NEXT CHALLENGE. NEXT LEVEL.

NEXSEN PRUET

WORKPLACE SAFETY

SOUTH CAROLINA HOSPITAL ASSOCIATION

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DISCUSSION TOPICS

- Definition of Workplace Violence
- OSHA and Workplace Violence
- Types of Workplace Violence
- Typology of Perpetrators and Examples of each
- Workplace violence statistics
- Alarming statistics in healthcare industry
- Cost of workplace violence
- What to do? How do we prevent?
DISCUSSION TOPICS

- Know Your Risk Factors
- Analyze Trends
- Hazard Prevention and Control
- Safety and Training
- Active Shooters
- Additional Resources
WHAT IS WORKPLACE VIOLENCE?

- The National Institute for Occupational Safety and Health (NIOSH) defines it as “any physical assault, threatening behavior or verbal abuse.”

- The US Department of Labor (DOL) defines it as “an action (verbal, written, or physical aggression) which is intended to control or cause, or is capable of causing death or serious bodily injury to oneself or others, or damage to property. Workplace violence includes abusive behavior toward authority, intimidating or harassing behavior, and threats.”
OSHA AND WORKPLACE VIOLENCE

OSHA requires employers to mitigate or prevent “recognizable hazards” which include workplace violence by:

- Insuring employees are involved and educated on process;
- Evaluating worksites to ensure safety requirements are met;
- Hazard prevention through the use of “panic alarms” or metal detectors;
- Safety and Health Training is provided.
Compliance with the program must be documented.

OSHA can fine employers for failing to take adequate measures to ensure workplace safety.

Example: OSHA fined a hospital $78,000 for ‘dozens’ of incidents involving patients and staff; one nurse sustained severe brain injuries.
TYPES OF WORKPLACE VIOLENCE

- Threats
- Vandalism
- Sabotage
- Stalking
- Physical Assault
- Sexual Assault
- Domestic Violence
TYPES OF WORKPLACE VIOLENCE (CONT’D)

- Attempted Homicide
- Homicide
- Product Contamination
- Arson/Bombing
- Terrorism.
Basically four broad types/categories of perpetrators:

- **Type I** – Criminal intent
- **Type II** – Customer/client/patient
- **Type III** – Co-worker
- **Type IV** – Personal (Domestic Violence coming to work).
 EXAMPLES OF EACH TYPE

TYPE 1

- Perpetrator has no association with workplace or employees
  - Example - Person with criminal intent commits armed robbery
EXAMPLES OF EACH TYPE

TYPE 2

- Perpetrator is a customer or patient of the workplace or employees

- Example- Intoxicated patient punches nurse’s aid
Type 3

- Perpetrator is a customer or former employee of the workplace
- Example- Recently fired employee assaults former supervisor.
EXAMPLES OF EACH TYPE

TYPE 4

‣ Perpetrator has a personal relationship with employee(s), none with the facility

‣ Example - Ex-husband assault ex-wife at her place of work.
WHY IS WORKPLACE VIOLENCE AND PREVENTION SUCH AN IMPORTANT TOPIC?

- Alarming statistics that are on-the-rise
  - Every year approximately 2 million American workers report having been victims of workplace violence.
  - According to the Department of Labor:
    - 409 people were fatally-injured, in 2014, in work-related attacks
      - Equals 16% of all workplace deaths for that year.
    - 15,980 people experienced trauma from non-fatal workplace violence that same year.
Between 2000 and 2013, roughly half of all active shooter incidents took place in the workplace, according to the FBI.

Nearly half of all workplace violence happens in public settings.

28% of workplace violence towards women comes from a relative or direct personal acquaintance.

80% of workplace violence involves a gun.
4 out of 10 supervisors are aware of at least one employee suffering from on-going domestic violence issues.

29,000 acts of rape or sexual assault are perpetrated against women at work each year.

250,000 women will miss at least one day of work in the next year because of someone stalking them.
WHO IS IMPACTED THE MOST?

