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The purpose of this document is to serve as a guide to help HealthSouth hospitals recognize the frequency and severity of workplace violence in health care in general, the risk of episodes of healthcare violence in each hospital specifically, and provide recommendations for how workplace violence prevention programs can be tailored to each hospital’s specific needs. This paper will also describe the required internal HealthSouth reporting mechanism for workplace violence events.

The United States has seen a marked increase in reports of episodes of violence in the health care setting according to The Joint Commission. In fact, according to the Occupational Safety and Health Administration (OSHA), health care workers experience violent assaults at a rate four times higher than other industries; for nurses and other personal care workers, this rate jumps to 12 times higher. An American Nurses Association study reported that the majority of nurses do not feel safe in their working environment.

HealthSouth Corporation is committed to the safety and security of its employees, patients, and other visitors. Any acts of violence in a HealthSouth hospital by anyone will not be tolerated. For the purposes of this document, and the Violence Prevention Program Policy RIS-679, violence is broadly defined as including, but not necessarily limited to, behavior involving employees, visitors, physician or patients, which causes or threatens to cause harm to anyone. Threats, verbal harassment or sexual harassment, in addition to actual physical harm are considered acts of violence. All HealthSouth hospitals are required to have a written workplace violence prevention program specific to the needs of that hospital. Currently there is no federal standard that requires workplace violence protections. OSHA has adopted guidelines and recommendations around workplace violence especially for the health care/social services industry although, as they are still recommendations, employers cannot be cited for violations.
The purpose of this document is to serve as a guide to help HealthSouth hospitals recognize the frequency and severity of workplace violence in health care in general, the risk of episodes of health care violence in each hospital specifically, and provide recommendations for how workplace violence prevention programs can be tailored to each hospital’s specific needs. This paper will also describe the required internal HealthSouth reporting mechanism for workplace violence events. To access this paper electronically, please go to HealthSouth’s intranet site/Corporate Services/Risk Management/Resources/Violence Prevention White Paper: Recommendations and Resources.

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HealthSouth Corporation is committed to the safety and security of its employees, patients and other visitors. Any acts of violence in a HealthSouth hospital by anyone will not be tolerated. For the purposes of this document, and the Violence Prevention Program Policy RIS-679, violence is broadly defined as including but not necessarily limited to, behavior involving employees, visitors, physicians, or patients, which causes or threatens to cause harm to anyone. In addition to actual physical harm, threats, verbal harassment, or sexual harassment are considered acts of violence.

Currently there is no federal standard that requires workplace violence protections. OSHA has adopted guidelines and recommendations around workplace violence especially for the health care/social services industry although, as they are still recommendations, employers cannot be cited for violations. However, employers can be cited for security hazards under the “general duty” clause. The general duty clause requires all employers to furnish a workplace that is free from recognized hazards that may cause death or serious injury to employees. It is indisputable that violence against health care providers is a recognized hazard and OSHA has begun to cite more and more employers under the general duty clause for failure to have programs in place intended to protect employees from this hazard.
The OSHA recommendations suggest that all employers establish a Workplace Violence Prevention Plan with the following five essential components:

- Management commitment and employee involvement in violence prevention
- Assessment and analysis of the workplace for security hazards
- Prevention and control of these hazards
- Training on how to prevent these hazards
- Evaluation of the plan

Certain states require that employers have workplace violence programs in place. Currently those states are: California, Connecticut, Illinois, Maryland, New Jersey and Oregon. HealthSouth hospitals in those states are expected to be aware of and incorporate state-specific requirements into their violence prevention plans. In addition to the OSHA guidance and the statutory requirements in certain states, The Joint Commission requires that leaders create and maintain a culture of safety throughout the organization, and implement a process for managing behaviors that undermine that culture.

It is clear that there are regulatory, accreditation and some statutory pressures to develop and implement a workplace violence prevention program, but the most important reason for doing so is to provide an environment where HealthSouth employees, patients and visitors are free from the added stress of threats to personal safety. Violence in the workplace has a negative effect on everyone: victims, witnesses and all who work in the institution. In addition to physical injuries, victims and witnesses suffer psychological trauma, the entire staff feels less safe, and the institution may be faced with low employee morale, monetary losses, liability issues and adverse effects on patient safety. **For this reason, all HealthSouth entities are required to have a formal, written, site-specific Workplace Violence Prevention Plan.** We hope you will find this document useful for understanding workplace violence prevention best practices in HealthSouth hospitals and implementing or revising your own program to enhance the safety of everyone in our hospitals.
A WORD ABOUT MANAGEMENT COMMITMENT AND EMPLOYEE INVOLVEMENT

Employees alone cannot create and implement an effective violence prevention program. Management commitment and employee involvement are complementary and essential elements of such a program. Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence. This commitment includes:

- Demonstrating organizational concern for employee emotional and physical safety and health;
- Exhibiting equal commitment to the safety and health of workers and patients/visitors;
- Assigning responsibility for the various aspects of the workplace violence prevention program to ensure that all managers, supervisors and employees understand their obligations;
- Allocating appropriate authority and resources to all responsible parties;
- Maintaining a system of accountability for involved managers, supervisors and employees;
- Supporting and implementing appropriate recommendations from pertinent committees.

OSHA encourages employers to understand every worker should understand the concept of “universal precautions for violence”-that is, that violence should be expected but can be avoided or mitigated through preparation. In addition, workers should understand the importance of a culture of respect, dignity, and active mutual engagement in preventing workplace violence. Employee involvement and feedback enable workers to develop and express their own commitment to safety and provide useful information to design, implement and evaluate the program.
HAZARD/THREAT ASSESSMENT
A link to the workplace violence risk assessment tool recommended by the Violence Prevention Task Force is found on page 12. This tool is designed to help HEALTHSOUTH hospitals identify and quantify risk associated with workplace violence events that may put patients, visitors, and staff in jeopardy, and potentially disrupt the hospital's ability to provide patient care. The results of this analysis can be used to guide risk mitigation activities that can help reduce threats to safety and security of all who enter our facility.

It is recommended that the workplace violence risk assessment be completed using a cross-functional or multidisciplinary team approach with representatives at all levels of the organization. A best practice model includes supervisory staff and frontline clinicians when completing the risk assessment, as these individuals can provide first-hand experiences to help the organization understand actual or potential risks for workplace violence. An example of the team composition could be: CNO, Nursing Supervisor/or Charge Nurse, RN, RNT, DTO, Therapists, Housekeeper, Unit Secretary, Director of Facilities, DQR.

Information for this assessment is generally collected through: (1) records analysis (injury/illness records/work comp claims related to violence, RL Solutions reports related to violence/potential violence; (2) job hazard analysis (see end of this chapter for more details); (3) employee feedback; and (4) patient/client surveys.

