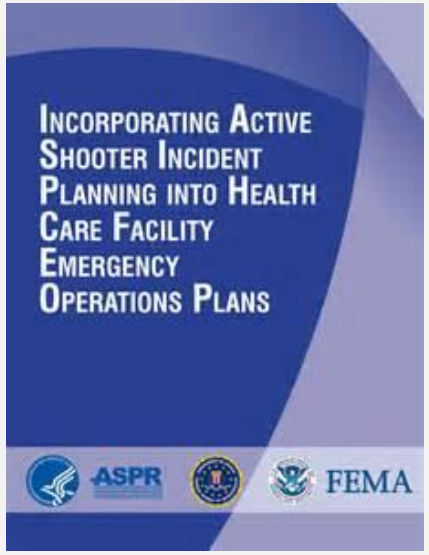
AGGRESSION IN HEALTHCARE: ARE YOU PREPARED?

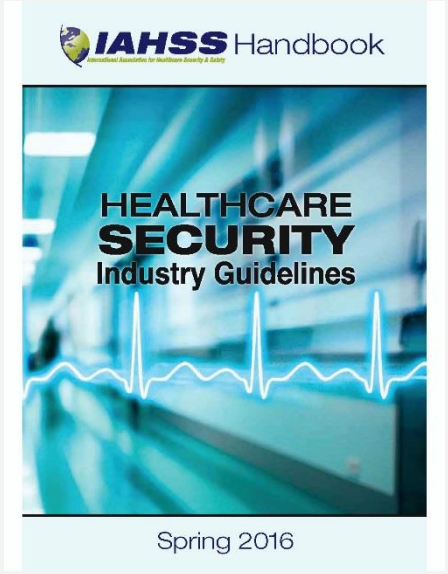
Assessing and Planning for the Management of Aggressive Patients and Others in the Healthcare Setting

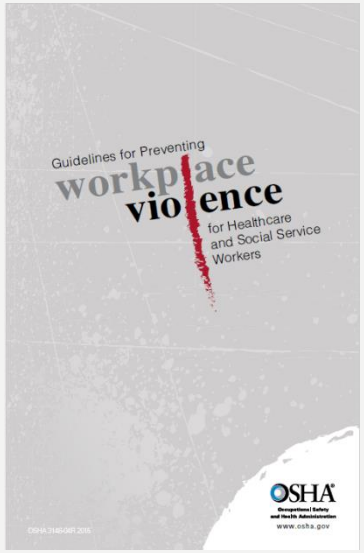
THIE

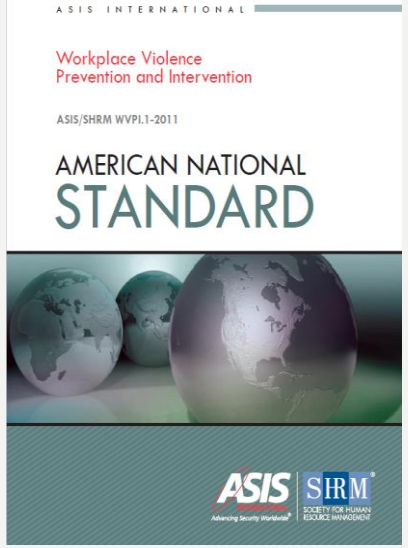
October 3, 2019

WHAT IS WORKPLACE VIOLENCE?









OSHA®

Depends on who you ask

UNITED STATES
DEPARTMENT OF LABOR

Find it in OSHA

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Safety and Health Topics / Healthcare

Healthcare

- Culture of Safety
- Infectious Diseases
- Safe Patient Handling
- Workplace Violence
- Other Hazards
- Standards and Enforcement

Workplace Violence

Workplace violence (WPV) is a recognized hazard in the healthcare industry. WPV is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It can affect and involve workers, clients, customers and visitors. WPV ranges from threats and verbal abuse to physical assaults and even homicide. In 2010, the Bureau of Labor Statistics (BLS) data reported healthcare and social assistance workers were the victims of approximately 11,370 assaults by persons; a greater than 13% increase over the number of such assaults reported in 2009. Almost 19% (i.e., 2,130) of these assaults occurred in nursing and residential care facilities alone. Unfortunately, many more incidents probably go unreported.

Hazard Evaluation and Solutions

In most workplaces where risk factors can be identified, the risk of assault can be prevented or minimized if employers take appropriate precautions. One of the best protections healthcare employers can offer their workers is to establish a zero-tolerance policy toward workplace violence. The policy should cover all workers, patients, clients, visitors, contractors, and anyone else who may come in contact with workers of the facility.

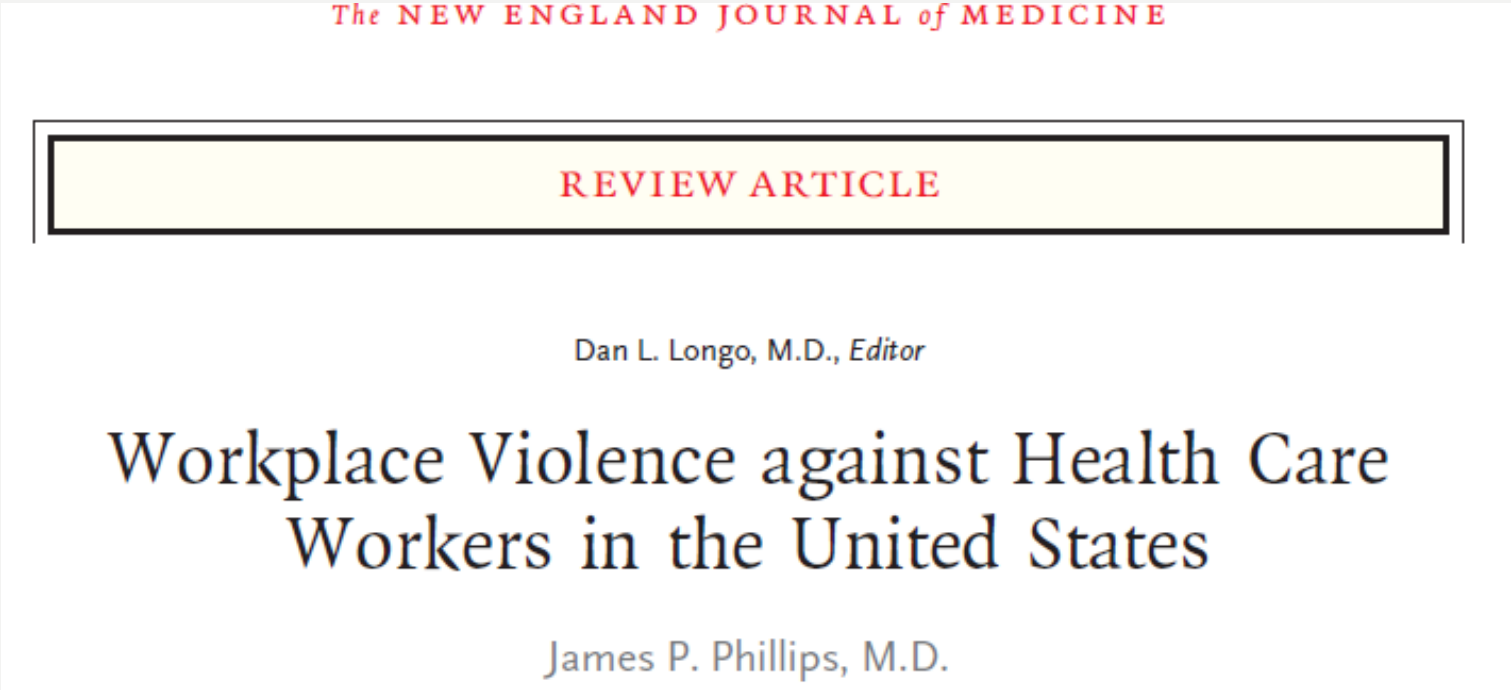
By assessing their worksites, employers in the healthcare industry can identify methods for reducing the likelihood of incidents occurring. OSHA believes that a well written and implemented Workplace Violence Prevention Program, combined with engineering controls, administrative controls and training can reduce the incidence of workplace violence. It is critical to ensure that all workers know the policy and understand that all claims of workplace violence will be investigated and remedied promptly.

OSHA has developed a Workplace Violence Safety and Health Topics Page with information that can help you properly evaluate your workplace and prepare to prevent or minimize the

Highlights

NEW OSHA's Request for Information: Preventing Workplace Violence in Healthcare and Social Assistance. On December 7, 2016, OSHA's Request for Information: Preventing Workplace Violence in Healthcare and Social Assistance was published in the *Federal Register*. This RFI solicits information on a range of questions relevant to

THE NUMBERS NOT ENTIRELY KNOWN



The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Workplace Violence against Health Care Workers in the United States

James P. Phillips, M.D.

"Health care workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored."