▶ The leading sector for workplace violence incidents is the healthcare industry.

▶ Between 2002 and 2013, incidents of serious workplace violence (those requiring days off for the injured worker to recuperate) were 4x’s more common in healthcare than in private industry on average.

▶ In 2013, healthcare workers had 7.8 cases of serious workplace violence per 10,000 full-time employees.
Violent Injuries Resulting in Days Away from Work, by Industry, 2002–2013

In 2013, 80 percent of violent incidents reported in healthcare settings were caused by interactions with patients.

- 12% Other client or customer;
- 3% Student;
- 3% Co-worker;
- 1% Suspect/Inmate;
- 1% Other/non-specified.
➤ 21% of registered nurses and nursing students reported being physically assaulted—and over 50% verbally abused—in a 12-month period. (2014)

➤ 12% of ER nurses experienced physical violence—and 59% experienced verbal abuse—during a 7-day period.

➤ 13% of employees in VA hospitals report assault each year.
In 2013, according to the Bureau of Labor Statistics, psychiatric aides experienced the highest rate of violent injuries, 10x’s higher than the next group.

Nursing assistants were next, followed by Registered Nurses.
80% of nurses do not feel safe in their workplace ( Peek-Asa, et al, 2009).

In a survey of 125 ED nurses, intensive care unit and general floor nurses at a regional medical center, 82% of ED nurses had been physically assaulted at work in one year ( May and Grubbs, 2002).

25% of psychiatric nurses experienced disabling injuries from patient assaults ( Quanbeck, 2006).

Studies show that between 35-80% of hospital staff have been physically assaulted at least once during their careers ( Clements, et al, 2005).
Violent Injuries Resulting in Days Away from Work, by Cause

- **Nursing, psychiatric, and home health aides**:
  - Hitting, kicking, beating, pushing: 4,000 cases
  - Injury by physical contact with person while restraining or subduing—unintentional: 3,000 cases
  - Injury by other person—unintentional or intent unknown—not elsewhere classified: 2,000 cases

- **Registered nurses**:
  - Hitting, kicking, beating, pushing: 1,500 cases
  - Injury by physical contact with person while restraining or subduing—unintentional: 1,000 cases
  - Injury by other person—unintentional or intent unknown—not elsewhere classified: 500 cases

- **Licensed practical and vocational nurses**:
  - Hitting, kicking, beating, pushing: 100 cases
  - Injury by physical contact with person while restraining or subduing—unintentional: 50 cases
  - Injury by other person—unintentional or intent unknown—not elsewhere classified: 25 cases

Most frequent victims are:

- Perpetrator (45%)
- Hospital Staff (20%)
- Patients (13%)
- Visitors (8%)
- Security officers/police (5%)
Most common motive:

- Grudge (27%)
- Suicide (21%)
- Ending life of an ill relative (14%)
- Escape attempts by patients in police custody (11%)
COST OF WORKPLACE VIOLENCE

- Emotional and mental trauma.
- Physical trauma.
- Caregiver fatigue, injury, and stress.
- Lower job satisfaction.
- Lower patient satisfaction.

- Studies show that patient satisfaction decreases as nurses become dissatisfied and burned out.
- Cost to company both in lost hours and actual dollars.
- Increased Workers’ Compensation premiums and payments.
For example, one hospital system had 30 nurses who required treatment for violent injuries in a particular year at a total cost of $94,156.00.

Self-insured organizations will bear this full cost.

If not self-insured, premiums can skyrocket.
Healthcare Worker Injuries Resulting in Days Away from Work, by Source

- Patient: 80%
- Other client or customer: 12%
- Student: 3%
- Coworker: 3%
- Other person (not specified): 1%
- Assailant/suspect/inmate: 1%

Data source: Bureau of Labor Statistics (BLS), 2013 data. These data cover three broad industry sectors: ambulatory healthcare services, hospitals, and nursing and residential care facilities. Source categories are defined by BLS.
STATES WITH ENHANCED PENALTIES FOR VIOLENCE AGAINST HEALTHCARE WORKERS
A persistent perception within the health care industry that workplace violence is “part of the job”

- Poor or non-existent institutional policies, procedures, staff training or supports
- Overly complex reporting procedures create a disincentive for reporting
REPORTING

- Concern that violence happens so frequently that it's time-consuming to report every event, in addition to a lack of response when time is taken to report.