The workplace violence risk assessment should be completed at least annually to identify where the organization may be vulnerable for workplace violence and to understand its current capabilities and mitigation strategies. The results of the workplace violence risk assessment should be presented to the Environment of Care/Safety Committee for consideration of current mitigation plans and the development and approval of future improvement initiatives.
HOW TO USE THE TOOL (READ DIRECTIONS CAREFULLY!)

For each event (see individual tabs), fill in the ranking section for **Probability**, then for each of the three categories for **Consequence**, and again for each of the three categories for **Mitigation**. Whenever possible, use actual data or local experience to create your rankings.

*Note: The consequences section should be evaluated without regard to mitigation. For example, for the Disruptive Behavior entry on the Patients versus Staff Events page, do not score a 1 (for low risk) in the "Disruption of Patient Care and Satisfaction" column because you know your hospital has a well-thought-out Code Grey policy and you implement the plan regularly. Those factors will be reflected in the Preparedness Planning, Response, and Training columns. Rather, the consequences section should reflect the actual risk to the hospital in that category.*

The green sections in the worksheets, labeled Risk, Risk Management Score, and Action Required will fill in automatically based on the input in the ranking sections.

The Risk column will be filled in as a product of probability and consequence.

The Risk Management Score column will produce a score for mitigation and preparedness levels, for response and recovery capabilities, and staff training level that is compared to the level of risk for each event. This score is a reflection of the organization’s coordinated application of resources to minimize, monitor, and control the probability and/or impact of the events. The Risk Management score reflects the Preparedness Planning, Response and Recovery Capability, and Staff Training scores.

*The Action Required column will show a YES if the risk is greater than the mitigation or if any of the three mitigation factors is scored less than 2, unless the probability of that risk is scored at 0. To cause the YES to disappear, improvement will have to occur until none of the three categories is scored at 1 and the mitigation is greater than the risk.*
Evaluate the risk associated with a given event and your hospital’s ability to respond to and recover from the event in light of the following:

Issues to consider for **Business Impact** include, but are not limited to:

1. Staff unable to follow normal routines
2. Interruption in health care services
3. Harm to facility reputation
4. Legal liability concerns

Issues to consider for **Preparedness Planning** include, but are not limited to:

1. Precipitating factors and event triggers such as:
   a. Impaired cognition
   b. Medical condition-related behavior
   c. Uncooperative/combative patient due to medical condition or treatment issues
   d. Escalation of concerns/complaints - patient/family
   e. Grief-related stress reaction
   f. Alcohol/drug withdrawal
   g. Prior history of violence
   h. Communication issues between patient/patient family and staff
   i. Insensitive or disrespectful interaction
   j. Protective status order - voluntary/involuntary
   k. Restraining order
   l. Intoxication
   m. Stalking
   n. Stress
2. Status of current emergency plans for the above

Issues to consider for **Response Capability** include, but are not limited to:

1. Staffing levels - each shift
2. Medical staff availability
3. Time to marshal an on-scene response
4. Scope of internal response capability
5. Historical success of response capability
6. Law enforcement response time

Issues to consider for **Staff Training Level** include, but are not limited to:

1. Competency level with crisis intervention and de-escalation protocols
2. Timely reporting of incident and contributing factors per hospital policy

Complete all worksheets, including Patient v Staff, Staff v Staff, Visitor or Patient Family-Related, External Staff events that spillover to the workplace, and random External events. A summary of your specific and overall relative threats will appear on the Summary worksheet.

*For a copy of the Workplace Violence Assessment Tool for Hospitals, please click on this link*
A job hazard analysis is an assessment that focuses on job tasks to identify hazards. It involves a thorough review of procedures and operations connected to specific tasks or positions to identify if they contribute to hazards related to workplace violence and/or can be modified to reduce the likelihood of violence occurring. In other words, the analysis examines the relationship between the employee, the task, tools, and the work environment. Worker participation is an essential part of the analysis. Priority for risk mitigation should be given to:

- Jobs with high assault rates due to workplace violence;
- Jobs that are new to an operation or have undergone procedural changes that may increase the potential for workplace violence; and
- Jobs that require written instructions, such as procedures for administering medicine, and steps required for transferring patients
CONTROLS AND PREVENTION STRATEGY
ENGINEERING CONTROLS

ENGINEERING CONTROLS MINIMIZE THE RISK OF WORKPLACE VIOLENCE BY CREATING A BARRIER BETWEEN THE WORKER AND HAZARD. THE FOLLOWING ARE GENERAL PREVENTION STRATEGIES. IMPLEMENTATION OF THESE AND THE ADDITION OF OTHER PREVENTION STRATEGIES SHOULD BE BASED ON THE HAZARDS IDENTIFIED BY THE HOSPITAL.

- Ensure bright & effective lighting - both exterior and interior of hospital. (Avoid the use of Low Pressure Sodium lights).
- Ensure all lighting controls (timers) are correctly programmed.
- Regularly inspect (at a minimum of quarterly) lights to replace burned out light lamps.
- Use panic/duress alarms at receptionist desks, brain injury units and other high risk areas. Test at least quarterly.
- Use surveillance cameras to monitor entrances, patient corridors, pharmacy, parking areas and other high risk areas. Use surveillance camera signage as a deterrent when cameras are utilized.
- Use card key access in place of keyed locksets on exterior doors. Update code accesses at least quarterly.
- Ensure ALL exterior doors are locked at all times, except for designated entrances.
- Control access with locks to work areas, charting rooms, lounges, and locker rooms.
- Maintain lockable and secure bathrooms for “staff only”.
- Install curved mirrors in hallway intersections or concealed areas.
- Arrange furniture and other objects to prevent staff entrapment and to minimize their use as a weapon.

- Remove any clutter from nurse’s station countertops that can be thrown at staff if used as a weapon.
- Provide comfortable waiting/day rooms for patients and visitors.
- Consider the use of security guards or a security roaming patrol service.
- Implement safety measures and signage to deter weapons inside the hospital; consider use of metal detectors.
- Consider the use of shatter resistant glass enclosures at pharmacy and nurses station.
- Cut back vegetation around the hospital, particularly around entrance to deter someone from hiding.
- Properly maintain vehicles that are used for patient transports.
- Designate a locked safe room for staff to use in emergencies situation. Use a pushbutton mechanical lockset or card access lock to the room.
- Consider installation of exterior door monitoring system at the nurse’s station that alarms after hours when a door is opened.
- Install time lock system that unlocks/locks exterior doors at a predetermined time.
ADMINISTRATIVE CONTROLS AND WORK PRACTICES

ADMINISTRATIVE CONTROLS AND WORK PRACTICES MINIMIZE THE RISK OF WORKPLACE VIOLENCE BY AFFECTING THE WAY STAFF PERFORM THEIR JOBS AND TASKS. RECOMMENDATIONS INCLUDE:

- Complete a Security Risk Assessment with the Safety Committee to determine potential risks and identify relevant preventive interventions.