And the problem is not new…

United States Government Accountability Office

GAO

Report to Congressional Requesters

March 2016

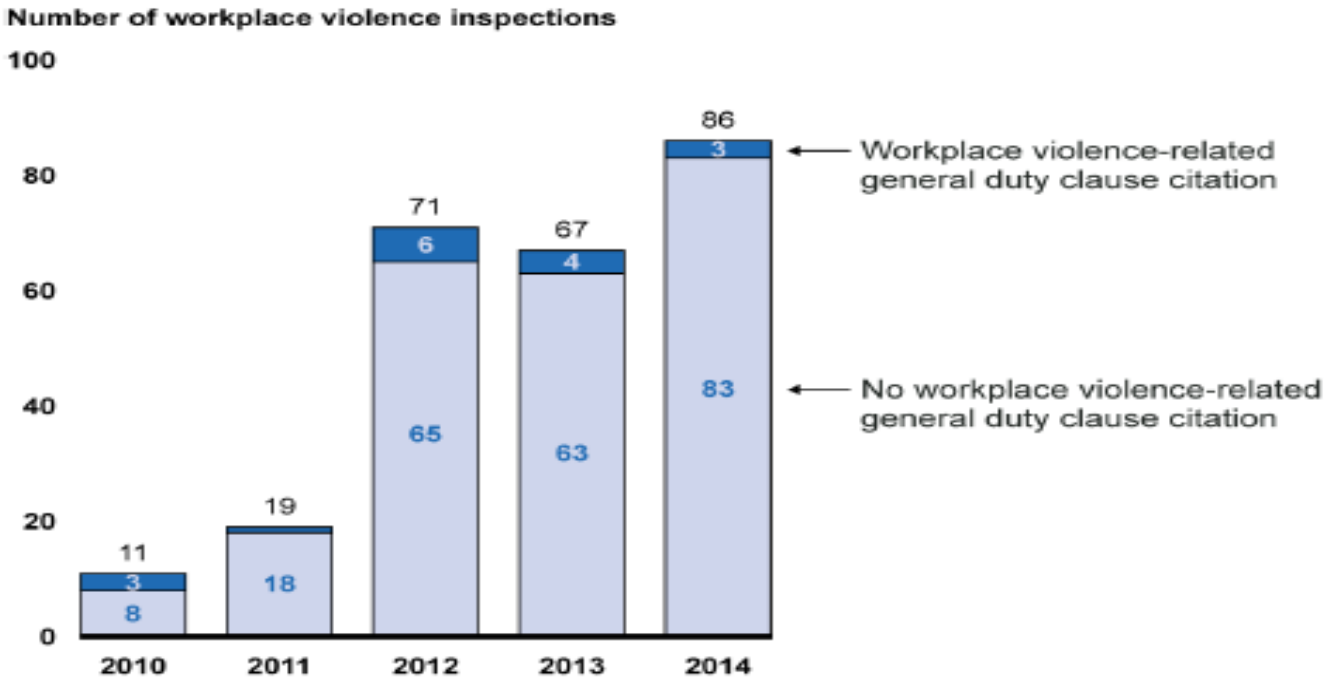
WORKPLACE SAFETY AND HEALTH

Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence

This Report is Temporarily Restricted Pending Official Public Rele

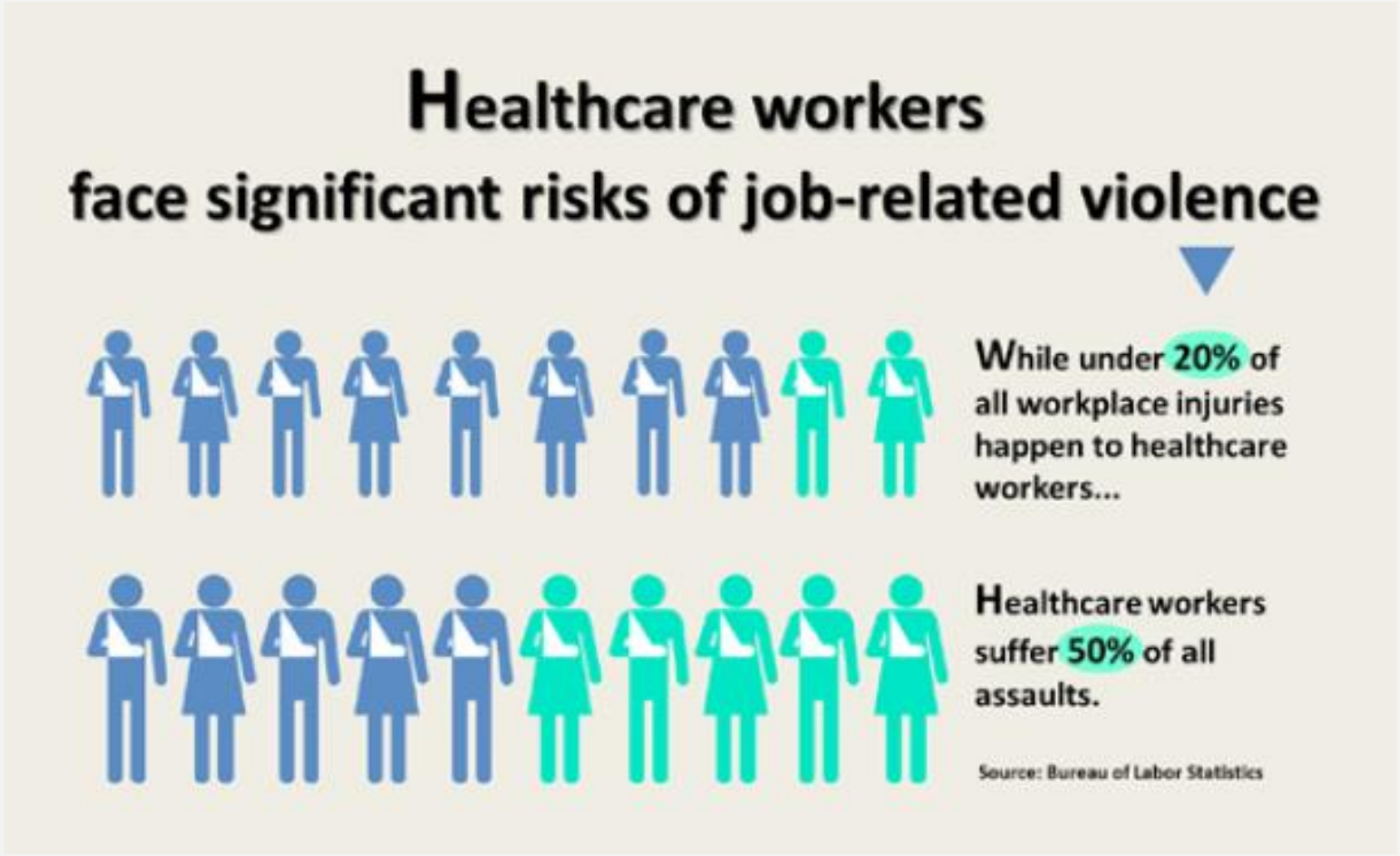
GAO-16-11

Figure 7: Number of OSHA Workplace Violence Inspections at Health Care Employers' Facilities Resulting in a General Duty Clause Citation, Calendar Years 2010-2014

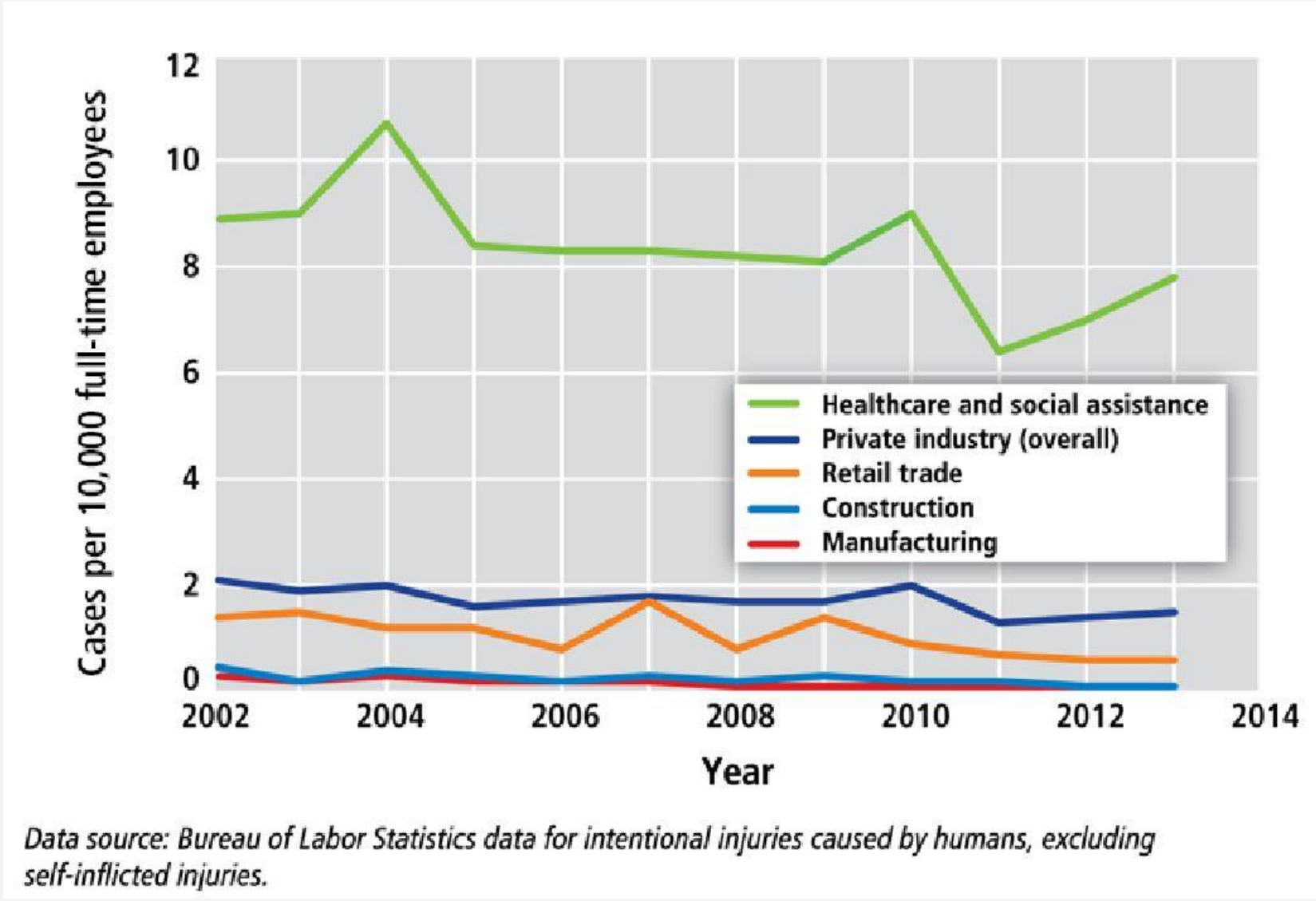


Source: GAO analysis of Occupational Safety and Health Administration (OSHA) enforcement data. | GAO-16-11