- Fear that reporting will reflect poorly on the nurse (victim blaming).

- Belief that some patients cannot be held accountable for their violent actions.
Soooooo......what do we do????
First, we get buy-in from all the stakeholders. Workplace Violence Prevention is a comprehensive process involving multiple stakeholders, including:

- Employees/Unions
- Security and Law enforcement
- Occupational Safety Professionals
- Clinical Care services
- Patients/Customer Services
- Legal and Regulatory Systems
- Leadership (all levels)
Next, we assess what we have and what we need. Do we have….

1. A workplace violence prevention and safety program?

2. If so, is it clearly set-out in the employee handbook or in a separate document of which the employees are aware?

3. Do we have a Crisis Emergency Response Team with designated leaders from across the departments?

4. Have we completed a safety risk assessment with a recognized security official? proactively searching for possible holes in the set-up

5. Have we developed a Field Safety Policy?

6. Do we have video surveillance?
ASSESS WHAT WE HAVE AND WHAT WE NEED (CONT’D)

- Do we have….

- 7. A complete analysis of our risk factors?

- 8. A clear line of reporting for staff members in case of an emergency? In other words, do staff members know who to report to and who is in charge?

- 9. A clear exit strategy for staff members and patients? In other words, are staff members clear on where they should go in the event of an emergency?

- 10. Training, training, training. You cannot predict how someone will react in a real emergency. BUT you can train as much as possible to ensure that everyone experiences as close as possible to the real thing.
OSHA Framework for Workplace Violence Prevention

- Management Commitment and Worker Involvement
- Record Keeping and Program Evaluation
- Worksite analysis
- Safety and Health Training
- Hazard Prevention and Control
KNOW YOUR RISK FACTORS

- Working directly with people who have a history of violence
- People who abuse drugs or alcohol, gang members, or distressed relatives or friends of patients or clients.
- Lifting, moving, and transporting patients and clients.
- Working alone in a facility or in patients’ homes.
- Poor environmental design of the workplace that may block employees’ vision or interfere with their escape from a violent incident.
- Poorly lit corridors, rooms, parking lots, and other areas.
- Lack of a means of emergency communication.
KNOW YOUR RISK FACTORS (CONT’D)

- Prevalence of firearms, knives, and other weapons among patients and their families and friends.

- Working in neighborhoods with high crime rates.

- Other risk factors are more organizational in nature, including:
  - Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff.
  - Working when understaffed in general—and especially during mealtimes, visiting hours, and night shifts. • High worker turnover.
  - Inadequate security and mental health personnel on site.
KNOW YOUR RISK FACTORS (CONT’D)

- Long waits for patients or clients and overcrowded, uncomfortable waiting rooms.
- Unrestricted movement of the public in clinics and hospitals. Perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges.
- Overemphasis on customer satisfaction as opposed to staff safety.
Facilities may find it useful to review the following types of records to identify trends and risk factors:

- Violence-related medical, safety, threat assessment, workers’ compensation, and insurance records.
- Logs of work-related injuries and illnesses, as required by OSHA (OSHA Forms 300 and 301).
- First reports of injury, incident/near-miss logs, and other incident reports, including police reports, general event logs, or daily logs.
In addition to reviewing records, the workplace violence prevention committee can review procedures and operations for different jobs and conduct employee surveys to identify violence hazards. Employee questionnaires and detailed baseline screening surveys are useful tools for pinpointing tasks that put workers at risk of violence. Periodic anonymous employee surveys, conducted at least annually or whenever operations change or incidents occur, can help to monitor the effectiveness of previously implemented hazard control measures and identify new or previously unnoticed risk factors and deficiencies in the environment, training, or work practices.
Patients and their families can also provide valuable input to help the workplace violence prevention team identify risk factors, understand patients’ perspectives, and design effective solutions.
Regular walkthrough assessments (such as environment of care rounds) can play a vital role in identifying and assessing workplace hazards. Walkthroughs may be conducted by members of the workplace violence prevention committee, including staff from each area and each shift, as well as facility maintenance or management personnel. They should cover all facility areas. The walkthrough itself is not the end of the assessment and review process: a complete process also includes post-assessment feedback and follow-up.
Remember, violence can occur anywhere, but psychiatric services, geriatric units, and high-volume urban EDs, admission areas, and waiting rooms often present the highest risks. The key to protecting employees and patients is inspecting all work areas, including exterior building areas and parking areas, as well as evaluating security measures.
First, engineering controls. Engineering controls are physical changes to the workplace that either remove a hazard or create a barrier between workers and the hazard. These controls are often the next best option if elimination and substitution are not possible.
Examples of Engineering Controls include:

- Changing floor plans to make exits more accessible and/or improve sightlines for staff.
- Improving lighting in remote areas or outdoor spaces for better visibility.
- Installing mirrors.
HAZARD PREVENTION AND CONTROL (CONT’D)

▶ Installing security technologies such as metal detectors, surveillance cameras, or panic buttons.

▶ Controlling access to certain areas (e.g., ICU, ED, birthing center, pediatric unit) with locked doors.

▶ Enclosing the nurses’ station or installing deep counters.

▶ Replacing furniture with heavier or fixed alternatives that cannot be easily used as weapons.
Next, administrative and work practice controls. These are changes to the way staff perform jobs or tasks, both to reduce the likelihood of violent incidents and to better protect staff, patients, and visitors should a violent incident occur. Administrative and work practice controls are appropriate when engineering controls are not feasible or not completely protective.
Examples include:

- Procedures and tools for assessing and periodically reassessing patients with regard to their potential for violent behavior. Some facilities conduct threat assessments on a patient’s admission and periodically afterwards. Research confirms the importance of formally assessing mitigating factors (including work, financial, psychological, social, and physical factors) as well as factors that increase risk (including anger and trauma, history of violence and arrests, alcohol use, and financial instability).
Procedures for tracking and communicating information regarding patient behavior.

Special procedures for patients with a history of violent behavior. • Adequate staffing on all units and shifts.
Providing training in de-escalation techniques, workplace safety practices, and trauma-informed care. Trauma informed care recognizes the lasting impacts of physical, psychological, and emotional trauma on a survivor, and it actively seeks to avoid re-traumatization. For example, caregivers should minimize coercive interventions and avoid introducing stimuli or cues that might remind the victim of a previous traumatic experience.

Emergency procedures so all staff know what to do if an incident occurs.

Policies and procedures that minimize stress for patients and visitors.
Engineering controls and administrative controls often work in concert to address risk in the healthcare setting. Both kinds of controls should be selected with careful regard to the nature of the hazard identified and the nature of the healthcare setting. For example, controls suitable for an urban ED might not be appropriate for a community care clinic. Instituting any combination of control and prevention methods requires a careful balance between providing a safe healthcare setting and maintaining a calming, welcoming, and workable environment for staff, patients, and visitors.
Implementing controls does not conclude the process of addressing workplace violence. Once controls are in place, periodic review and evaluation can ensure that they are adequately addressing hazards identified during the site assessment process, highlight areas of weakness, and help to identify new or emerging risks that might require modification of existing controls or adoption of additional measures. In addition, if an incident occurs, employers can help their workers by providing timely medical and/or mental healthcare services (as appropriate) and conducting a post-incident debriefing where all involved or affected staff meet to conduct a blame-free root cause analysis that considers what happened, what should have happened, why the difference, and how to prevent a similar problem in the future. Access to an employee assistance program can help a worker cope with the ongoing trauma and stress that often accompany an assault or injury.
• Review of the facility’s workplace violence prevention policies and procedures.