- Conduct a periodic survey with staff to determine what concerns they have and what situations they encounter that make them nervous (such as asking a visitor to leave, walking to the parking lot, etc.).

- State clearly to patients, visitors, vendors and employees that violence is not permitted or tolerated.

- Establish a liaison with local police. Give police physical layouts of hospital. Offer free meals/coffee to uniformed officers. Provide a place (chair/desk) where they can complete their daily paperwork. Report all incidents of violence.

- Consider periodic inservices on personal safety provided by law enforcement or other experts.

- Require employees to report all assaults or threats to a supervisor or manager. Complete event report on all such incidents through RL Solutions.

- Designate a trained response team to respond to emergencies.

- Establish a system (code) to alert appropriate personnel and/or trained response team when violence is threatened.

- Provide management support during emergencies. Respond to complaints timely.

- Establish a system/process for patients who have been a victim of violence (see sample policy on Protective Status in Resources.).

- Identity all staff with HealthSouth ID badges.
ADMINISTRATIVE CONTROLS AND WORK PRACTICES (CONTINUED)

- Ensure all vendors sign in and have proper identification.
- Establish a visitor sign-in process.
- Post & enforce established visiting hours.
- Determine the behavioral history of new patients to learn about any past violent or assaultive behaviors.
- Prepare contingency plans to treat patients who are “acting out” or making verbal and/or physical threats or attacks. Use properly trained employees and licensed independent practitioners to help diffuse the situation.
- Discourage employees from wearing necklaces or chains to help prevent possible strangulation in violent situations.
- During environmental rounds, always check for sharp objects that may be in drawers or cabinets that could be used in a violent situation.
- Provide security escorts for staff to parking lots at night. If security is not available, encourage employees to use the “buddy system”.
- Offer counseling to any employee who has been a victim of workplace violence or threatened.
Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their coworkers through established policies and procedures.

A formal training program is highly recommended, such as the “Non-Violent Crisis Intervention Program” offered through CPI. Additional information can be found at www.crisisprevention.com. This program allows for a staff member to become a certified instructor and then train additional staff per program guidelines.

There is also a Healthstream course that may be assigned to employees titled “Workplace Violence”. This course has four sections: This introductory lesson provides the course rationale and goals. Lesson 2 discusses violence in the healthcare setting. This includes risk factors for violent patient behavior. Lesson 3 presents the key parts of a Workplace Violence Prevention Program. Finally, lesson 4 describes how to deal with aggressive behavior in the workplace.

Training for all employees

Every employee should understand the concept of "universal precautions for violence"—that is, that violence should be expected but can be avoided or mitigated through preparation. Frequent training also can reduce the likelihood of being assaulted.

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards. It also includes instructions to limit physical interventions in workplace altercations whenever possible, unless enough staff or emergency response teams and security personnel are available. In addition, all employees should be trained to behave compassionately toward coworkers when an incident occurs.
The training program should involve all employees, including supervisors and managers.

New and reassigned employees should receive an initial orientation before being assigned their job duties. Visiting staff, such as physicians, should receive the same training as permanent staff. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations and drills.

Topics may include management of assaultive behavior, professional assault-response training, police assault-avoidance programs or personal safety training such as how to prevent and avoid assaults. A combination of training programs may be used, depending on the severity of the risk.

Employees should receive required training annually.
What training should cover

The training should cover topics such as:

- The workplace violence prevention policy;
- Risk factors that cause or contribute to assaults;
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults;
- Ways to prevent or diffuse volatile situations or aggressive behavior, manage anger and appropriately use medications as chemical restraints;
- A standard response action plan for violent situations, including the availability of assistance, response to alarm systems and communication procedures;
- Ways to deal with hostile people other than patients and clients, such as relatives and visitors;
- The location and operation of safety devices such as alarm systems, along with the required maintenance schedules and procedures;
- Ways to protect oneself and coworkers, including use of the "buddy system;"
- Policies and procedures for reporting and recordkeeping;
- Information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences; and
- Policies and procedures for obtaining medical care, counseling, workers' compensation or legal assistance after a violent episode or injury.
Training for supervisors and managers

Supervisors and managers need to learn to recognize high-risk situations, so they can ensure that employees are not placed in assignments that compromise their safety. They also need training to ensure that they encourage employees to report incidents.

Supervisors and managers should learn how to reduce security hazards and ensure that employees receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and to make any necessary changes in the physical plant, patient care treatment program and staffing policy and procedures to reduce or eliminate the hazards.

Training for personnel responsible for security

Personnel responsible for security need specific training from the hospital, including the psychological components of handling aggressive and abusive clients, types of disorders and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. At least annually, the team or coordinator responsible for the program should review its content, methods and the frequency of training. Program evaluation may involve supervisor and employee interviews, testing and observing and reviewing reports of behavior of individuals in threatening situations.

References:
Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, U.S. Department of Labor Occupational Safety and Health Administration, OSHA 3148-04R 2015

Occupational Hazards in Hospitals, DHHS (NIOSH) Publication No. 2002-101
Any episode of violent behavior by any non-employee (e.g. patients, visitors, licensed independent practitioners) should trigger the completion of an event report in RL Solutions as soon after the event as possible. **Violence is broadly defined as including but not necessarily limited to, behavior involving employees, visitors, physicians, or patients, which causes or threatens to cause harm to anyone. In addition to actual physical harm, threats, verbal harassment, or sexual harassment are considered acts of violence.** The creation of such a report allows the hospital to track and trend occurrences and evaluate each to assist in the evaluation of hazard controls and identify training needs. HealthSouth will not tolerate retaliation against any employee for making a good faith report of an episode of violent behavior.

The Safety/Security form in RL Solutions is the ideal place to report such events. Reporters should review the “Specific Event Types” and make the selection that best fits the circumstance being reported. If an employee is injured during the event a **WORKERS’ COMPENSATION INJURY/ILLNESS INVESTIGATION REPORT** should be completed and the employee referred for treatment in compliance with Risk Policy 612: *Workers’ Compensation Claims Management.*

**Investigation Best Practice:**
The process of analyzing an incidence of violence behavior should follow good investigative practices. There are two primary reasons why hospital incidents should be investigated. First, we investigate to understand what happened and why, and second to determine if there are actions necessary to prevent a recurrence. The goal of the violence prevention program is to decrease the risk of harm to our patients, visitors and employees and reduce the financial risk to the hospital. Therefore, we need to investigate fully and accurately the circumstances and causes of incidents. The following questions and answers may help clarify investigative best practices in the aftermath of an episode of violent behavior:

**When to investigate incidents?**
It is important that any investigation occurs as soon as possible. The less time between an incident and the investigation, the more accurate the information that can be obtained.
How should an investigation proceed?
First of all, the individuals conducting the investigation must begin with an open mind. No assumptions should be made and any judgment should be based on information that is known to be complete and accurate. In addition, the investigation should proceed in a discreet and confidential manner.