THE SCOPE IS HUGE

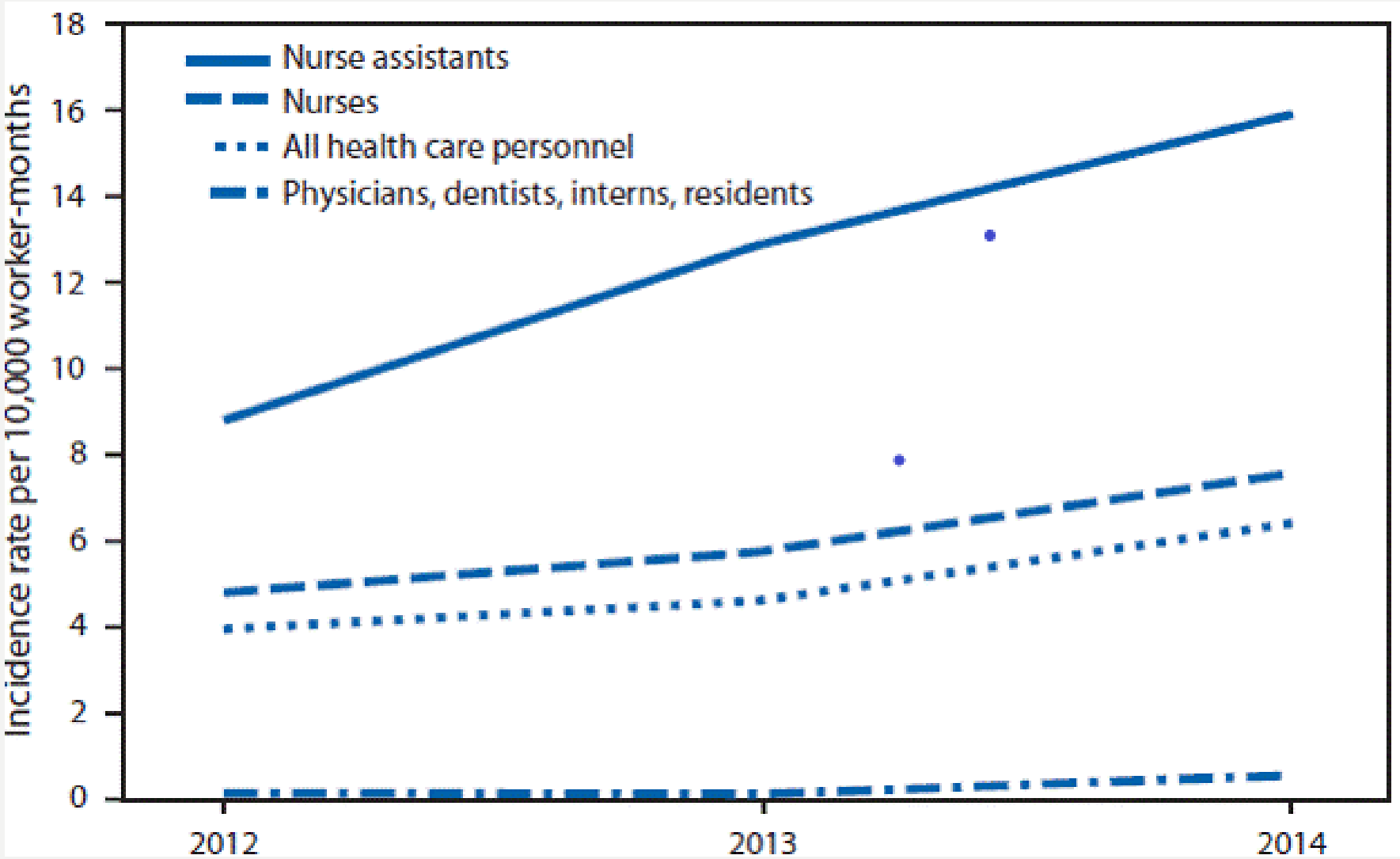


HUMAN CAUSED INJURIES

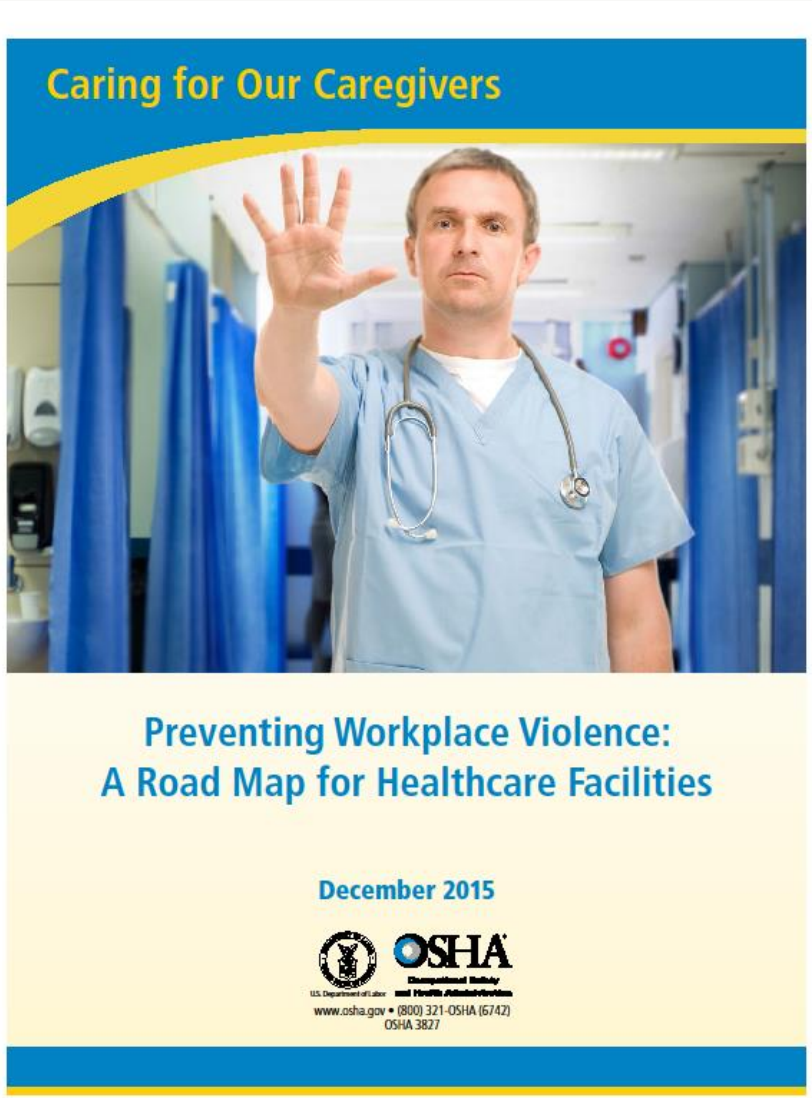


Data source: Bureau of Labor Statistics data for intentional injuries caused by humans, excluding self-inflicted injuries.

HUMAN CAUSED INJURIES



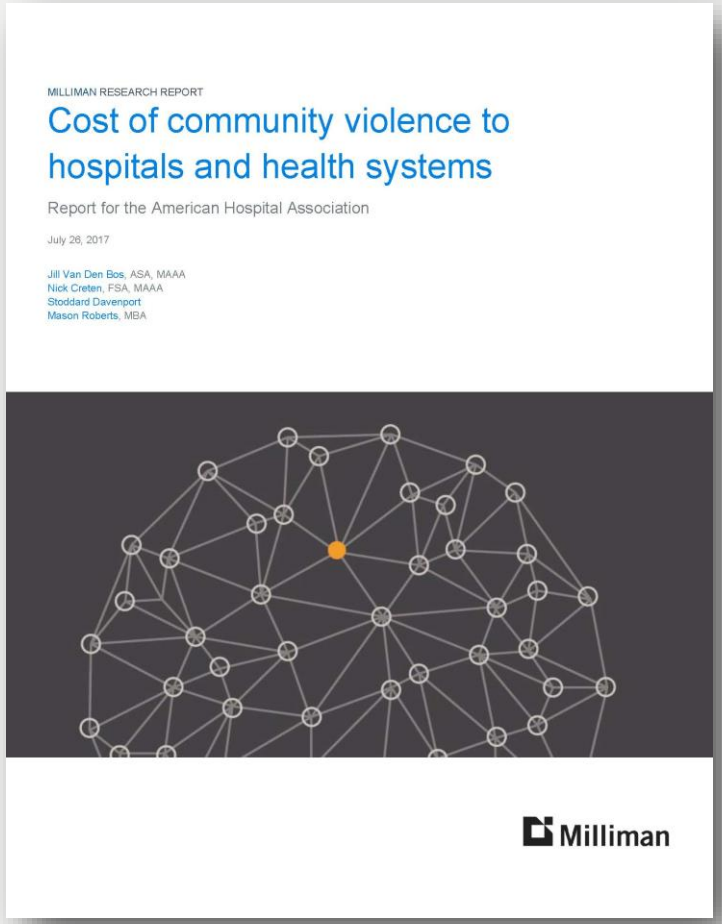
Morbidity and Mortality Weekly Report (*MMWR*)



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

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

THE COSTS…..



"Overall, we estimated that proactive and reactive violence response efforts cost U.S. hospitals and health systems approximately $2.7 billion in 2016. This includes $280 million related to preparedness and prevention to address community violence, $852 million in unreimbursed medical care for victims of violence, $1.1 billion in security and training costs to prevent violence within hospitals, and an additional $429 million in medical care, staffing, indemnity, and other costs as a result of violence against hospital employees."

WHAT OSHA IS SAYING

UNITED STATES
DEPARTMENT OF LABOR

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OSH Act of 1970 - Table of Contents

SEC. 5. Duties

(a) Each employer --

(1) shall 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; 29 USC 654

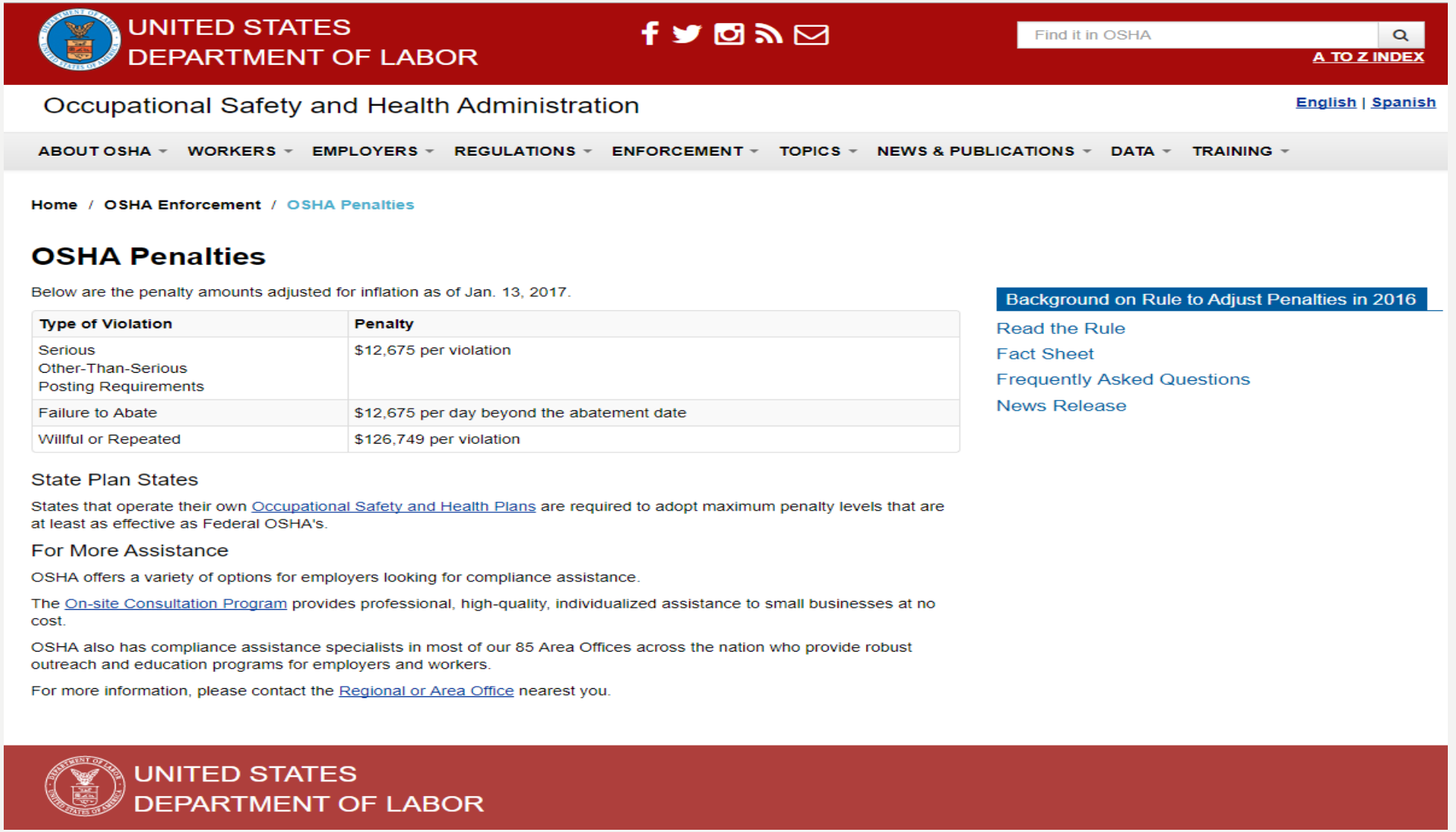
(2) shall comply with occupational safety and health standards promulgated under this Act.

(b) Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this Act which are applicable to his own actions and conduct.

OSH Act of 1970 - Table of Contents

UNITED STATES
DEPARTMENT OF LABOR

POSSIBLE FINES



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Home / OSHA Enforcement / OSHA Penalties

OSHA Penalties

Below are the penalty amounts adjusted for inflation as of Jan. 13, 2017.