• Create procedures for obtaining a patient’s risk profile before admission (where feasible).

• Assess risk factors that cause or contribute to assaults.

• Policies and procedures for assessing and documenting patients’ or clients’ change in behavior.

• Make aware of the location, operation, and coverage of safety devices such as alarm systems, along with the required maintenance schedules and procedures.
SAFETY AND HEALTH TRAINING (CONT’D)

- Recognition of escalating behavior, warning signs, or situations that may lead to assaults.
- De-escalation techniques to prevent or defuse volatile situations or aggressive behavior.
- Approaches to deal with aggressive behavior in people other than patients and clients, such as relatives, visitors, or intruders. • Proper use of safe rooms or areas where staff can find shelter from a violent incident.
- A standard response action plan for violent situations, typically referred to as “codes,” including the availability of assistance, response to alarm systems, and communication procedures.
- More generally, what to do in case of a workplace violence incident—i.e., responsibilities of others who are not directly responding to the event.
SAFETY AND HEALTH TRAINING (CONT’D)

- Self-defense procedures where appropriate.
- Progressive behavior control methods, including when and how to use medications or physical restraints properly and safely when necessary.
- Ways to protect oneself and coworkers, including working in teams when necessary.
Importance of getting early assistance.

Policies and procedures for reporting and recordkeeping.

Policies and procedures for obtaining medical care, counseling, workers’ compensation, or legal assistance after a violent episode or injury.
GENERAL TRAINING RECOMMENDATIONS

› Add information about facility-specific policies, procedures, and potential risk factors when using existing packaged training programs.

› Ensure that training and policies cover all types of workplace violence, not just violence by patients against employees. Many training programs, policies, and procedures focus exclusively on the latter. These programs fail to address employee-on-employee or employee-on-patient violence, robbery and theft (such as theft of drugs, or of hospital or employee property), and domestic violence.

› Provide frequent opportunities to practice skills and demonstrate competency.
WHO GETS TRAINING

All workers who are reasonably expected to interact with patients, including admissions staff, can benefit from workplace violence prevention training. So can supervisors and managers. Other support staff can benefit from awareness about their responsibilities in the event of a workplace violence incident. Affiliated physicians, temporary staff, and contract workers should receive the same training as permanent staff, and new and reassigned workers should receive an initial orientation that includes training in the prevention of workplace violence.
Because duties, work locations, and patient interactions vary by job, violence prevention training can be more effective if it is customized to address the needs of different groups of healthcare personnel, particularly:

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

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

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

- Working with patients with violent behavior
- Violence escalation cycle and violence-predicting factors
- Verbal and physical de-escalation techniques
- Self-defense, with a hands-on component
Direct caregivers can also benefit from specialized violence prevention training tailored to the specific patient populations they work with—for example, behavioral health patients, the developmentally disabled, and geriatric patients with Alzheimer’s and other forms of dementia.
ED nurses experience physical assaults at one of the highest rates of all nurses. Nurses in the ED may find themselves exposed to patients who have a history of violence, aggressive behavior associated with certain psychotic disorders, substance abuse, dementia, and other conditions.
SUPPORT STAFF

Housekeeping, food service, maintenance, and other support staff can benefit from workplace violence prevention training, especially if their duties take them to patient areas or if they otherwise have contact with patients. All staff should be aware of systems that rely on environmental symbols, such as color codes to convey safety information about individual patients, as well as what code situations announced over the public address system (e.g., “code gray”) mean and how they should respond. Other safety precautions include staying a safe distance from the patients, not leaving maintenance tools unattended, and not allowing patients to reach for gowns and bags with strings while delivering laundry.
Security personnel need to know the layout of the facility, including entrance and exit points and how to restrict or control access. They need specific training on the unique needs of providing security in the healthcare environment, including the psychological components of handling aggressive and abusive behavior, and ways to handle aggression and defuse hostile situations. They also need training in policies and procedures detailing how and when security personnel interact with patients during code situations.
SUPERVISORS AND MANAGEMENT

