recordkeeping requirements. (b) A report made available: (A) May not include any personally identifiable information; and (B) May be used only for the purposes of conducting a review of the assault prevention and protection program under ORS 654.414 or for other purposes that are related to improving the program.

Table 8.1.

For more information on compliance with Oregon OSHA requirements for recording and reporting injuries, illnesses, and fatalities and violence prevention regulations go to: http://osha.oregon.gov/Pages/topics/recordkeeping-and-reporting.aspx

Washington requirements for Recordkeeping related to WPV New 2020

Revised Code of Washington (RCW) Chapter 49.19 **RCW SAFETY—HEALTH CARE SETTINGS RCW 49.19.040** **Violent Acts -Records *(Effective January 1, 2020)***
Each health care setting shall keep a **record of any violent act against an employee**, a patient, or a visitor occurring at the setting. At a minimum, the record shall include: (1) The health care setting's name and address; (2) The date, time, and specific location at the health care setting where the act occurred; (3) The name, job title, department or ward assignment, and staff identification or social security number of the victim if an employee; (4) A description of the person against whom the act was committed as: (a) A patient; (b) A visitor; (c) An employee; or (d) Other; (5) A description of the person committing the act as: (a) A patient; (b) A visitor; (c) An employee; or (d) Other; (6) A description of the type of violent act as a: (a) Threat of assault with no physical contact; (b) Physical assault with contact but no physical injury; (c) Physical assault with mild soreness, surface abrasions, scratches, or small bruises; (d) Physical assault with major soreness, cuts, or large bruises; (e) Physical assault with severe lacerations, a bone fracture, or a head injury; or (f) Physical assault with loss of limb or death;

Revised Code of Washington (RCW) Chapter 49.19 **RCW SAFETY—HEALTH CARE SETTINGS RCW 49.19.040** **Violent Acts -Records *(Effective January 1, 2020)***
(7) An identification of any body part injured; (8) A description of any weapon used; (9) The number of employees in the vicinity of the act when it occurred; and (10) A description of actions taken by employees and the health care setting in response to the act. ***Record Retention*** • Each record shall be kept for **at least five years following the act reported**, during which time it shall be available for inspection by the department upon request.

Table 8.2.

References and Resources Related to this Section

Caring for Our Caregivers. Preventing Workplace Violence: A Road Map for Healthcare Facilities (December 2015). Occupational Safety and Health Administration (OSHA). https://www.osha.gov/Publications/OSHA3827.pdf

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Program Improvement & Sustainability

Step 15

Sustaining the WPV Program

It is critical that there is a clear plan of activities that will be conducted to facilitate the organization's ability to sustain WPV program efforts.

One of the greatest challenges to sustaining any safety program is the impact of frequent employee turnover that occurs in health care. Changes in senior leadership can impact overall organizational safety culture and shift the service focus within an organization, and changes in mid-level management can impact safety culture within units and departments. Ongoing turnover of other employees can present a challenge when maintaining standardized hazard prevention procedures, and safety culture within a team or work groups. Employee turnover also impacts program resources (budget, personnel etc.), as related to ongoing employee education and training etc.

The information about WPV program development provided in this toolkit is modeled on evidence based best practices for the design of sustainable employee and patient safety programs. If you use the program elements and related activities recommended in this toolkit to develop and implement a WPV program that is customized to your organization or facility, then you will have built a strong foundation that will allows you to successfully sustain your program.

Remember, a safety program cannot be sustained effectively by one person e.g., the WPV program coordinator, or a safety or security manager. Successful safety programs are those that use an interdisciplinary and multifaceted approach that is integrated into the organization's culture. In other words, WPV prevention and control becomes just a normal *part of everyday work.*

Chapter 6 *'Sustain Knowledge'* of **The Implementation of Best Practice Guidelines (2nd ed.). (2012).** *Toolkit by the* Registered Nurses' Association of Ontario (RNAO), provides further discussion about best practice to sustain best practices in health care.

http://rnao.ca/bpg/resources/toolkit-implementation-best-practice-guidelines-second-edition

Proactive injury prevention

Tracking injury rates and reviewing incident reports when performing ongoing evaluation of your WPV program allows you to determine if the frequency and severity of WPV related injuries are declining, and to plan strategies to prevent hazards or situations from occurring again after an incident. However, these are measurements of *past performance* (i.e., lagging indicators). They are not reliable indicators of what will happen related to the future performance of the organization or facility, nor do they allow you to mitigate hazards and risk before an incident occurs.