Type of Violation	Penalty
Serious Other-Than-Serious Posting Requirements	$12,675 per violation
Failure to Abate	$12,675 per day beyond the abatement date
Willful or Repeated	$126,749 per violation

State Plan States

States that operate their own Occupational Safety and Health Plans are required to adopt maximum penalty levels that are at least as effective as Federal OSHA's.

For More Assistance

OSHA offers a variety of options for employers looking for compliance assistance.

The On-site Consultation Program provides professional, high-quality, individualized assistance to small businesses at no cost.

OSHA also has compliance assistance specialists in most of our 85 Area Offices across the nation who provide robust outreach and education programs for employers and workers.

For more information, please contact the Regional or Area Office nearest you.

Background on Rule to Adjust Penalties in 2016

Read the Rule
Fact Sheet
Frequently Asked Questions
News Release

UNITED STATES DEPARTMENT OF LABOR

SO WHAT ARE "WE" DOING?

American Hospital Association

AHA State Issues Forum Meeting
May 5, 2018, 8:45 am to 1:00 pm
Washington Hilton Hotel, Lincoln Room

2018 IAHSS Annual Conference & Exhibition
50th ANNIVERSARY
April 15-18 | Chicago, IL

IAHSS Annual General Meeting
of IAHSS Members

April 16, 2018

26th ANNUAL
American Hospital Association
LEADERSHIP SUMMIT

July 26-28, 2018 | San Diego, California
Manchester Grand Hyatt

Stakeholder Meeting

January 10, 2017

Testimony to be included with written responses to RFI

OSHA Rule-making processes take up to seven years

AGENDA

OSHA

Workplace Violence Stakeholder Meeting

Department of Labor/Occupational Safety and Health Administration

January 10, 2017

Morning Session (9:00 a.m.)

1. **Welcome: Jordan Barab, Deputy Assistant Secretary for OSHA**

2. **Participants' experiences with workplace violence in the healthcare and social assistance sector:**
   - Opening statements (from those who registered), including personal stories by workers about being harmed and/or injured by violence in a healthcare or social assistance workplace.
   - Based on your experience, have you noticed any changes in the nature or extent of your organization or facility's workplace violence incidents? Have you noticed any factors that have affected your experience? If so, how have these factors impacted your facility or organization?

Lunch (12:00 noon)

Afternoon Session (1:00 p.m.)

1. **Success stories:**
   - Participants share success stories about reducing workplace violence from the perspectives of employees, facilities, and organizations.
   - What caused your organization to start paying more attention to workplace violence? Did you start with a single policy, a single procedure, or a few steps of the program, or did you implement an entire program? What was your model?

2. **Protecting workers from workplace violence:**
   - Since first publishing its *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* in 1996, OSHA's approach has been programmatic and focused on five essential elements. In your experience, have you found some elements more effective than others? Are you aware of and/or do you have any experience with alternative approaches?
   - If your state has laws that require employers/facilities to reduce risks for workplace violence, what has been your experience complying with these requirements? Are there any specific provisions included in your state law that you think should or should not be included in a potential OSHA standard? If so, what are these provisions and what is the reason for your assessment?
   - Are there any specific controls or interventions that you have found to be effective in reducing workplace violence in environments where healthcare and/or social assistance workers are employed? How did you determine the effectiveness of these controls or interventions?
   - Are you aware of any research that OSHA should be sure to consider?

3. **Advice for the Agency moving forward:**
   - What recommendations do you have for OSHA so it can make the right decisions moving forward to prevent workplace violence?

4. **Closing (4:45 p.m.)**

Federal Register / Vol. 81, No. 235 / Wednesday, December 7, 2016 / Proposed Rules 88147

General Electric Company: Docket No. FAA–2016–9167; Directorate Identifier 2016–NE–20–AD.

(a) Comments Due Date

We must receive comments by January 23, 2017.

(b) Affected ADs

None.

(c) Applicability

This AD applies to General Electric Company (GE) GE90–76B, GE90–85B, GE90–90B, GE90–94B, GE90–110B1, and GE90–115B turbofan engines with a fuel/oil lube/servo cooler ("main heat exchanger") part number (P/N) 1838M88P11 or 1838M88P13, with a serial number listed in paragraph 1.A of GE Service Bulletin (SB) GE90–100 SB 79–0034, Revision 03, dated August 05, 2016; or SB GE90 SB 79–0058, Revision 02, dated August 05, 2016.

(d) Subject

Joint Aircraft System Component (JASC) Code 7921, Engine Oil Cooler.

(e) Unsafe Condition

This AD was prompted by an engine and airplane fire. We are issuing this AD to prevent failure of a main heat exchanger, which could result in an engine fire.

(f) Compliance

Comply with this AD within the compliance times specified, unless already done.

(g) Required Actions

Within 12 months after the effective date of this AD, replace the main heat exchanger with a part eligible for installation.

(h) Definition

For purposes of this AD, a part eligible for installation is a main heat exchanger with a P/N and serial number not listed in paragraph (c) of this AD or a main heat exchanger repaired in accordance with the Accomplishment Instructions, paragraphs 3.C.(2) through 3.C.(7), of GE SB GE90–100 SB 79–0034, dated December 3, 2014; Revision 01, dated August 14, 2015; Revision 02, dated November 6, 2015; or Revision 03, dated August 5, 2016; or GE SB GE90 SB 79–0058, dated August 18, 2015; Revision 01, dated December 10, 2015; or Revision 02, dated August 05, 2016.

(i) Alternative Methods of Compliance (AMOCs)

(1) The Manager, Engine Certification Office, FAA, may approve AMOCs for this AD. Use the procedures found in 14 CFR 39.19 to make your request. You may email your request to: *ANE-AD-AMOC@faa.gov.*

(2) Before using any approved AMOC, notify your appropriate principal inspector, or lacking a principal inspector, the manager of the local flight standards district office/certificate holding district office.

(j) Related Information

(1) For more information about this AD, contact John Frost, Aerospace Engineer, Engine Certification Office, FAA, 1200 District Avenue, Burlington, MA 01803; phone: 781–238–7756; fax: 781–238–7199; email: *john.frost@faa.gov.*

(2) For service information identified in this AD, contact General Electric Company, GE-Aviation, Room 285, 1 Neumann Way, Cincinnati, OH 45215, phone: 513–552–3272; email: *aviation.fleetsupport@ge.com.*

(3) You may view this referenced service information at the FAA, Engine & Propeller Directorate, 1200 District Avenue, Burlington, MA. For information on the availability of this material at the FAA, call 781–238–7125.

Issued in Burlington, Massachusetts, on November 16, 2016.

Colleen M. D'Alessandro,

Manager, Engine & Propeller Directorate, Aircraft Certification Service.

[FR Doc. 2016–28667 Filed 12–6–16; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

29 CFR Part 1910

[Docket No. OSHA—2016–0014]

RIN 1218–AD 08

Prevention of Workplace Violence in Healthcare and Social Assistance

AGENCY: Occupational Safety and Health Administration (OSHA), DOL.

ACTION: Request for Information (RFI).

SUMMARY: Workplace violence against employees providing healthcare and social assistance services is a serious concern. Evidence indicates that the rate of workplace violence in the industry is substantially higher than private industry as a whole. OSHA is considering whether a standard is needed to protect healthcare and social assistance employees from workplace violence and is interested in obtaining information about the extent and nature of workplace violence in the industry and the nature and effectiveness of interventions and controls used to prevent such violence. This RFI provides an overview of the problem of workplace violence in the healthcare and social assistance sector and the measures that have been taken to address it. It also seeks information on issues that might be considered in developing a standard, including scope and the types of controls that might be required.

DATES: Submit comments on or before April 6, 2017. All submissions must bear a postmark or provide other evidence of the submission date.

ADDRESSES: Submit comments and additional materials by any of the following methods:

Electronically: Submit comments and attachments electronically at *http://www.regulations.gov,* which is the Federal eRulemaking Portal. Follow the instructions online for making electronic submissions.

Facsimile: OSHA allows facsimile transmission of comments and additional material that are 10 pages or fewer in length (including attachments). Send these documents to the OSHA Docket Office at (202) 693–1648. OSHA does not require hard copies of these documents. Instead of transmitting facsimile copies of attachments that supplement these documents (for example, studies, journal articles), commenters must submit these attachments to the OSHA Docket Office, Technical Data Center, Room N–3653, OSHA, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210. These attachments must identify clearly the sender's name, the date, subject, and docket number OSHA–2016–0014 so that the Docket Office can attach them to the appropriate document.

Regular mail, express mail, hand delivery, or messenger (courier) service: Submit comments and any additional material (for example, studies, journal articles) to the OSHA Docket Office, Docket No. OSHA–2016–0014 or RIN 1218–AD 08, Technical Data Center, Room N–3653, OSHA, U.S. Department of Labor, 200 Constitution Ave., NW., Washington, DC 20210; telephone: (202) 693–2350. (OSHA's TTY number is (877) 889–5627.) Contact the OSHA Docket Office for information about security procedures concerning delivery of materials by express mail, hand delivery, and messenger service. The hours of operation for the OSHA Docket Office are 10 a.m. to 3:00 p.m., e.t.

Instructions: All submissions must include the Agency's name and the docket number for this Request for Information (OSHA–2016–0014). OSHA will place comments and other material, including any personal information, in the public docket without revision, and these materials will be available online at *http://www.regulations.gov.* Therefore, OSHA cautions commenters about submitting statements they do not want made available to the public and submitting comments that contain personal information (either about themselves or others) such as Social Security numbers, birth dates, and medical data.

If you submit scientific or technical studies or other results of scientific research, OSHA requests (but is not

SUMMARY:

Workplace violence against employees providing healthcare and social assistance services is a serious concern. Evidence indicates that the rate of workplace violence in the industry is substantially higher than private industry as a whole. OSHA is considering whether a standard is needed to protect healthcare and social assistance employees from workplace violence and is interested in obtaining information about the extent and nature of workplace violence in the industry and the nature and effectiveness of interventions and controls used to prevent such violence. This RFI provides an overview of the problem of workplace violence in the healthcare and social assistance sector and the measures that have been taken to address it. It also seeks information on issues that might be considered in developing a standard, including scope and the types of controls that might be required.

OSHA & Worker Safety

Guidelines for Zero Tolerance

New OSHA publication helps prevent violence in the health care setting

According to the Bureau of Labor Statistics, in 2013, 27 of the 100 fatalities that occurred in health care and social service settings were due to assaults and violent acts. Moreover, of all the assaults that occurred between 2011 and 2013 in all workplaces across the country—an average of 24,000 per year—70% to 74% occurred in health care and social service settings.

Now consider this: Research indicates that workplace violence (WPV) is underreported—suggesting that the actual rates may be much higher.

"There's a culture in many health care settings that accepts violence as a part of the job, that expects it when working with a patient or client who has a violent history," says Dionne Williams, director, Office of Health Enforcement for the Occupational Safety and Health Administration (OSHA). "Often, the thinking is, 'Let's not get the patient or client in trouble. Let's not escalate the issue.' It's one of the alarming things we've learned about WPV."

One of the best protections employers can offer their workers is a policy of zero tolerance toward violence in the workplace. A second protection is a well-written and implemented WPV-prevention program.