When questioning those with information about the incident, it is preferable to ask open-ended questions and not put words into witnesses’ mouths. It is also important to let all parties know we are not looking to blame anyone, but rather, emphasize the importance of seeking the reasons for the incident to prevent a recurrence.

Who do I interview? Make sure you are aware of everyone involved in the event, present at the time of the event or may be aware of possible pertinent information. Depending on the nature of the incident and outcome, all may need to be interviewed. If witnesses have given written statements, secure all copies and save into the RL Systems report.

Is there other evidence I should review? Yes. You may find pertinent information in the following documents/resources:

- Medical record review
- CCTV tape review if available (secure copies)
- Nurse call system tracking
- Visitor sign in sheets
POST EVENT JOB ANALYSIS

Following an episode of violence/threatened violence or a near miss, a job analysis must be performed. This analysis should focus on:

• Analyzing the positions that were affected;
• Identifying if existing procedures and operations were followed and if not, why not (in some instances, not following procedures could result in more effective protections);
• Identifying if staff were adequately qualified and/or trained for the tasks required; and
• Developing, if necessary, new procedures and operations to improve staff safety and security.

How do I know when I am through? This is hard to answer. However, once you have exhausted all possible sources of information, you are likely at the end of your investigation. Consulting with Corporate Risk Management can help you determine if there are other avenues to explore.
POST EVENT CARE OF EMPLOYEE

HealthSouth considers the appropriate care of employees following incidents of workplace violence to be critically important. These steps should be followed/considered:

• First aid as able;
• Worker’s compensation report as applicable;
• Need for EAP services;
• Transportation to receive care as needed.
HOME HEALTH
SAFETY TIPS FOR HOME HEALTH WORKERS

Getting there and back:

1. Consider working with an escort in high-crime areas, and if possible, schedule visits during daylight hours.
2. Be sure of the location and have accurate directions to the house or apartment. Have more than one person to call in case you need directions.
3. Always let your supervisor/manager know your location and when to expect you to report back.
4. When driving alone, have the windows rolled up and doors locked.
5. Know the location of the local police or fire department so that driving there for safety is an option.
6. Park the vehicle in a well-lit area, away from large trees or shrubs where a person could hide.
7. Keep healthcare equipment, supplies, and personal belongings locked out of sight in the trunk of the vehicle. Avoid entering the trunk of your vehicle at the patient’s home. Prepare the materials needed for the visit in advance and carry them with you.
8. Before getting out of the car, check the surrounding location and activity. If you feel uneasy, do not get out of the car.
9. Stay in your car and contact your manager if you notice anything that might threaten your security, such as strong odors from a drug lab, gunshots, or shouting and sounds of fighting.
10. Confirm with your patients shortly before your visit, so they are expecting you.
11. Make sure your car is filled with gas and in good working condition.
12. Don’t park in the patient’s driveway. Park in the street.
In the field or during a visit:

1. During the visit, use basic safety precautions by (1) being alert, (2) evaluating each situation for possible violence, and (3) watching for signals of impending violent assault, such as verbally expressed anger and frustration, threatening gestures, signs of drug or alcohol abuse, or the presence of weapons.

2. Notify your employer if you observe an unsecured weapon in the client’s home.

3. Maintain behavior that helps to defuse anger by (1) presenting a calm, caring attitude, (2) not matching threats, (3) not giving orders, and (4) acknowledging the person’s feelings.

4. Avoid behaviors that may be interpreted as aggressive (for example, moving rapidly or getting too close, touching unnecessarily, or speaking loudly).

5. Know where the bathrooms and exits are, and make sure there is a clear path to them.

6. If possible, keep an open pathway for exiting.

7. Trust your judgment and avoid situations that don’t feel right.

8. If you are being verbally abused, ask the abuser to stop. If the abuser does not stop, then leave and notify your supervisor/manager. Don’t be afraid to shorten a visit if things get out of control or you feel threatened.

9. If you cannot gain control of the situation, shorten the visit and remove yourself from the situation. If you feel threatened, leave immediately.

10. Keep your cell phone in your pocket – not away from you in a bag or purse or in the car. Maintain the phone turned on during visits.

11. Do your paperwork and documentation in the home before you go to your car. Don’t linger in your car if you can help it.

12. Encourage patients to turn on porch lights.

13. Carry a flashlight and use it when you walk to and from your car in dark areas.

14. If you need help, use your cell phone to call your supervisor/manager or 911, depending on the severity of the situation.

15. If you observe a crime, contact the police.
General Tactics:
1. Conduct visits during daylight hours whenever possible
2. Take a self-defense course
3. Consider carrying a personal alarm or noise making device such as a whistle
4. Only carry a minimal amount of cash
5. Always carry ID
6. Make sure your cell phone battery is fully charged before you head to your visits
7. Let someone know when you are done and expected home
8. Dress to protect yourself. Wear shoes and clothes that make it easy for you to move quickly.
9. Avoid wearing expensive jewelry or carrying a purse. Avoid any accessory that could potentially be dangerous such as necklaces or scarves.

Sources:

*The Occupational Safety and Health Administration, the National Institute of Occupational Safety and Health at the Centers for Disease Control, Wild Iris Medical Education, Inc., the Home Healthcare Nurse journal,* "Promoting Personal Safety during Outreach, Shelter and Home Visits" by the Health Care for the Homeless Network, Pam Albers of the New Orleans Family Justice Center, Jamey Boudreaux of the Louisiana-Mississippi Hospice and Palliative Care Organization, and the Homecare Association of Louisiana
HOME HEALTH WORKPLACE VIOLENCE RISK ASSESSMENT TOOL

This home health workplace violence risk assessment tool is designed to help HEALTHSOUTH HHAs identify and quantify risk associated with workplace violence events that may put patients, caregivers, families, visitors and staff in jeopardy, and potentially disrupt the agency's ability to provide patient care. The results of this analysis can be used to guide risk mitigation activities that can help reduce threats to safety and security of all who enter a patient's home.

It is recommended that the workplace violence risk assessment be completed using a cross-functional or multidisciplinary team approach with representatives at all levels of the organization. A best practice model includes supervisory staff and frontline clinicians when completing the risk assessment as these individuals can provide first-hand experiences to help the organization understand actual or potential risks for workplace violence.