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

- **Classroom plus hands-on instruction.** Workplace violence prevention training has traditionally taken the form of classroom instruction (e.g., seminars) combined with active “learning by doing” in the form of role-plays, simulations, and drills. Interactive exercises make training more effective by allowing participants to practice and apply the skills they have learned, such as de-escalation and self-defense techniques.
Safety training can take several forms:

- **Just-in-time training.** Some facilities have designated one or more trainers or “safety coaches” for each unit or floor. These individuals can offer guidance and coaching in real-time—for example, if they see a colleague struggling to de-escalate an agitated patient. They can also run ad hoc or scheduled refresher sessions, which may be particularly useful and relevant to workers because the training takes place in their own work environment.
Safety training can take several forms:

- **Web-based training.** This increasingly popular approach offers fidelity of presentation and automated documentation while requiring minimal supervision and allowing flexible timing and pace. However, it does not provide hands-on practice with physical skills, which are widely considered to be an essential element of many programs. Thus, Web-based training may be more effective when paired with live instruction and practice—a “blended” approach.
HOW AND WHEN TO TRAIN?

Safety training can take several forms:

▶ The National Institute for Occupational Safety and Health (NIOSH) has developed a Web-based training program (www.cdc.gov/niosh/topics/violence/training_nurses.html) to help healthcare workers learn about the key elements of a comprehensive workplace violence prevention program, how organizational systems impact workplace violence, how to apply individual strategies, and how to develop skills for preventing and responding to workplace violence.
All training programs should include an evaluation component. At least annually, the team or coordinator responsible for the program should review the content, methods, and frequency of training. Program evaluation may involve supervisor and employee interviews, testing, observing, and reviewing reports of how staff have responded to threatening situations.
An increasing number of healthcare facilities have begun to incorporate violence-themed situations called “active shooter” scenarios into their training programs. An active shooter is a person who is actively engaged in killing or attempting to kill people in a confined and populated area, such as a hospital ED. The shooter might target specific people or choose victims randomly. Scenarios that could lead to an active shooter situation might include rival gang members being treated in the ED, an estranged ex-husband visiting the maternity unit in violation of a restraining order, or a former patient or family member distraught over perceived misdiagnosis or mistreatment of a relative.
Although active shooter situations are rare, they can have a huge impact on a healthcare organization and the broader community. Because these situations are often over quickly before law enforcement arrives, healthcare organizations must prepare and train their staff to respond appropriately.
Healthcare organizations can take to prepare for active shooter incidents:

- Involve local law enforcement in your plans
- Develop a communication plan
- Assess and prepare your building
- Establish processes and procedures to ensure patient and employee safety
- Train and drill employees
- Plan for post-event activities
CMC has developed a Workplace Violence Team. The team has adopted many changes to address WPV, including:

- Additional trainings for staff (Active shooter, etc)
- Uniformed officers assigned to ED and with psych patients
- Additional outside lighting
- Glassed in areas that collect money, glass to go around ED triage reception desk
- Concrete Pylons at all drive up entrances
- Panic Buttons at all desks where patients/visitors enter and at all ED station desks
- Electronic badging
- Quality review measures—what worked and did not work
OSHA defines workplace violence as physically and psychologically damaging actions that occur in the workplace.

Examples:
- Direct physical assaults (with or without weapons)
- Written or verbal threats
- Physical or verbal harassment
- Homicide

45% of all workplace violence incidents occur in the healthcare setting

The 2nd leading cause of fatal occupational injury in the US
Workplace Violence in Healthcare

- Between 40 and 75% of health care workers report having suffered physical or verbal abuse from a patient, coworker, intruder or visitor

- 13% of days away from work were the result of violence in 2016

- The 2nd leading cause of fatal occupational injury in the US
Workers’ compensation insurance typically have to pay the cost of injuries and missed days.