"Health care organizations rightfully focus significant effort on improving patient outcomes," says Williams. "One measure we see is the avoidance of patient restraints, even for those who act out or become potentially violent. A few states have laws that prohibit restraints. We're trying to come up with recommendations that balance improvement in patient health with employee safety."

New WPV guidelines from OSHA

In 2015, OSHA updated its Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. The 2015 edition makes use of new data, research, and experience to recommend procedures for reducing—or, ideally, eliminating—WPV. The guidelines explain the components of a WPV-prevention program, and they include checklists to identify risk factors.

Williams notes that the new guidelines focus on particulars of the setting and how they relate to causes and controls. Citing epidemiological studies, for example, the guidelines note that "inpatient and acute psychiatric services, geriatric long term care settings, high-volume urban emergency departments, and residential and day social services present the highest risks. Pain, devastating prognoses, unfamiliar surroundings, mind- and mood-altering medications, drugs, and disease progression can all cause agitation and violent behaviors."

Williams particularly mentions the effort OSHA has made to address key differences between settings, remarking that each has its own risk factors, some related to patients or settings—for example, being located in a high-crime area—and others related to the organization—for example, lack of WPV-related training or policies.

The guidelines consider these five settings:

- Hospitals
- Residential treatment facilities, such as nursing homes and other long-term care facilities
- Nonresidential treatment/service centers, such as small neighborhood clinics and mental health centers
- Community care facilities, such as group homes
- Field settings, such as the homes that health care workers or social workers visit

Building blocks for WPV prevention

The new OSHA guidelines recommend the following five components for a violence-prevention program in the workplace:

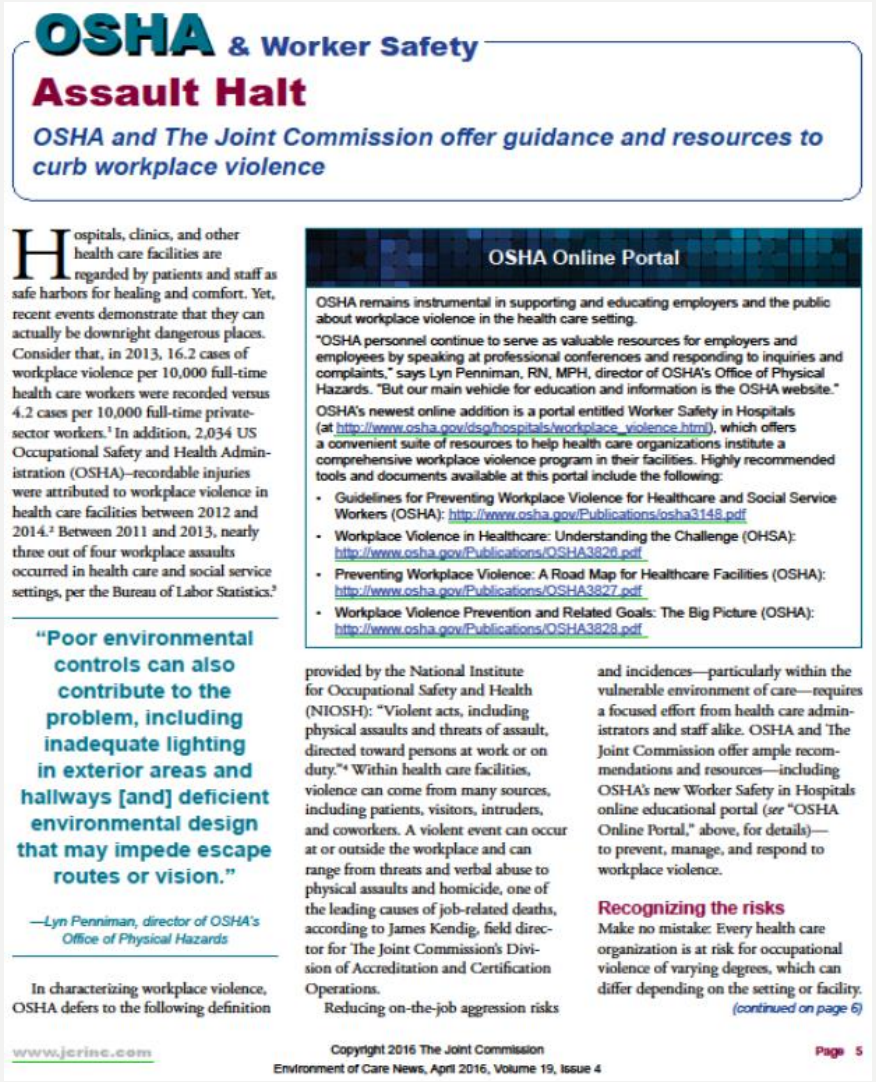
1. **Leadership commitment and employee participation.** The visible involvement of top management provides motivation and resources for workers and employers to deal effectively with WPV. In addition, a team of employees with appropriate training and skills—and adequate resources—will be in the best position to develop and implement the program. This team should create and disseminate a clear policy of zero tolerance for WPV. This zero tolerance should extend even to verbal and nonverbal threats. Williams emphasizes the importance of both management commitment and employee involvement in the WPV-prevention program.
2. **Worksite analysis and hazard identification.** A team that includes senior management, supervisors, and

Environment of Care News, August 2015, Volume 18, Issue 8

	Hospital	Residential Treatment	Nonresidential Treatment/Service	Community Care	Field Workers (Home Health Care, Social Service)
Security/silenced alarm systems	• Panic buttons or paging system at workstations or personal alarm devices worn by employees			• Paging system • GPS tracking* • Cell phones	
	• Security/silenced alarm systems should be regularly maintained, and managers and staff should fully understand the range and limitations of the system.				
Exit routes	• Where possible, rooms should have two exits. • Provide employee "safe room" for emergencies. • Arrange furniture so workers have a clear exit route.		• Where possible, counseling rooms should have two exits. • Arrange furniture so workers have a clear exit route.	• Managers and workers should assess homes for exit routes.	
	• Workers should be familiar with a site and identify the different exit routes available.				
Metal detectors—handheld or installed	• Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for services being provided and the types of barriers put in place. • Metal detectors should be regularly maintained and assessed for effectiveness in reducing the weapons brought into a facility. • Staff should be appropriately assigned and trained to use the equipment and remove weapons.				
Monitoring systems and natural surveillance	• Closed-circuit video—inside and outside • Curved mirrors • Proper placement of nurses' stations to allow visual scanning of areas • Glass panels in doors/walls for better monitoring		• Closed-circuit video—inside and outside • Curved mirrors • Glass panels in doors for better monitoring		
	• Employers and workers will have to determine the appropriate balance of creating the suitable atmosphere for services being provided and the types of barriers put in place. • Staff should know if video monitoring is in use and whether someone is always monitoring the video.				

* Employers and workers should determine the most effective method for ensuring the safety of workers without negatively impacting working conditions.

Source: OSHA. Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. (Updated: Apr 2, 2015.) Accessed Jul 1, 2015. https://www.osha.gov/Publications/osha3148.pdf. For a list of engineering controls, see pp. 13–17.



OSHA & Worker Safety

Assault Halt

OSHA and The Joint Commission offer guidance and resources to curb workplace violence

Hospitals, clinics, and other health care facilities are regarded by patients and staff as safe harbors for healing and comfort. Yet, recent events demonstrate that they can actually be downright dangerous places. Consider that, in 2013, 16.2 cases of workplace violence per 10,000 full-time health care workers were recorded versus 4.2 cases per 10,000 full-time private-sector workers.[1] In addition, 2,034 US Occupational Safety and Health Administration (OSHA)–recordable injuries were attributed to workplace violence in health care facilities between 2012 and 2014.[2] Between 2011 and 2013, nearly three out of four workplace assaults occurred in health care and social service settings, per the Bureau of Labor Statistics.[3]

"Poor environmental controls can also contribute to the problem, including inadequate lighting in exterior areas and hallways [and] deficient environmental design that may impede escape routes or vision."

—Lyn Penniman, director of OSHA's Office of Physical Hazards

In characterizing workplace violence, OSHA defers to the following definition provided by the National Institute for Occupational Safety and Health (NIOSH): "Violent acts, including physical assaults and threats of assault, directed toward persons at work or on duty."[4] Within health care facilities, violence can come from many sources, including patients, visitors, intruders, and coworkers. A violent event can occur at or outside the workplace and can range from threats and verbal abuse to physical assaults and homicide, one of the leading causes of job-related deaths, according to James Kendig, field director for The Joint Commission's Division of Accreditation and Certification Operations.

Reducing on-the-job aggression risks and incidences—particularly within the vulnerable environment of care—requires a focused effort from health care administrators and staff alike. OSHA and The Joint Commission offer ample recommendations and resources—including OSHA's new Worker Safety in Hospitals online educational portal (*see* "OSHA Online Portal," above, for details)—to prevent, manage, and respond to workplace violence.

Recognizing the risks

Make no mistake: Every health care organization is at risk for occupational violence of varying degrees, which can differ depending on the setting or facility.

(continued on page 6)

OSHA Online Portal

OSHA remains instrumental in supporting and educating employers and the public about workplace violence in the health care setting.

"OSHA personnel continue to serve as valuable resources for employers and employees by speaking at professional conferences and responding to inquiries and complaints," says Lyn Penniman, RN, MPH, director of OSHA's Office of Physical Hazards. "But our main vehicle for education and information is the OSHA website."

OSHA's newest online addition is a portal entitled Worker Safety in Hospitals (at http://www.osha.gov/dsg/hospitals/workplace_violence.html), which offers a convenient suite of resources to help health care organizations institute a comprehensive workplace violence program in their facilities. Highly recommended tools and documents available at this portal include the following:

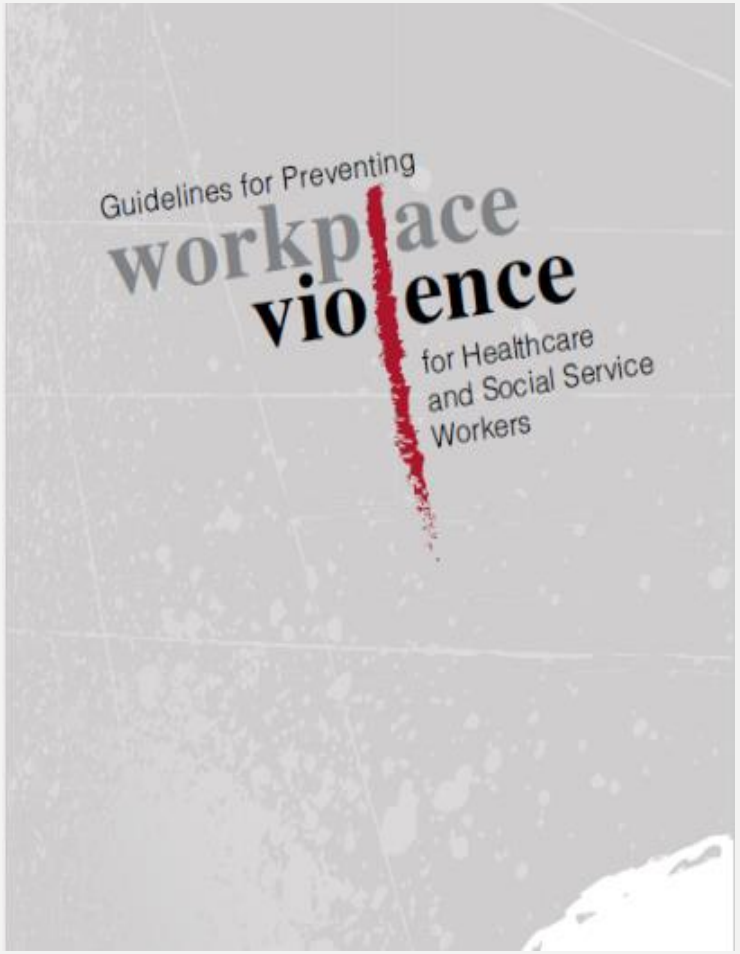
- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers (OSHA): http://www.osha.gov/Publications/osha3148.pdf
- Workplace Violence in Healthcare: Understanding the Challenge (OHSA): http://www.osha.gov/Publications/OSHA3826.pdf
- Preventing Workplace Violence: A Road Map for Healthcare Facilities (OSHA): http://www.osha.gov/Publications/OSHA3827.pdf
- Workplace Violence Prevention and Related Goals: The Big Picture (OSHA): http://www.osha.gov/Publications/OSHA3828.pdf

