Workplace Violence Prevention: Implementing Strategies for Safer Healthcare Organizations
July 25, 2018
Q & A Document

Notification and Reporting-related

QUESTION 1: Are verbal altercations reportable, in which the employee experiences stress?

A: With regard to external reporting, OSHA reporting and recording requirements are based on physical injuries and illnesses. States may have their own requirements. Joint Commission reporting expectations relate to Sentinel Events. Please see the Sentinel Event Policy and Procedures page (https://www.jointcommission.org/sentinel_event_policy_and_procedures/) for more information.

That being said, an effective workplace violence prevention program, includes the internal reporting of incidents and near misses to allow the employer to make a comprehensive assessment of the potential for workplace violence.

QUESTION 2: How are others improving their rates of reporting incidents?

A: Reporting rates improve on units that incorporate discussions about workplace violence and safety concerns into their regular staff/unit meetings. Some hold daily safety huddles where they create a safe place for employees to discuss violence. This transparency about workplace violence data enhances reporting. To sustain reporting, it is important to feed information back to staff and to use the information through tailored interventions to improve safety.

QUESTION 3: Are reportable events inclusive of the hospital-employed police officers if they are injured?

A: Yes, if they are seriously injured on hospital property.

QUESTION 4: We use a practice alert to notify staff that a patient has been violent in the past. Should we only allow supervisors to place these on the chart, or should floor nurses be allowed to do this? How long should they remain on the chart?

A: The Joint Commission does not prescribe how such actions are completed, but rather encourages leaders at organizations to conduct a risk assessment in order to determine how alerting staff to potentially violent individuals should be accomplished. Organizations should consider the criteria needed to flag an individual, training for those with the authority to do so, and the appropriate length of time for a flag to remain in place in relation to why the alert was created (e.g., an acute event related to response to bad news vs. dementia or other chronic conditions).

QUESTION 5: If you use an electronic medical record (EMR), it isn't always available to put in an alert and we don't always get a choice in the EMR we have to use.

A: Flagging a patient in the EMR is one effective way to alert staff of potential violence, but it is not the only way. Organizations can alert others to potential violence in the same way that they

would with allergies to medications or pertinent medical history. Organizations and their leaders must determine what resources are available to be allocated to this important notification and design it in a way that works for their own current documentation system.

QUESTION 6: Are there any criteria for flagging violent patients?

A: There are examples of criteria and resources on The Joint Commission workplace violence (WPV) portal. One basic criterion is to flag patients with history of recent violence either against healthcare workers or brought to the organization because of a violent activity (e.g., violent crime). It is important to demonstrate escalating behavior, document escalating behavior, and develop specific interventions for the escalating levels. Flagging the electronic health record is sometimes reserved for the more egregious risks since it follows the patient through their healthcare experience. Additionally, organizations should have criteria for who documents this on the electronic record and what criteria warrants this documentation.

Vendor and Contractor-related questions

QUESTION 7: Describe what mitigation and follow up is in place for contractors.

A: OSHA recommends that contractors and employers set out their respective responsibilities for compliance with applicable OSHA standards and the Occupational Safety and Health Act (OSH Act) in their contract. While OSHA currently has no standard for workplace violence, under the OSH Act, Section (5)(a)(1), employers are required to provide a place of "employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm." Employers should conduct a hazard assessment, provide training, and implement necessary controls to ensure its employees are protected from all recognized or foreseeable sources of workplace violence.

QUESTION 8: What type of training is recommended for vendors (outside guard services, hearing officers/members of the court, etc.) who are not regularly and consistently in the hospital?

A: Similar to contractors, vendors and employers should assess which workers have the potential for being exposed to workplace violence and provide appropriate training based on the hazard assessment.

QUESTION 9: What type of training is recommended for vendors?

A: See above, similar to contractors, vendors and employers should assess which workers have the potential for being exposed to workplace violence and provide appropriate training based on the hazard assessment.

QUESTION 10: Touch on dual employer responsibilities, how do you fold in contracted staff into the workplace violence (WPV) program?

A: See above, similar to contractors, vendors and employers should assess which workers have the potential for being exposed to workplace violence and provide appropriate training based on the hazard assessment.

QUESTION 11: Does The Joint Commission require a specific vendor or recommended vendor like Crisis Prevention Institute (CPI) for employee training?

A: The Joint Commission does not make vendor recommendations for de-escalation training. There are successful internally-developed tools and programs as well as CPI. The organization's goal should be to provide training that matches its risks through the use of its hazard vulnerability analysis and emergency operations plan.

Related to the Michigan study as presented by Dr. Arnetz

QUESTION 12: What specific data does each department for this have on their dashboards?

A: Number of violent events by type (I-IV), most often patient-to-worker (Type II) and worker-to-worker (Type III). These can be for any period of time (past month; half-year; year) and are also presented as rates/100 full-time equivalents. If incidents resulted in injury, loss time management costs related to those incidents are also included. Data on the incidents can also be broken down by type of event (assault, verbal abuse, etc.); the unit and location of the event; and the job category of the worker(s) involved.

QUESTION 13: Did this cover any data related to patient to patient violence?

A: No, our study focused specifically on violence directed towards health care staff.

QUESTION 14: Were there specific interventions that were the most effective for reduction in incidents?

A: Our analyses were on a group level (intervention vs. control) and did not examine changes in workplace violence rates over time in specific units. Units implemented environmental, administrative, and/or behavioral interventions depending on their specific workplace violence data and context.