The workplace violence risk assessment should be completed at least annually to identify where the organization may be vulnerable for workplace violence and to understand its current capabilities and mitigation strategies.
HOW TO USE THE TOOL

For each event (see individual tabs) fill in the ranking section for **Probability**; then for each of the three categories for **Consequence**, and again for each of the three categories for **Mitigation**. Whenever possible, use actual data or local experience to create your rankings.

*Note: The consequences section should be evaluated without regard to mitigation. For example, for the Disruptive Behavior entry on the Patients versus Staff Events page, do not score a 1 (for low risk) in the "Disruption of Patient Care and Satisfaction" column because you know your facility has a well-thought-out Code Grey policy and you implement the plan regularly. Those factors will be reflected in the Preparedness Planning, Response, and Training columns. Rather, the consequences section should reflect the actual risk to the facility in that category.*

The green sections in the worksheets, labeled Risk, Risk Management Score, and Action Required will fill in automatically based on the input in the ranking sections.

The Risk column will be filled in as a product of probability and consequence.

The Risk Management Score column will produce a score for mitigation and preparedness levels, for response and recovery capabilities, and staff training level that is compared to the level of risk for each event. This score is a reflection of the organization’s coordinated application of resources to minimize, monitor, and control the probability and/or impact of the events. The Risk Management score reflects the Preparedness Planning, Response and Recovery Capability, and Staff Training scores.

*The Action Required column will show a YES if the risk is greater than the mitigation or if any of the three mitigation factors is scored less than 2, unless the probability of that risk is scored at 0. To cause the YES to disappear, improvement will have to occur until none of the three categories is scored at 1 and the mitigation is greater than the risk.*
Evaluate the risk associated with a given event and your organization’s ability to respond to and recover from the event in light of the following:

Issues to consider for **Probability** include, but are not limited to:
1. Patient population
2. Historical data - home health specific
3. Available statistics

Issues to consider for **Business Impact** include, but are not limited to:
1. Staff unable to follow normal routines
2. Interruption in health care services
3. Harm to agency reputation
4. Legal liability concerns

Issues to consider for **Preparedness Planning** include, but are not limited to:

1. Precipitating factors and event triggers such as:
   a. Impaired cognition
   b. Medical condition-related behavior
   c. Uncooperative/combative patient due to medical condition or treatment issues
   d. Escalation of concerns/complaints - patient/family
   e. Grief-related stress reaction
   f. Alcohol/drug withdrawal
   g. Prior history of violence
   h. Communication issues between patient/patient family and staff
   i. Insensitive or disrespectful interaction
   j. Protective status order - voluntary/involuntary
   k. Restraining order
   l. Intoxication
   m. Stalking
   n. Stress
2. Status of current emergency plans for the above

Issues to consider for **Response Capability** include, but are not limited to:
   1. Staff ability/training
   2. Family member/caregiver availability
   3. Scope of internal response capability
   4. Historical success of response capability
   5. Law enforcement response time

Issues to consider for **Staff Training Level** include, but are not limited to:
   1. Competency level with crisis intervention and de-escalation protocols
   2. Timely reporting of incident and contributing factors per hospital policy

Complete all worksheets, including Patient v Staff, Staff v Staff, Visitor or Patient Family-Related, External Staff events that spillover to the workplace, and random External events. A summary of your specific and overall relative threats will appear on the Summary worksheet.

For a copy of the Workplace Violence Assessment Tool for Home Health entities, please click on this link
WHEN CONFUSED PATIENTS FIGHT BACK!

PREVENTING, RECOGNIZING AND DEFUSING COMBATIVE BEHAVIOR IN THE CONFUSED PATIENT

Anyone who has been a health care provider for any length of time has been there. You are performing your routine vital sign checks and you go in to take Ms. Smith’s. You find her resting with her eyes closed. As you reach her arm and start placing the BP cuff around her arm you tell her what you are doing. You can tell she is startled and she reaches up and grabs your stethoscope with one hand and starts slapping at your arms with the other.

Confused patients exhibiting combative behavior is not uncommon in care settings. While there is little research on the incidence in acute rehabilitation hospitals, a 2006 study suggested that 88,000 of the approximately 1.3 million residents in nursing homes nationally are physically aggressive each week. Another study published in 2014 looked at 214 episodes of patient violence and found that cognitive impairment was a factor in 40% of these episodes. With the aging baby boomer population that number is likely to increase. This chapter discusses prevention and mitigation techniques to use to try to reduce the incidence of combativeness in confused patients and includes a power point presentation that may be used for staff education.

What kinds of behaviors are considered “combative”? The list includes, but may not be limited to:
- Resisting care-this is where the patient aggressively hampers efforts to bathe or dress or provide care;
- Verbal aggression-arguing, cursing, accusing, or threatening;
- Fighting-endangering other patients or caregivers with punches, kicks, bites or other potentially harmful acts.
Managing these behaviors in an individual who is cognitively intact is one thing, but managing them in patients with cognitive impairments is another. Sometimes there is the tendency to just accept the combativeness, particularly when the patient is confused, as ‘part of the job’. We must not fall into that trap. These episodes can cause serious injuries to the patient as well as the employee. While we will never completely prevent such outbursts, we need to be diligent to try to assess, understand and work to prevent or modify combative behavior. Doing so will result in better care for patients and greater work satisfaction for employees.

**Training**

The ability to understand, predict and possibly prevent episodes of combative behavior starts with training. We will review the importance of each of these skills as well as discuss post-event response.

**Understanding**

A care-giver needs to understand that combative behavior in the confused patient is typically not directed at the individual caregiver and must not take the actions as a personal attack. Usually combativeness in a confused patient is a mechanism for communicating a need, want or desire when they are having a hard time doing so. There are several underlying conditions or situations that predispose a confused patient to combativeness.

First of all is the diagnosis of **dementia**. In this disease, both personality and thinking abilities deteriorate and this deterioration usually worsens over time. Patient’s with dementia may have a difficult time understanding what is going on in the care setting—even cognitively intact people struggle with this-leading to the urge to strike out at a caregiver.

**Other health-related causes** can also lead to combative behavior in the confused individual. Sensory impairments, acute illness, loss of control over bodily functions, disturbances in body image, multiple illnesses and disabilities, substance abuse related conditions, changes in medications or loss of sleep can all trigger escalating behavior. Think about your patients. More than one of these conditions apply to many patients in the rehabilitation setting. Is it any wonder they become combative?