Employers are responsible for providing a safe and healthful workplace for their employees. OSHA's role is to assure the safety and health of America's working men and women by setting

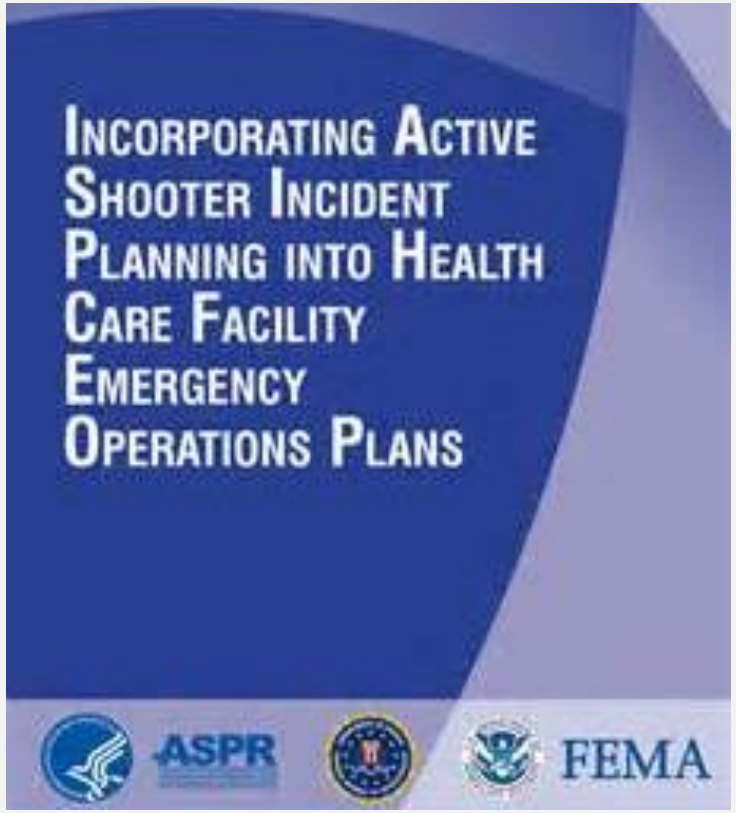
and enforcing standards; providing training, outreach and education; establishing partnerships; and encouraging continual improvement in workplace safety and health.

This handbook provides a general overview of a particular topic related to OSHA standards. It does not alter or determine compliance responsibilities in OSHA standards or the *Occupational*

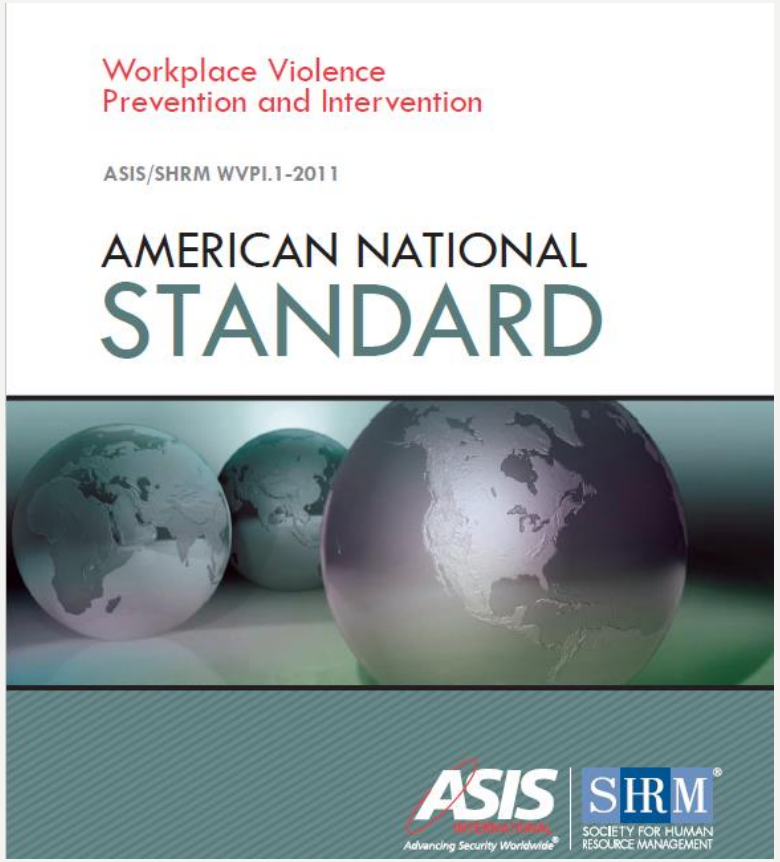
Safety and Health Act of 1970. Because interpretations and enforcement policy may change over time, you should consult current OSHA administrative interpretations and decisions by the Occupational Safety and Health Review Commission and the courts for additional guidance on OSHA compliance requirements.



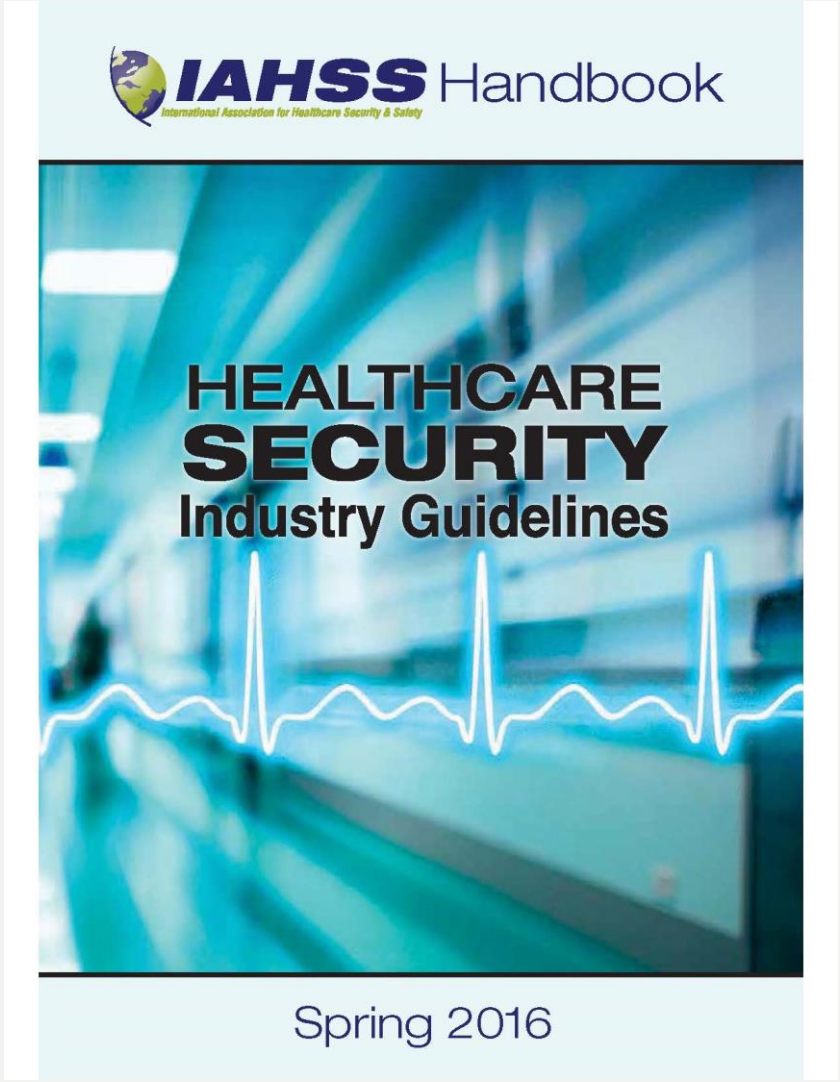
- The Impact of Workplace Violence on Healthcare and Social Services Workers
- Risk Factors
- Violence Prevention Programs
- Workplace Violence Program Checklists



- Utilizing a team to develop the active shooter response plan
- Developing specific communication response procedures
- Having a well-functioning emergency alert system
- Identifying potential safe rooms
- Training employees on handling an event

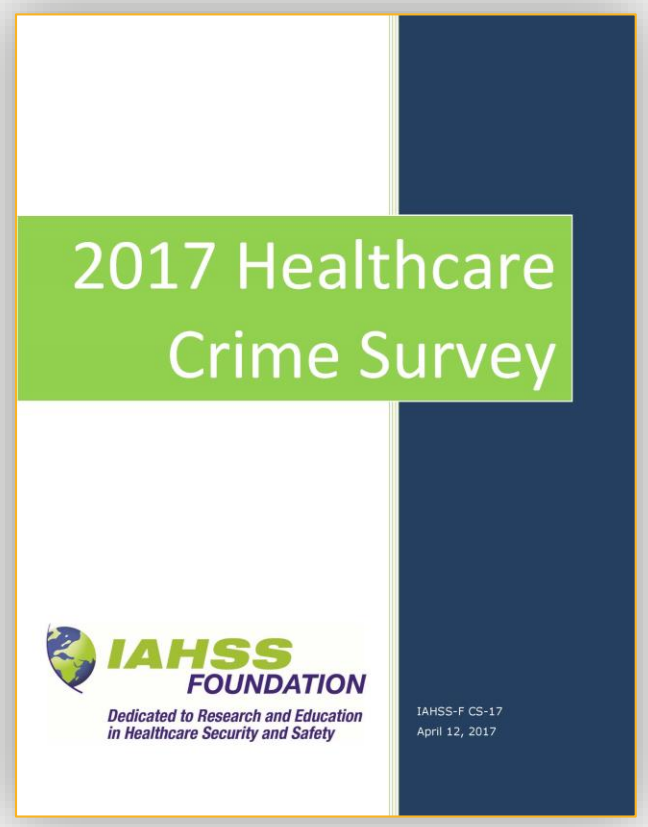


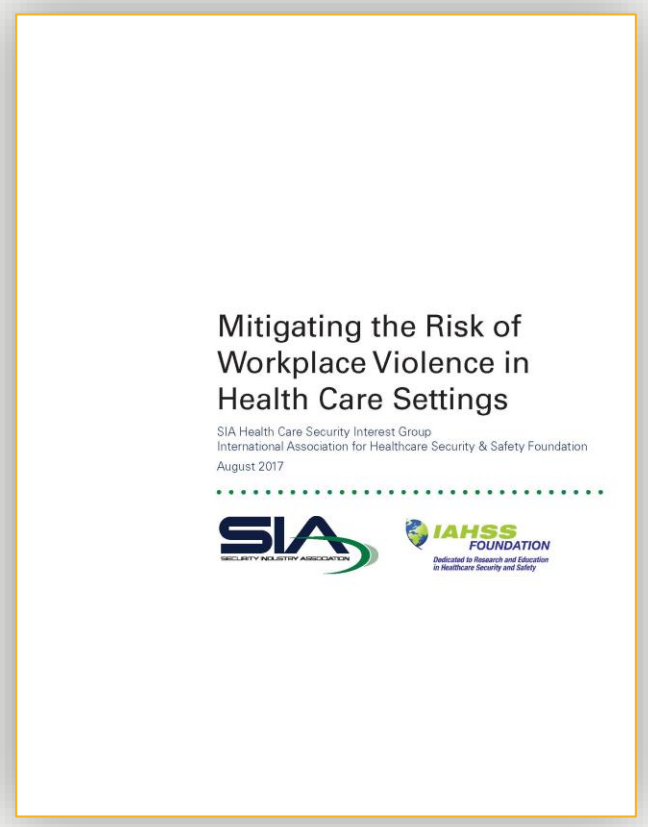
- Scope
- References
- Definitions
- Establishing Multidisciplinary Involvement
- Planning Prevention and Intervention Program
- Threat Response Management
- The Role of Law Enforcement
- Intimate Partner Violence
- Post Incident Management