One of the key activities in sustaining a successful WPV program is the implementation of activities that allow you to *prevent* WPV related incidents instead of *reacting* to them.

You have already started to incorporate proactive strategies into your WPV plan when conducting staff surveys, and safety and security assessments of the physical environment, to identify and address hazards before WPV related incidents occur.

Proactive strategies as identified in **Tool 8a**, that should be used to sustain your WPV program include periodic:

- Safety and security assessments of the physical environment
- Staff and patient surveys and interviews
- Review of your program and all related processes

- Implementing a process to facilitate development and integration of design principles facility wide that enhance security and employee safety when work areas/departments are remodeled and when new construction occurs.

  Note: This process should involve design and construction departments or facilities planning and engineering, and other key departments as necessary, the WPV committee, and the managers and employees affected by the change.

  The process should mandate that the WPV committee be notified at the concept phase of a construction project so that they can review safety and security needs immediately. Incorporating safety and security design principles at the concept stage of a project is far less costly than having to retrofit or incorporate a solution after construction is completed etc.

  In addition, design a process that ensures the WPV Committee is notified and involved if someone e.g., a department manager, is considering purchasing any safety or security related equipment or tools; developing or changing existing WPV related procedures; or when new patient care processes are to be implemented etc.

  Do not forget when implementing changes to work areas or introducing new safety/security equipment etc., to conduct user testing/evaluation before the change or purchase occurs to facilitate successful implementation. Considerations for conducting *Pilot Testing* are discussed in ***Section 7.***

Other activities that can assist to proactively address WPV hazards and risk include:

- Identifying security/violence prevention related issues as part of regular safety and Environment of Care rounds.
- Ensuring that a process is in place to address hazards that are identified e.g., high hazard issues are addressed immediately with report back to the WPV Committee. Non-immediate issues are elevated to the WPV Committee to be addressed.
- Establishing an ongoing relationship with local law enforcement and educating them about the nature and challenges of working with potentially violent patients.
- Periodic review by local law enforcement representatives, workers compensation insurer, private consultants and/or other expert third-party experts to evaluate program processes and procedures. *Note:* Oregon OSHA and Washington State Labor & Industries consultation services can also provide a consultant *free of charge* to review of your WPV program.

Activities that can assist to sustain a WPV Program

Patient and employee safety literature provides many other examples of activities that can assist to facilitate culture change and sustain safety related programs that the WPV Committee can review and incorporate into the program based appropriateness for your organization. These include:

- Executive rounding and other existing rounding practices that engage employees and include a focus on worker and patient safety.
- Department based, and organization wide safety huddles.
- Hand-off practices at shift change that incorporate clear communication about patients (and visitors/families) at risk for violence etc.
- Unit based safety coaching conducted by members of the WPV Committee and/or unit based safety champions or coaches. Coaches can review how employees are addressing care needs and management of patients at risk of violence etc., and provide 'just-in' time training as needed.
- Ongoing staff training including training for new hires, periodic refresher training, and training when there is a change in practice or procedure etc. (as detailed in the WPV Education plan). Adapt periodic training to keep it 'fresh' and new as feasible, to facilitate continued employee support and enthusiasm about the program.
- Ongoing marketing and communications efforts (as detailed in the WPV Communications plan).
- Processes to develop and implement recommendations/actions from safety huddles/employee ideas and suggestions.
- Continued celebration of successes and sharing of program activities, milestones met, outcomes, and lessons learned, with all stakeholders. This includes incorporating program goals on the senior leadership dashboard or other primary communication tool for monthly or quarterly review.
- A process to recognize and reward employee ideas and safety behaviors and to disseminate learnings i.e., how they made an impact on a patient, family member, or another employee as appropriate. For example, having employees or teams that demonstrate safety behaviors or have ideas that prevent WPV etc., share them with leadership or have a place recognize these employees that is visible to their coworkers, management and patients e.g., safety boards on units.

Take care not to reward employees or departments for the achieving the lowest injury rate as this can motivate employees *not to report* safety related incidents including those related to WPV. Given that WPV is hugely underreported in health care, it is important that recognition programs reward desired safety behaviors etc. This approach can help to facilities further change and compliance with WPV program process and policy.