**Psychosocial factors** can influence lead to combative behavior. These patients have had significant life changes and are justifiably frustrated by the loss of control they have experienced. Also, remember, in a hospital we provide care that can be painful, intimate and just plain scary. A confused patient may easily misinterpret what a provider is trying to do. These patients may have issues with controlling their feelings and may act out when faced with certain situations.
The environment can make a huge difference in whether a confused patient will become combative. Hospitals are generally not relaxing environments. In fact, just the opposite. There are very bright lights and radios and TVs on in most every room. Usually there are intrusive overhead pages, constant traffic of people (mostly strangers) coming and going. The patient rooms can be cluttered—particularly when the patient requires various equipment—and the patient may be uncomfortable with the way their belongings are arranged. A patient may change rooms at least once and maybe more times while hospitalized and may have multiple roommates. In addition, they typically have no control over the routine which can also change frequently. Finally, “working noise” can cause agitation in confused patients. This phrase describes the noise inherent to hospitals such as bed and chair alarms, IV pumps, feeding tube pumps, etc. This sort of environment is enough to grate on anyone’s nerves, much less someone who can’t understand why they are there.

The last cause of combative behavior in confused patients we will discuss is the one that health care workers have the most control over. The literature refers to it as “unskilled care-giving”. How the health care worker approaches and deals with the confused patient can make a huge difference. Examples of unskilled care-giving include being overly authoritarian or making moves or gestures or touching the patient in a way that startles or frightens them. Being impatient with the person or rough or hurried during care-giving can make a difficult situation worse for a confused patient. Also, using a loud, directive voice can make the patient feel vulnerable and may be perceived as demeaning.

Learning To Predict
Now that we have identified factors that may predispose a confused patient to combative behavior, let’s look at clues a health care worker should watch for that may indicate escalating behavior. A study in a geriatric ward revealed that pacing around the bed universally preceded episodes of violent behavior. That same study also indicated that all patients who became violent had previously demonstrated shoving behavior. Other signs that a confused patient may be about to become combative include agitation, nervousness, frustration, fear, panic, despair, guilt, suspiciousness, hostility, annoyance and resentment.
One researcher uses the acronym STAMP to indicate the potential for violence in emergency department patients and those who accompany them. The five interconnected components are:

- **S**taring and eye contact
- **T**one and volume of voice
- **A**nxiety
- **M**umbling
- **P**acing

As behavior escalated, the researchers reported that the number of STAMP components and cues increased.

**Learning To Prevent**
Health care workers should have an understanding of actions that can be taken to reduce the likelihood of injury from confused patients who become aggressive. First of all, care-givers should take certain **personal safety measures**. Earrings, necklaces and hairstyles that can be grabbed or pulled should be avoided. Overly-loose clothing can be grabbed and should also be avoided as well as tight clothing which can restrict movement.

Watch your **body language**; non-verbal communication is critical. Don’t fold your arms across your chest or put your hands in your pockets. Approach the patient from the front, not the back and move with them, not ahead of them. Don’t stand face to face with the agitated patient and be sure to keep yourself at a safe distance if the potential for striking out exists. Don’t touch the patient if their behavior starts to escalate.

How you **communicate verbally** is also very important. Use a gentle and relaxed tone when addressing the patient and always identify yourself and address the patient by name. Also explain what you are going to do before touching the patient. Use short, simple words and ask one question at a time, allowing time for answers. Avoid pronouns like “he” or “she” and instead use names. Avoid negative comments or comments that imply the patient should know something (i.e., “surely you know what day today is”). Don’t talk over or about the patient as if they are not present.
Here are some additional tips. You may need to break the task into small steps. Keep the patient’s routine as regular and simple as possible and allow the patient the opportunity to participate in decision making as much as possible. Even if the decision just involves which shirt they want to wear today. Focus on their abilities and not their lost skills and be flexible. The patient may need to rest between stimulating activities. Finally, rely on the tenets of CPR-Comfort, Professionalism and Respect - in dealing with the confused patient who has become aggressive.

What Happens If They Still Escalate?

So let’s go back to our example described at the beginning of the article. You attempt to perform routine vital signs on a patient who becomes combative and starts resisting and slapping at your hands. It is always important to remember DON’T ARGUE with a confused patient. If their behavior is escalating, accept instead of contradict their reality. If they believe it is Friday and you tell them repeatedly it is Saturday causing them to get more agitated, are you really accomplishing anything? It may be better in this situation to just accept that at this moment they believe it is Friday. Validate their feelings of confusing and anger while maintaining your composure. Get yourself at eye level instead of towering over the patient and don’t make demands while they are anxious. Respond to the problems and not the words the patient may be saying.

It may be that the best option is to terminate the care or treatment you are attempting to provide. Forcing the patient to comply can cause more harm than good. Do you really think the blood pressure of the patient who is resisting would be an accurate reading anyway? If it isn’t care that is urgent, such as a routine blood pressure, you may be able to try again after a cooling off period. You may need to considering having another care give make the attempt, or if the family is present they may be able to help de-escalate the combative behavior. However, you may need to consult with the charge nurse or supervisor if necessary care is being refused. A call to a physician may also be required if the care or treatment is vital.
**Post Event Activities**

When the dust has settled there is documentation that needs to be completed. An RL Solutions event report should be completed using the “Safety/Security” form and choosing “disorderly person” from the list of specific event types. This documentation is critical in helping your hospital track and trend how often employees are faced with these situations. Any event that impacts the patients care plan or well-being should be documented factually in the medical record.

Work with the interdisciplinary team to identify triggers and interventions to reduce the likelihood of combative behavior in confused patients and when they are identified make sure all team members are aware of a particular patient’s triggers and interventions that have worked in the past. Remember that one study showed that 53% of patients who exhibit violent behavior have had prior violent episodes. For this reason it is critically important to share a history of violent actions with the treatment team.

It is important to remember that there is a significant payoff when employees are trained to deal with these difficult situations. Instituting strategies to recognize, predict and defuse episodes of combative behavior in confused patients can improve patient satisfaction, decrease employee turnover and burnout and reduce the likelihood and severity of injuries to patients and employees.

Let’s look at a scenario......
WE’VE ALL BEEN THERE…..

Time for routine blood pressure checks. Ms. Smith is resting with her eyes closed. You tell her you are going to check her pressure as you are putting the cuff around her arm. She reaches up and grabs your stethoscope with one hand and starts slapping at your arms with the other.

The Prevalence

A 2006 study suggested that 88,000 of the approximately 1.3 million residents in nursing homes nationally are physically aggressive each week.
A study published in the August 4, 2014 Journal of Advanced Nursing looked at 214 episodes of patient violence and cognitive impairment was a factor in 40% of these episodes.

What Are Considered Combative Behaviors?

- Resisting care-aggressively hampering efforts at bathing or dressing, for example
- Verbal aggression-arguing, cursing, accusing, or threatening
- Fighting-endangering other patients or caregivers with punches, kicks and other hurtful acts

Managing these occurrences is complicated when the patient has cognitive impairment. There is likely a propensity to accept the combativeness, particularly with confused patients, as ‘part of the job’.
However, these events can cause serious injuries to the patient as well as the employee. We need to be as concerned about these episodes as we are when cognitively intact patients and visitors become aggressive. Your ability to assess, understand and work to prevent or modify combative behavior will result in better care for patients and greater work satisfaction for you.