QUESTION 15: Was the approximate $11,000 lost in the Michigan study seen as significant to administration?

A: Yes. Unit administrators welcomed the information on costs associated with workplace violence events; it had never been summarized for them before. Most of the supervisors we met with had good knowledge of the injuries their staff had incurred but they were often surprised at the violence-related costs.

QUESTION 16: Was the case study at Detroit Medical Center also repeated over time to see if the changes made were adhered to, and if the rates kept decreasing, stayed the same, or went back up?

A: Unfortunately, we were not able to repeat the study or carry out a longer-term follow-up. We did follow the study units for 2 full years after the intervention. However, at the two-year mark, rates of injury due to violence had decreased in the intervention group but increased in the control group.

QUESTION 17: Did you see an increase in reporting or any culture change in the inner-city emergency department that was included in the study? How can you implement a culture change among employees who view workplace violence as "just part of the job"?

A: Our analyses were on a group level (intervention vs. control) and did not examine changes in workplace violence rates over time in specific units. Changing the culture about workplace violence will depend on management promotion of a violence prevention climate. Hospital workers must know that management takes workplace violence seriously and does everything possible to reduce violence and promote worker safety. This entails encouraging reporting and documentation of violent events; regular review of incidents that do occur so that prevention efforts can be implemented; and creating a safe, non-punitive environment where workers feel comfortable in discussing workplace violence and conflict.

Miscellaneous

QUESTION 18: There are recommendations for active shooter drills and de-escalation, is there consideration for recommending training for physical control measures for weaponless attacks?

A: Organizations are encouraged to work with local security and law enforcement teams to determine what best suits their staff in their particular setting and event. It may vary from "run, hide, fight" to self-defense, to other tactics depending on the setting and whether additional patients or staff are at risk.

OSHA guidance does not specify specific training; rather it focuses on the development of a comprehensive workplace violence prevention program, which includes conducting a hazard assessment to determine what steps should be taken to reduce the likelihood of workers being injured due to workplace violence.

QUESTION 19: What are some best practices for support assistance for persons affected?

A: Examples of practices include debriefing with all staff, including the person affected, after a violent incident. It is important for everyone to learn from the victim's experience, and to ensure that the victim feels supported by colleagues and management in the open discussion. Another practice includes Employee Assistance Program (EAP) referral and follow up; the length and requirements of EAP relationship depend on the severity of the incident. The goal is to avoid the “I’m fine” syndrome and hopefully prevent post-traumatic stress disorder. Violence is NOT an expected experience in the healthcare workers day.

QUESTION 20: We are starting a staff-driven (with strong leadership backing and resources) hospital task force on workplace violence (WPV) and kicked it off with this webinar. My plan is to use the 7 actions outlined in the Sentinel Event Alert (SEA) #59. I recognize OSHA also has guidelines. In an effort to keep focused and on track (this is such a broad and emotional topic), does The Joint Commission recommend the 7 actions, with use of OSHA as a resource?

A: Each organization is different and must first conduct an assessment of their own environment in regards to workplace violence (WPV). Individuals from high-risk areas both

known and identified in the Sentinel Event Alert (SEA) #59 (emergency departments, psychiatric settings, home care, long term care, etc.) should be involved in this initial assessment. Areas of risk can be organized identifying likelihood as well as level or risk as shown in Dr. Arnetz's study to assist in prioritizing resources and action. The importance of education and training for front line staff cannot be emphasized enough. Without both, WPV initiatives will not be successful or sustainable. Also stated in the webinar is the importance of data. It is the cornerstone to any successful intervention. Similarly, executive leadership support is essential (refer to Joint Commission standards LD.03.01.01, LD 04.01.01 EP2, and LD 04.04.05). Using the 7 actions with the use of OSHA as a resource is an excellent action plan. Each action should be tailored to fit the needs of the unit on which it is implemented.

QUESTION 21: Sometimes we are required to discontinue restraints and/or medications before a patient is transferred to another facility. Why is this a requirement that risks staff and the patient?

A: There is no Joint Commission standard that states this. It is up to the organization to make this decision after conducting a risk assessment as well as complying with state laws and regulatory requirements.

QUESTION 22: This is all very high level and a solid starting point. Is there a point where The Joint Commission or any other regulatory body might reflect on an internal / external security role within healthcare other than the rather unspecific guidance currently provided?

A: As each organization has unique circumstances in terms of size, number of providers and staff as well as resources, the security needs of each hospital may be very different. It is the expectation that each organization conducts a risk assessment with the guidance of the tools and resources provided in the webinar, the Sentinel Event Alert (SEA) #59 as well as listed resources on The Joint Commission website. In particular, action #6 addresses training and de-escalation that is recommended for all staff, including security staff. A link to 10 de-escalation tips provided by The Crisis Prevention Institute is provided as well as many examples of other steps taken by organizations to address security in their facilities. Specific decisions such as panic buttons, security staff staffing and roles and responsibilities of those involved in workplace violence (WPV) prevention planning and actions are the responsibility of each organization.

QUESTION 23: How do you prevent the combative nature of residents in long term care from contributing to workplace violence incidents?

A: As stated in the webinar, the use of data is imperative to the reduction of workplace violence. By gathering and analyzing data on their own opportunities for improvement, organizations can begin to develop an action plan on the path to zero staff and patient harm. Key individuals from the long term care units should be included from the very beginning as their knowledge of the patient population, work flow, current staff and resources will assist in ensuring that the action plan is one that will lead to the desired results of a reduction in workplace violence.