As your WPV program matures (after initial successes and high-risk hazards are addressed) revisit the structure and membership of your WPV committee. Do some members want to be replaced with other coworkers from the same department? Are there other stakeholders that should be on the committee? Could the work of the WPV be conducted by the facility employee safety committee? This may be necessary in smaller facilities where personnel resources are limited etc.

As the program matures consider how to use employee or department-based safety teams to audit work areas and solve problems.

Keep up to date about new strategies and evidence available to prevent and respond to violence in the health care as they develop.

All of the above activities, and many of those already described throughout this toolkit help to achieve ongoing management and employee engagement and support for the WPV program.

As discussed in ***Section 1*** of this toolkit, WPV prevention is relatively new in health care so consider sharing information about your WPV program and lessons learned with other health care professionals and organizations through:

- Publication of articles in peer review safety and health, nursing and health care leadership journals, and other service trade publications.
- Presentations made at local, state, and national health care related conferences, e.g., the Oregon Governor's Safety and Health (GOSH) conference which is held every two years in Portland and the annual Washington State Governor's Industry Safety and Health (GISH) conference.

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Facilities Design

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The Center for Health Design **New 2020**

- **Behavioral & Mental Health Toolbox**
  Tools webinars and more
  https://www.healthdesign.org/behavioral-mental-health-toolbox
- **Comprehensive Test Methods for Products in Behavioral Health Environments at the Design in Mental Health Network**
  PDF and Webinar
  https://www.healthdesign.org/insights-solutions/comprehensive-test-methods-products-behavioral-health-environments-design-mental

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Domestic Violence 10.10

Additional Resources – Miscellaneous

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Framework Guidelines for Addressing Workplace Violence in the Health Sector: The Training Manual (2005). International Labor Organization, International Council of Nurses, World Health Organization, and Public Services International. http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_108542.pdf

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Linking Services and Safety: Together Creating Safer Places of Service Findings and recommendations from a working group on violence and aggression in the healthcare sector (2008). Health Services Executive Ireland. http://www.hse.ie/eng/staff/Resources/hrstrategiesreports/Linking_Service_Safety_Summary.pdf

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Responses of Nurses and Other Healthcare Workers to Sexual Harassment in the Workplace (2019). Online Journal of Issues in Nursing, 24(1). Burke Draucker, C. New 2020

The influence of personal dispositional factors and organizational resources on workplace violence, burnout, and health outcomes in new graduate nurses: A cross-sectional study (2012). Laschinger, H. K. S., & Grau, A. L. International journal of nursing studies, 49(3), 282-291.

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Violence in the Health Sector. Proceedings of the Fourth International Conference on Violence in the Health Sector Towards safety, security and wellbeing for all (2014). 22 – 24 October 2014, Miami (FL), USA. http://www.oudconsultancy.nl/Resources/Proceedings%204th%20Workplace%20Violence.pdf

Violence in the Workplace: Policy and Procedures Manual for Human Resource Professionals (2010). Connecticut State Dept. of Developmental Services. www.ct.gov/dmhas/lib/dmhas/publications/WPVManual.pdf

Violence Prevention – Resources from the CDC related to Child, Youth, Elder, Intimate partner, and sexual abuse/violence. https://www.cdc.gov/ViolencePrevention/index.html

University of Washington Department of Environmental and Occupational Health Sciences School of Public health

- **Workplace Violence Resource Page resources for professionals across a *variety of industries.*** https://osha.washington.edu/pages/workplace-violence-resource-page?inf_contact_key=5fd29e0609d6eb6a265f1f86e44b8f5956edad622626cf626fc4dcca1d762657

Canadian Centre for Occupational Health and Safety

- **Violence in the Workplace - Warning Signs for Violence** https://www.ccohs.ca/oshanswers/psychosocial/violence_warning_signs.html

Prevention of Violence in the Workplace British Columbia Interactive toolkit
http://innovation.ghrp.ubc.ca/povdemo/

WorkSafe BC Violence Prevention Resources for Health Care
https://www.worksafebc.com/en/health-safety/hazards-exposures/violence

Books
Handbook of Modern Hospital Safety, Second Edition (2009). Charney, W. CRC Press, Jul 28, 2009.