Proper Training Can Help

Combativeness is not usually directed at the individual caregiver, nor is it a personal attack. It is usually a mechanism for communicating a need, want or desire when they cannot articulate verbally.

Causes

Dementia
- Both personality and thinking abilities deteriorate
- Worsens over time
- Combative behavior may result from an inability to understand what is going on in the care setting

Other health-related causes
- Sensory impairments
- Acute illness
- Loss of control over bodily functions
- Disturbances in body image
- Multiple illnesses and disabilities
- Substance abuse related conditions
- Changes in medications
- Loss of sleep
Psychosocial
- Feeling threatened by life changes and frustrated by loss of control
- May misinterpret your attempts to provide care
- May not be able to control feelings

Environmental
- Very bright/dim lights
- Blaring radios and TV
- Intrusive overhead pages
- Cluttered room
- Constant traffic of people coming and going
- Change of rooms, roommates or routines
- Disregard for the way the patient wants their belongings arranged
- “Working noise”-bed/chair alarms, IV pumps, feeding tube pumps

Unskilled care-giving
- Overly authoritarian
- Making gestures that startle or frighten
- Rough or hurried handling during care-giving
- Impatient
- Loud, directive voice can make the patient feel vulnerable and may be perceived as demeaning
LEARN TO PREDICT

A study in an acute geriatric ward reported that pacing around the bed universally preceded episodes of violent behavior. And all patients who became violent had previously demonstrated shoving behavior.

Agitation, nervousness, frustration, fear, panic, despair, guilt, suspiciousness, hostility, annoyance, and resentment. One researcher uses the acronym STAMP to indicate the potential for violence in emergency department patients and those who accompany them. The five interconnected components are:

- Staring and eye contact
- Tone and volume of voice
- Anxiety
- Mumbling
- Pacing

As behavior escalated, the researchers reported that the number of STAMP components and cues increased.
LEARN TO PREVENT

**Care-Giver Personal Safety Measures**
- Avoid earrings/necklaces/hair styles that can be grabbed
- Clothing not overly loose (can be grabbed) or tight (restricts movement)

**Watch Your Own Body Language**
- No arms folded or hands in pocket
- No standing face to face
- Always approach agitated patients from the front, not the back
- Be sure to be at a safe distance if potential for hitting exists
- Move with the patient not ahead or after
- Explain what you are going to do before touching the patient
- Do not initiate physical contact if behavior starts to escalate

**Watch your verbal communications**
- Rely on the tenets of CPR (compassion, professionalism and respect)
- Identify yourself and address the patient by name
- Use short, simple, familiar words
- Ask one question at a time and allow time for responses
- Avoid using pronouns such as “he” or “she”; instead, identify people by name
- Avoid negative statements and comments (e.g., “you know who that is, don’t you?”)
- Don’t talk over or about the patient as if they are not there
Other Approaches to Reduce Risk
- Always rely on tenets of CPR-Comfort, Professionalism and Respect
- May need to break series of tasks into single acts
- Try to keep routine as regular and simple as possible, avoiding change when possible
- Allow the patient an opportunity to participate/make choices-ask close ended question
- Focus on the patients abilities not lost skills
- Be flexible/alter situations
- Rest between stimulating activities

Three Important Rules If Behavior Escalates
- Don’t argue!
- Don’t argue!
- Don’t argue!
DE-ESCALATION

- Accept instead of contradict the confused patient’s reality
- Validate feelings of confusion, anger
- Maintain your composure—respond calmly and express support. Use positive and friendly facial expressions
- Respond calmly
- Use relaxed, gentle tone of voice
- Actively listen and look for clues to triggers
- Get yourself at eye level
- Don’t demand
- Respond to the problem not the words
- Terminate the situation the patient feels is threatening
- May try again later after cooling off period
- **Consult with charge nurse/supervisor about necessity of care triggering escalation**
- **May need to notify MD if treatment/therapy/care is necessary**
- May need to assign a different caregiver
- Recruit family/friend of the patient to assist
POST EVENT ACTIVITIES

- Complete RL Solutions report-Safety/Security form, specific event type: “disorderly person”
- Work with the interdisciplinary team to identify triggers and interventions to reduce the likelihood of combative behavior
- Communicate, communicate, communicate. One study showed that 53% of patients who exhibit violent behavior have had prior violent episodes.

Instituting strategies to recognize, predict, and defuse episodes of combative behavior in confused patients can improve patient satisfaction, decrease employee turnover and burnout and reduce the likelihood and severity of injuries to patients and employees.

References


Hoff, L. Slatin, C. Workplace health and safety: report of PHASE/MNA focus groups. University of Massachusetts Lowell.

Lehman, S. What makes hospital patients turn violent? Downloaded from http://uk.reuters.com/assets/print?aid=UKKCN0HH10G20140922.


Managing difficult behaviors associated with ADLs in patients with dementia. Sanford Center for Aging. University of Nevada, Reno.

PERIODIC EVALUATION
PERIODIC EVALUATION

An evaluation of the hospital’s violence prevention program is recommended for determining its effectiveness. HealthSouth hospitals should perform this evaluation annually. The evaluation is typically conducted by the Environment of Care/Safety Committee. The goals of such a review are:

- To identify any problem or deficiencies that can then be corrected
- Allow for management to review program effectiveness and re-evaluate policies, training and environmental design/measures on a regular basis
- Analyze trends, measure improvements and keep abreast of new trends to reduce workplace violence

The annual evaluation will consist of the following:

- Risk assessment
- Review of injury/illness records/work comp claims related to violence
- Review of RL reports of violent behavior.* When analyzing violent behavior, it would be helpful to run a report on the following (all in the Safety/Security form):
  - Abuse/Assault
  - Abduction
  - Bomb Threat
  - Disorderly Person
  - Threat of Violence
  - Unauthorized Person/Access/Trespassing
  - Weapons on Premises

*Corporate Risk can build reports for each hospital upon request.
Complaints or concerns filed the prior year related to safety/security
Records of training programs, attendees and qualifications of trainers

Establishing a relationship with local law enforcement and soliciting their assistance with evaluation of the program has been very beneficial for many hospitals.

Finally, the results of the annual review should be reported to the Medical Executive Committee (MEC) and Governing Body.
SAMPLE POLICIES/RESOURCES

This chapter contains sample policies and other resources hospitals may use to develop site-specific policies.
DISRUPTIVE PATIENT/FAMILY PROTOCOL

Purpose: To promote a safe and therapeutic environment for patients and a safe working environment for members of the health care team. This plan describes a process for a structured response to escalating behaviors demonstrated by a patient and/or visitors.