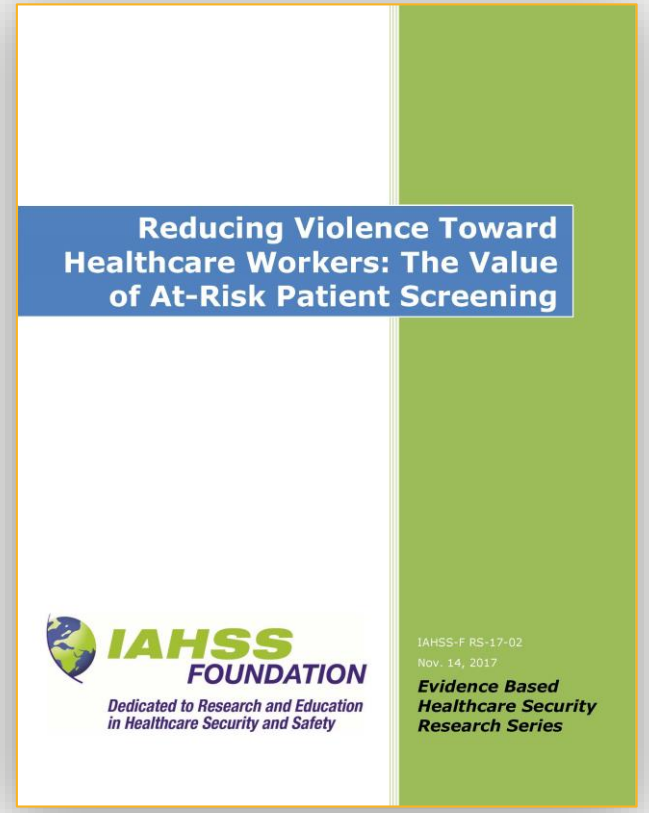


- Security Risk Assessments
- Violence in Healthcare
- Management of Weapons
- Searching Patients
- Security in the Emergency Setting
- Behavioral/Mental Health Areas
- Prisoner Patient Security
- Security Sensitive Areas
- Active Shooter

IAHSS FOUNDATION RESEARCH







OVERWHELMED?!

MUST HAVES

- Gain Leadership buy in from the beginning
- Include your security and emergency management teams in the planning stages
- Establish a culture that supports reporting and use the data
- Ensure you have adequate policies and training pertaining to workplace violence?

FIRST STEPS….

Everything starts with the risk assessment process

Annual Risk Assessments

Threat and Vulnerability Analysis

Threat Assessment teams

Data review

Bring ALL the stakeholders to the table

Administration

Clinical

Security

Ancillary

External stakeholders; i.e. Law Enforcement

A SUCCESSFUL PROGRAM REQUIRES A CULTURE OF SAFETY?

- Is safety everyone's responsibility?
- Do supervisors reinforce that responsibility? Do they offer safety tips?
- Is reporting easy? Does is include reporting of near misses, hotlines? Can it be done anonymously?
- Can people express concerns freely? Is doing so encouraged? Is it non-punitive?
- Saying "If you see something, say something" only works if it is comfortable to do so.

THE RISK ASSESSMENT PROCESS

- Risks identified due to location of Healthcare Facility
- Risks associated with types of services provided
- History of violence / potential for violence – your data
- How is access to facilities/areas of facility managed
- Capabilities, expectations and training of staff; those with security response responsibilities and others
- Availability of external responders to assist in an emergency

SAMPLE HVA

THREAT EVENT/ HAZARD	CATEGORY	PROBABILITY	SEVERITY = MAGNITUDE of IMPACTS						SEVERITY IMPACTS	UNMITIGATED RISK	PREPAREDNESS	RELATIVE RISK
			HUMAN IMPACT		FACILITIES IMPACT		INSTITUTIONAL IMPACT					
		Relative likelihood this will occur	*Potential deaths or injuries*		*Physical damage and costs*		*Interruption research & teaching Impact reputation/image*		*Overall Impact (Average)*	*Probability x Severity Impacts*	*Level of Preparedness*	*Unmitigated Risk/Preparedness*
Natural Hazards Technological Human Caused		*1 = Not occur 2 = Doubtful 3 = Possible 4 = Probable 5 = Inevitable*	*Question 1*	*Question 2*	*Question 1*	*Question 2*	*Question 1*	*Question 2*	*1 = Lowest 5 = Highest*	*1 = Lowest 25 = Highest*	*1 = None 2= Poor 3= Fair 4=Good 5=Prepared*	
Terrorism	Human Caused	3.00	1.00	5.00	4.00	2.00	3.00	1.00	**2.67**	**8.00**	2.00	**4.00**
External Cyber Attack	Human Caused	4.00	1.00	1.00	1.00	1.00	3.00	1.00	**1.33**	**5.33**	2.00	**2.67**
Security Breach	Human Caused	3.50	3.00	4.00	2.00	1.00	1.00	2.00	**2.17**	**7.58**	3.00	**2.53**
Epidemic	Natural	3.00	1.00	3.00	1.00	1.00	3.00	3.00	**2.00**	**6.00**	3.00	**2.00**
Biological Exposure	Technological	4.00	3.00	3.00	2.00	1.00	3.00	3.00	**2.50**	**10.00**	5.00	**2.00**
Hostage Situation	Human Caused	3.00	1.00	4.00	1.00	1.00	2.00	2.00	**1.83**	**5.50**	3.00	**1.83**
Earthquake	Natural	3.00	3.00	4.00	2.00	3.00	3.00	3.00	**3.00**	**9.00**	5.00	**1.80**
Mass Casualty Incident	Human Caused	3.00	1.00	5.00	2.00	1.00	4.00	4.00	**2.83**	**8.50**	5.00	**1.70**
Infection	Technological	3.00	3.00	3.00	1.00	1.00	4.00	5.00	**2.83**	**8.50**	5.00	**1.70**
Tornado	Natural	3.00	1.00	2.00	2.00	2.00	2.00	1.00	**1.67**	**5.00**	3.00	**1.67**
Snow Fall	Natural	5.00	3.00	3.00	1.00	1.00	1.00	1.00	**1.67**	**8.33**	5.00	**1.67**
Security Systems Failure	Human Caused	3.00	1.00	1.00	1.00	1.00	2.00	4.00	**1.67**	**5.00**	3.00	**1.67**
Protest	Human Caused	4.00	1.00	3.00	2.00	1.00	3.00	2.00	**2.00**	**8.00**	5.00	**1.60**
Civil Unrest	Human Caused	3.00	1.00	5.00	2.00	1.00	2.00	3.00	**2.33**	**7.00**	5.00	**1.40**
Bomb or Suspicious Device	Human Caused	3.00	1.00	4.00	3.00	2.00	2.00	2.00	**2.33**	**7.00**	5.00	**1.40**
Active Shooter	Human Caused	3.00	1.00	5.00	2.00	1.00	2.00	3.00	**2.33**	**7.00**	5.00	**1.40**
Suicide	Human Caused	3.00	4.00	3.00	1.00	1.00	1.00	1.00	**1.83**	**5.50**	4.00	**1.38**
Blizzard	Natural	4.00	3.00	3.00	1.00	1.00	1.00	1.00	**1.67**	**6.67**	5.00	**1.33**
Severe Thunderstorm	Natural	5.00	2.00	2.00	1.00	1.00	1.00	1.00	**1.33**	**6.67**	5.00	**1.33**
Fire or Explosion	Technological	3.00	1.00	1.00	2.00	3.00	3.00	3.00	**2.17**	**6.50**	5.00	**1.30**
Workplace Violence	Human Caused	3.00	2.00	4.00	2.00	1.00	2.00	2.00	**2.17**	**6.50**	5.00	**1.30**
Solar Flares	Natural	2.00	1.00	1.00	1.00	1.50	2.00	1.00	**1.25**	**2.50**	2.00	**1.25**

ASSESS PREVENTION AND RESPONSE CAPABILITY

COLLECT YOUR DATA

Determine who collects data – Clinical, Human Resources, Risk Management, Safety, Security

Promote a culture of safety – report everything (verbal, physical, on-site, off-side, bullying, patient, visitor, staff (both offender and victim)

Share data – understand the problem, if it exists, in total

Safe reporting, multidisciplinary training, lessons learned / corrective actions.

Measure Return on Investment – maybe a reduction in lost time

MAKE REPORTING EASY!

QUICK

CONCISE

ACCESSIBLE

ANONYMOUS?

GENERAL THREAT CATEGORIES

- Patient on Staff
- Patient on Patient
- Staff on Patient
- Staff on Staff
- Visitors on Staff
- Visitors on Patients

CREATE YOUR PLANS
Now that you have….