Long Term Care

Addressing workplace violence among nurses who care for the elderly. (2014). Rodwell, J., & Demir, D. JONA: The Journal of Nursing Administration, 44(3), 152-157. **New 2020**

Minimizing workplace violence in LTC facilities and other related resources. iadvance senior care, Canada. https://www.iadvanceseniorcare.com/minimizing-workplace-violence-in-ltc-facilities/

Musculoskeletal pain and reported workplace assault: a prospective study of clinical staff in nursing homes (2014). Miranda, H., Punnett, L,. Gore, R.J. Hum Factors. 2014 Feb;56(1):215-27.

Perceptions and implications of violence from care home residents with dementia: a review and commentary (2011). Scott, A., et. al. Int. J Older People Nurs. 2011 Jun;6(2):110-22.

Workplace hazards faced by nursing assistants in the United States: a focused literature review. (2017). Walton, A. L., & Rogers, B. International journal of environmental research and public health, 14(5), 544. **New 2020**

Worksafe BC 2009–Violence in LTC
https://www.youtube.com/watch?v=OZmmti-rL90

Public Services Health and Safety Association (PSHSA) 2019 Ontario Canada
Extensive WPV Toolkit for LTC
https://www.pshsa.ca/emerging-issues/issues/workplace-violence-in-healthcare/workplace-violence-leadership-table-phase-2

Home Health/Community Workers

Refer to Section 6 for more information about training for Home Care Workers

A communication skills intervention for community healthcare workers reduces perceived patient aggression: A pretest / post-test study (2014). Swain, N., Gale, C., International Journal of Nursing Studies, 51, 9, 1241.

A risk assessment screening tool for community health care workers (2010). Lundrigan, E., Hutchings, D., Mathews, M., Lynch, A., & Goosney, J. *Home Health Care Management & Practice*, *22*(6), 403-407.

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New Jersey Home Health Care Aides Survey Results. (2019). Home Health Care Management & Practice, 1084822319831933. Ridenour, M. L., Hendricks, S., Hartley, D., & Blando, J. D. **New 2020**

Prevalence of Violence Toward Community Nurses: A Questionnaire Survey (2017). Gabrovec B. Workplace Health Safety. Nov;65(11):527-532. Epub 2017 Apr 17.

Risk Assessment Tool and Safety Program Keep Home Care Workers Safe (2011) ECRI
http://westernhealth.nl.ca/uploads/research/Risk-Assessment-home-care-workers.pdf

Violence, job satisfaction, and employment intentions among home healthcare registered nurses (2009). Canton A.N. et. al. Home Health Nurse. 2009 Jun;27(6):364-73.

Workplace health and safety issues among community nurses: a study regarding the impact on providing care to rural consumers. (2015). Terry, D., Lê, Q., Nguyen, U., et al. BMJ Open. (5). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4538262/pdf/bmjopen-2015-008306.pdf

Workplace violence prevention policies in home health and hospice care agencies (2013). Gross, N., Peek-Asa, C., Nocera, M., et al. The Online Journal of Issues in Nursing. 18(1): Manuscript 1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4538262/

American Hospital Association

Podcast: Hospitals Against Violence: The Impact of Violence on Home Health Care Providers February 2017
http://www.aha.org/advocacy-issues/violence/17homehealthpodcast.shtml

NIOSH

Training Curriculum for Homecare Workers

Caring for Yourself While Caring for Others is a free and curriculum developed by NIOSH to assist trainers in meeting the health and safety training needs for homecare workers with respect to hazards commonly encountered in homecare workplaces and practical solutions to manage risks and improve safety. https://www.cdc.gov/niosh/docs/2015-102/default.html

WorkSafe BC

Leave When It's Unsafe - Video for community health care workers
https://www.worksafebc.com/en/health-safety/hazards-exposures/violence

Public Services Health and Safety Association (PSHSA) 2019 Ontario Canada

Violence Prevention Toolkit for Home Care. New 2020
https://www.pshsa.ca/emerging-issues/issues/workplace-violence-in-healthcare/workplace-violence-leadership-table-phase-2

Lateral Violence/Bullying

Abusive supervision, thwarted belongingness, and workplace safety: A group engagement perspective. (2019). Journal of Applied Psychology. Yang, L. Q., Zheng, X., Liu, X., Lu, C. Q., & Schaubroeck, J. M. New 2020