Caregiver fatigue, injury, and stress are tied to a higher risk of medication errors and patient infections.

Studies have found higher patient satisfaction levels in hospitals where fewer nurses are dissatisfied or burned out.

Injuries and stress are common factors that drive some caregivers to leave the profession. The estimated cost of replacing a nurse is $27,000 to $103,000.
Studies have found higher patient satisfaction levels in hospitals where fewer nurses are dissatisfied or burned out.
The Occupational Safety and Health Act’s (OSH Act) General Duty Clause requires employers to provide a safe and healthful workplace for all workers covered by the OSH Act. Employers who do not take reasonable steps to prevent or abate a recognized violence hazard in the workplace can be cited.
Conway Medical Center (CMC) established the WPV Committee June 2015

A standing Subcommittee of the Environment of Care (EOC) Committee to be proactive and voice concerns regarding workplace safety and security.

Meet quarterly (minimally) and make recommendations on ways to prevent and/or make improvements in handling workplace violence.
WORKPLACE VIOLENCE PREVENTION COMMITTEE PURPOSE

- Assess the vulnerabilities and direct and indirect threats in the workplace across all Organizational Properties.
- Review and monitor Quality Audits to determine the presence of patterns, hazards, conditions, operations and other situations that present risks.
- Recommend preventative actions to be taken.
- Monitor Security Performance Indicators.
- Discuss security concerns and identify patterns of problems through records review.
- Establish a liaison (coordination and collaboration) with local Law Enforcement and Emergency Services.
WORKPLACE VIOLENCE PREVENTION COMMITTEE MEMBERSHIP

- Quality/Risk Management
- Security
- Human Resources
- Physician Champion
- Front Line Staff
- Customer Service
- Employee Health
- EOC Liaison
“If you see something, say something” Safety Campaign

Independent Security Consultant

Therapeutic Options Class

Review SHARE reports

Robbery Brochure

Annual Security Fair

Protective glass/panic button instillation on multiple units
WORKPLACE VIOLENCE PREVENTION COMMITTEE ACTIONS

- Gang education for the ED staff
- Active Shooter Training
- Tasers for Security Staff
- Supported Legislation for healthcare worker protection
- Security Survey
- New Signage
- Attendance at the Annual Southeastern Safety and Security Healthcare Council Conference
FORMING A WPV PREVENTION COMMITTEE

➤ Buy-in from top management is critical

➤ All levels of organization should be included in training

➤ Program must be based on your type of workplace and risk profile

➤ Conduct a systematic workplace risk assessment

➤ Search the Web for supplemental sources (e.g. OSHA)

➤ SCHA Workplace Safety Toolkit (available soon)
REFERENCES

- Occupational Safety and Health Administration (OSHA). 2015. Guidelines for preventing workplace violence for healthcare and social service workers. No. 3148-04R.


# Resources

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<thead>
<tr>
<th>Author</th>
<th>Title</th>
<th>Description</th>
<th>URL</th>
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<tbody>
<tr>
<td>OSHA</td>
<td>Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers</td>
<td>Voluntary guidelines for reducing workplace violence in the healthcare and social service sectors. The guidelines emphasize the importance of management support and employee engagement.</td>
<td><a href="https://www.osha.gov/Publications/osha3148.pdf">https://www.osha.gov/Publications/osha3148.pdf</a></td>
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<tr>
<td>Emergency Nurses Association</td>
<td>Workplace Violence Toolkit</td>
<td>Toolkit with templates and examples designed specifically for the ED.</td>
<td><a href="https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/toolkitpg1.htm">https://www.ena.org/practice-research/Practice/ViolenceToolKit/Documents/toolkitpg1.htm</a></td>
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 QUESTIONS/COMMENTS?

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