FORMED YOUR TEAM

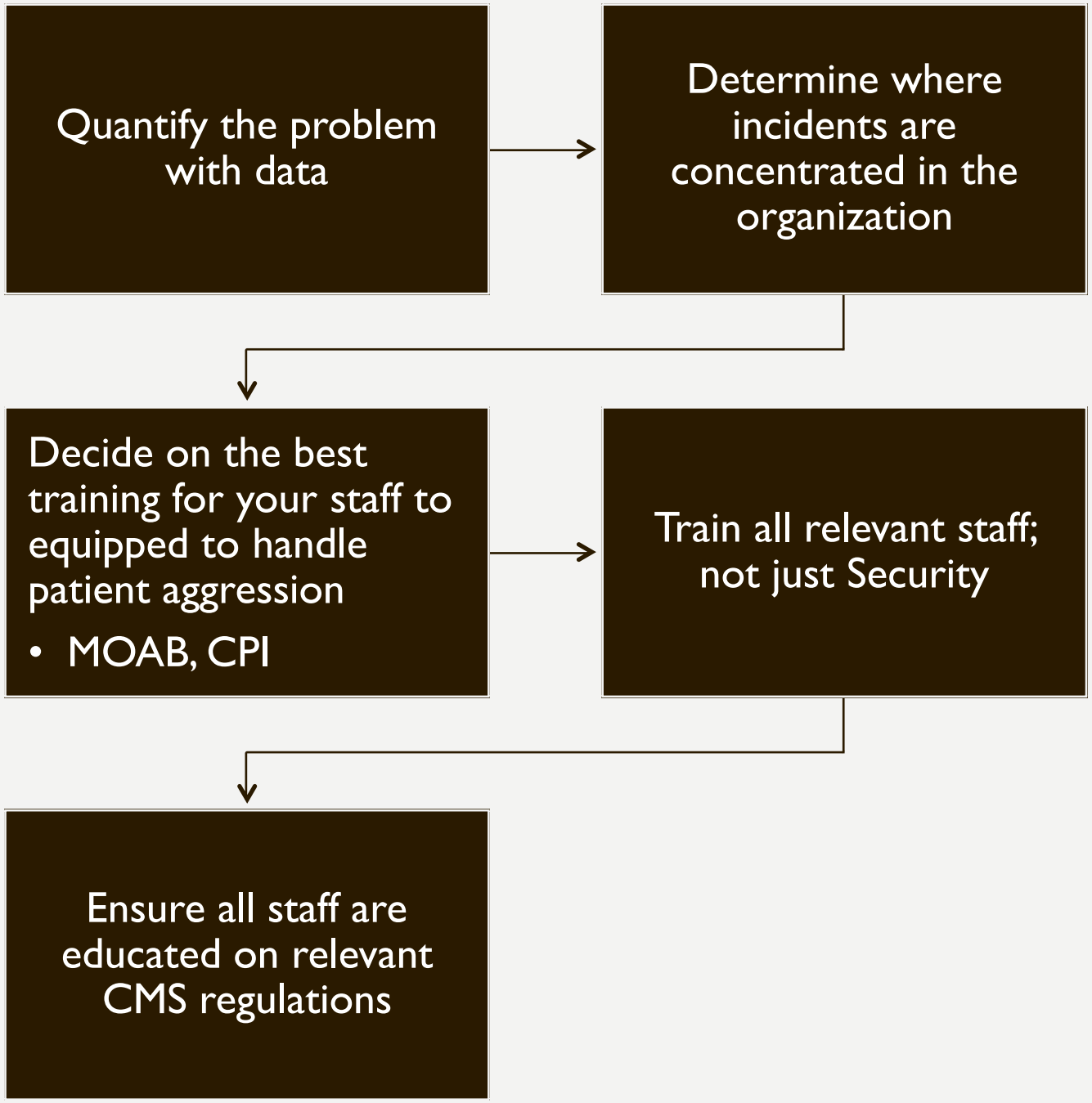
CONDUCTED RISK ASSESSMENTS

COLLECTED YOUR DATA

ANALYZED THE DATA

REVIEWED AVAILABLE RESOURCES

ADDRESSING PATIENT VIOLENCE



TRAINING & EDUCATION

Provide education on facility procedures regarding awareness, harassment, reporting, notification, response

Train all staff and, where possible, include local response agencies in such training as active shooter response

Conduct varied training – policy/procedure education, role playing, functional exercises

ACTIVE ASSAILANT THREATS

- Should be included as part of your plan
- Consider how notification would be made
- Consider identifying safe rooms on all units
- Allow staff a mechanism to role play
- Consider Stop The Bleed training

Active shooter training with local law enforcement is something to consider as part of your workplace violence training program

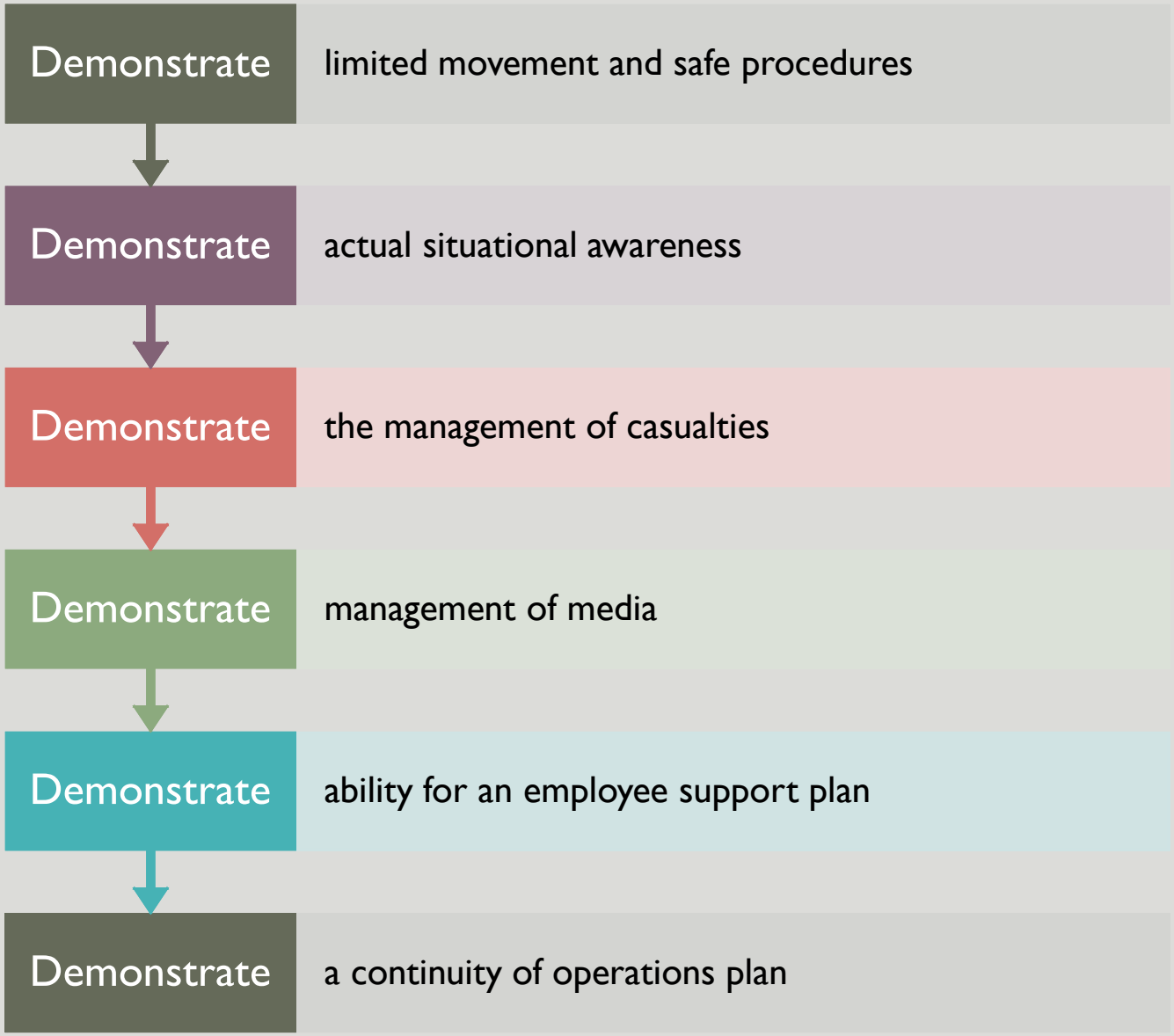
The following video was filmed on February 3, 2015 during BMC's latest Live Action Active Shooting Exercise. The visual and auditory demonstration of what you can do to protect yourself will be used as a training tool for BMC employees and staff.


01:15

COMMUNICATION AND CRISIS AWARENESS

- RUN HIDE FIGHT
- HCF - different methodology with patient care
- Use common terms for first responders
- Alert systems
- Test your ICS as often as possible

ACTIVE SHOOTER EXERCISES AND EVALUATIONS



RECOVERY AND DEBRIEFING

THE IMPORTANCE OF DESIGN

- Accessibility
- Ability to secure
- Safe Spaces
- Wall materials
- Doors swing
- Windows

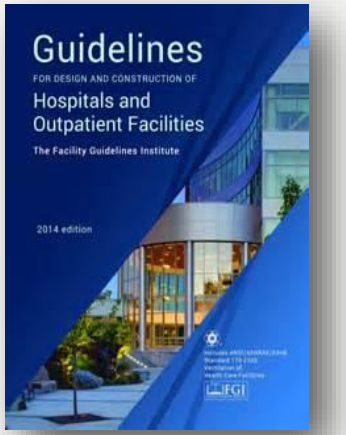
DESIGN YOUR ENVIRONMENT WITH SAFETY IN MIND

Include security representatives in design stage of renovations and new construction

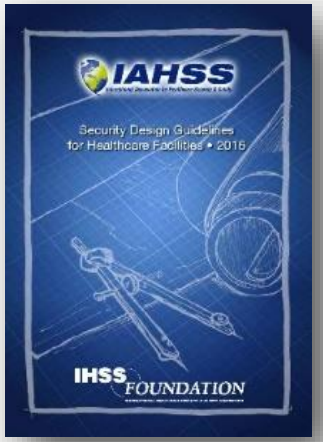
Use available design guidelines

Ensure design team is aware of risk assessment and data on violence

DESIGN GUIDELINES



- FGI and IAHSS Security Design Guidelines.
- Methods of securing higher risk areas
- Ability to secure Emergency Department entrance(s) as well as access to rest of facility from the Emergency Department.
- Safe Rooms – regular rooms in plan that can be secured from areas of potential violence
- Alternate Entry / Egress points that can be used if a specific area is under controlled access or locked down



WORKPLACE VIOLENCE VIDEO TRAINING TOOLS

Armed – are you ready? Video

Live Action Active Shooter Exercise Video

Employee Active Shooter Video

Workplace Violence Scenarios

REFERENCE LIST

- ASIS International's Workplace Violence Prevention and Intervention Standard
- Bureau of Labor Statistics “Occupational Injuries, Illnesses, and Fatalities among Nursing, Psychiatric, and Home Health Aides, 1995–2004”
- Department of Homeland Security's "Active Shooter: How to Respond" educational booklet
- Health Facilities Management, Reducing Workplace Violence Incidents, June 6, 2015, Accessed June 13, 2016.
- Health & Human Services Office of the Assistant Secretary for Preparedness and Response, “Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans”
- IAHSS Security Industry Guidelines - Active Shooter guideline
- IAHSS Security Design Guidelines for Healthcare Facilities
- International Council of Nurses “Nursing Matters” fact sheet, 2009
- Joint Commission Topic Library Item on “Violence/Security/Active Shooter”
- OSHA Field Directive CPL 02-01-052 “Enforcement Procedures for Investigating or Inspecting Workplace Violence Incidents”
- OSHA's Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers
- Sentinel Event Alert, Issue 45: Preventing violence in the health care setting
- Vivid On-Line Training for Active Shooter (not hospital specific)
- We Care Team at BJH, Accessed June 13, 2016
- Workplace Violence against Health Care Workers in the United States, Engl J Med 2016; 374:1661-1669April 28, 2016DOI: 10.1056/NEJMra1501998, accessed June 13, 2016.

ANJANETTE HEBERT

Director of Healthcare

PalAmerican Security

ahebert@palamerican.com

337-207-7829

Owner/Consultant
Cypress All Hazards Planning and Consulting