A task force to address bullying (2016). Keller, R., Budin, W. C., & Allie, T. AJN The American Journal of Nursing, 116(2), 52-58.
https://journals.lww.com/ajnonline/Abstract/2016/02000/A_Task_Force_to_Address_Bullying.25.aspx

Break the bullying cycle (2012). Townsend, T., American Nurse Today. January 2012 7(1)12-15.
https://www.americannursetoday.com/break-the-bullying-cycle/

Bullying has no place in health care (2016) Quick Safety. The Joint Commission New 2020
https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/joint-commission-online/quick_safety_issue_24_june_2016pdf.pdf?db=web&hash=84E4112AB428AD3CA1D5B9F868A1AD10

Bullying and Workplace Violence. American Nurses Association http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence

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Combating Disruptive Behaviors: Strategies to Promote a Healthy Work Environment (2010). Joy Longo, DNS, RNC-NIC Online J Issues Nurse. 2010 15(1)**.**

Creating a Nurse-Led Culture to Minimize Horizontal Violence in the Acute Care Setting: A Multi-Interventional Approach (2016). Parker, K. M., Harrington, A., Smith, C. M., Sellers, K. F., & Millenbach, L. Journal for nurses in professional development, 32(2), 56-63. http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol152010/No1Jan2010/Combating-Disruptive-Behaviors.html

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How One Organization Used Evidence to Address Lateral Violence Among Nurses (2017). Salter, D. S. In Creating Healthy Work Environments 2017 (17-20 March). STTI.

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No laughing matter: workplace bullying, humor orientation, and leadership styles (2019). Mills, C. B., Keller, M., Chilcutt, A., & Nelson, M. D. Workplace health & safety, 67(4), 159-167. **New 2020**

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"Nurses Eat Their Young": A Novel Bullying Educational Program for Student Nurses (2017). Gillespie, G.L.,et. al. J Nurs Educ Pract. 7(7):11-21. Epub 2017 Feb 12.

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http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_40.htm

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The New Age of Bullying and Violence in Health Care: Part 4 (2018). Managing Organizational Cultures and Beyond. Professional case management, 23(6), 294-306. Fink-Samnick, E. **New 2020**

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Workplace Incivility and Productivity Losses Among Direct Care Staff (2008). Scott Hutton, S & Gates, D, FAAN AAOHN J. 2008 Apr;56(4):168-75.

Canadian Center for Occupational Health and Safety (CCOHS)

Information on workplace bullying,
http://www.ccohs.ca/oshanswers/psychosocial/bullying.html

Public Services Health and Safety Association (PSHSA) 2019 Ontario Canada

Bullying In The Workplace **New 2020**
https://www.pshsa.ca/resources/bullying-in-the-workplace

WorkSafe Victoria, Australia.

Workplace bullying – prevention and response (2012).
https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0010/211006/ISBN-Workplace-bullying-prevention-response-2012-10.pdf

Books

Ending nurse-to-nurse hostility: Why nurses eat their young and each other **(2006).**
Bartholomew, K. HC Pro, Inc. Marblehead, MA.

Journals

Journal of Interpersonal Violence Sage Publishing
https://journals.sagepub.com/home/jiv

Domestic Violence

A Call to Action: The Nursing Role in Routine Assessment for Intimate Partner Violence (2012). Family Violence Prevention Fund
https://www.futureswithoutviolence.org/userfiles/file/HealthCare/nursing.pdf

AHRQ Innovations Healthcare Exchange New 2020
https://www.innovations.ahrq.gov/

Search by 'violence' and many case studies related to a broad range of violence related topics

Emergency Nurses Association *New 2020*
https://www.ena.org/practice-resources/resource-library/clinical-practice-guidelines

- **Intimate Partner Violence Clinical Practice Guideline**
- **Intimate Partner Violence CPG Synopsis**

Minnesota Department of Health
https://www.health.state.mn.us/facilities/patientsafety/preventionofviolence/toolkit.html

Risk Identification

- Metro Compact - Domestic Violence Assessment Form (PDF)

OSHA

- Assaulted and/or Battered Employee Policy*
  https://www.osha.gov/SLTC/etools/hospital/hazards/workplaceviolence/employeepolicy.html

Worksafe BC

Addressing Domestic Violence in the Workplace: A Handbook for Employers 2015
www.worksafebc.com