Definitions:

- **Disruptive Behavior:**
  - Any behavior that negatively impacts the caregivers’ ability to effectively provide care to the patient
  - Behaviors that interfere with a supportive and safe working environment for our staff.

- **Behavioral Plans:** Formal limit setting (verbal or written) with statement of consequences that are enforceable and provide some enforceable, undesirable outcome if the disruptive behaviors continue.

Protocol:
This protocol recognizes three general behavioral levels and provides interventions that may be instituted in response to each. The three behavioral levels are described below:

- **Level One:** Should be seen as signs of discontent and addressed as such.
- **Level Two:** Indicative of serious discontent and/or potentially volatile behaviors to come.
- **Level Three:** Dangerous and staff need a strong support network in place with regular communication.

The following chart provides descriptions of behaviors indicative of each level:
<table>
<thead>
<tr>
<th>Level One Behaviors (Building Tension)</th>
<th>Level Two Behaviors (Disruption)</th>
<th>Level Three Behaviors (Violence)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Signs:</strong></td>
<td><strong>Physical signs same as Level One</strong></td>
<td><strong>Physical Signs:</strong></td>
</tr>
<tr>
<td>- Defensive body language-be aware of building “energy”</td>
<td>- Raising voice</td>
<td>- Raising voice</td>
</tr>
<tr>
<td>- Pacing, fidgeting, intense stares, clenched fist/teeth</td>
<td>- Threatening gestures</td>
<td>- Threatening gestures</td>
</tr>
<tr>
<td>- Pacing, fidgeting, intense stares, clenched fist/teeth</td>
<td>- Invading personal space</td>
<td>- Invading personal space</td>
</tr>
<tr>
<td><strong>Statements:</strong></td>
<td><strong>Statements:</strong></td>
<td><strong>Statements:</strong></td>
</tr>
<tr>
<td>- I told you I don’t need....</td>
<td>- Rude language</td>
<td>- Verbal threats about personal safety</td>
</tr>
<tr>
<td>- My mom can’t wait any longer, she needs a doc now</td>
<td>- Threatening lawsuits</td>
<td>- Verbal threats about personal safety</td>
</tr>
<tr>
<td>- My mom is really sick and you aren’t doing anything</td>
<td>- Invading personal space</td>
<td>- Verbal threats about personal safety</td>
</tr>
<tr>
<td>- I’ve been waiting an hour</td>
<td>- Statements:</td>
<td>- Verbal threats about personal safety</td>
</tr>
<tr>
<td>- I’ve been waiting an hour</td>
<td>- I am being threatened</td>
<td>- Not thinking rationally</td>
</tr>
<tr>
<td>- I am being deprived</td>
<td>- Not thinking rationally</td>
<td>- Not thinking rationally</td>
</tr>
<tr>
<td>- My requests are being ignored</td>
<td>- Will not calm down easily</td>
<td>- Will not calm down easily</td>
</tr>
<tr>
<td><strong>Implications:</strong></td>
<td><strong>Implications:</strong></td>
<td><strong>Implications:</strong></td>
</tr>
<tr>
<td>- I am being threatened</td>
<td>- Not thinking rationally</td>
<td>- Staff feels threatened and/or does not feel safe to enter room alone</td>
</tr>
<tr>
<td>- I am being deprived</td>
<td>- Will not calm down easily</td>
<td>- Staff feels threatened and/or does not feel safe to enter room alone</td>
</tr>
<tr>
<td>- My requests are being ignored</td>
<td><strong>Other Signs:</strong></td>
<td>- Staff feels threatened and/or does not feel safe to enter room alone</td>
</tr>
<tr>
<td>- Unrealistic demands</td>
<td>- Patient/family very angry</td>
<td>- History of violence</td>
</tr>
<tr>
<td>- Visible discord among family</td>
<td>- about “everything”</td>
<td>- History of violence</td>
</tr>
<tr>
<td>- Information shared among family members not accurate</td>
<td>- Refusing discharge</td>
<td>- History of violence</td>
</tr>
<tr>
<td>- Family restricting other family member visits</td>
<td>- Interfering with patient care</td>
<td>- History of violence</td>
</tr>
<tr>
<td>- Family seeks out different caregivers with same questions</td>
<td>- Individual refuses to leave room when requested to do so</td>
<td>- History of violence</td>
</tr>
<tr>
<td>- Family/patient appear confused about plan of care</td>
<td>- “under the influence”</td>
<td>- History of violence</td>
</tr>
<tr>
<td>- History of violence</td>
<td>- Excessive worry or unusual concerns expressed by family members</td>
<td>- History of violence</td>
</tr>
<tr>
<td>- Family actively declines to be involved</td>
<td>- Family appears overwhelmed and unable to take part in decision making</td>
<td>- History of violence</td>
</tr>
<tr>
<td>- Family appears overwhelmed and unable to take part in decision making</td>
<td>- History of violence</td>
<td>- History of violence</td>
</tr>
</tbody>
</table>
Specific actions to be taken for each level of behavior are below:

## Level One Behaviors:

<table>
<thead>
<tr>
<th>Front Line Staff</th>
<th>First Level Team Conference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes:</td>
<td>May Include:</td>
</tr>
<tr>
<td>• Primary care nurse</td>
<td>• Case management</td>
</tr>
<tr>
<td>• Charge nurse</td>
<td>• Nurse manager/charge nurse</td>
</tr>
<tr>
<td>• Other staff present at time</td>
<td>• Lead therapist</td>
</tr>
<tr>
<td></td>
<td>• Physician and/or APN/PA</td>
</tr>
<tr>
<td>Actions:</td>
<td>Objectives:</td>
</tr>
<tr>
<td>• You are not the target</td>
<td>• Identify family spokesperson (if applicable)</td>
</tr>
<tr>
<td>• Don’t take it personally</td>
<td>• Identification of key issues</td>
</tr>
<tr>
<td>• Remain calm, quiet, rational, professional</td>
<td>• Barriers to communication and care</td>
</tr>
<tr>
<td>• Okay to say I am sorry you are unhappy</td>
<td>• Identify resolution</td>
</tr>
<tr>
<td>• Listen and ask questions</td>
<td>• Members of team will be chosen to deliver the message and expectations to the patient/family if not in conference</td>
</tr>
<tr>
<td>• Summarize (clarifies and show interest)</td>
<td></td>
</tr>
</tbody>
</table>

**Goal:**
- Address problem (never promise more than you can do)
- Clarification of information
- Honest expression of staff observations and concerns
- Identification of common goals

If concerns and behaviors cannot be addressed consider First Level Team Conference

<table>
<thead>
<tr>
<th>Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Deliver message verbally to patient/family if not present</td>
</tr>
<tr>
<td>• Monitor</td>
</tr>
</tbody>
</table>
# Level Two Behaviors:

<table>
<thead>
<tr>
<th>All Staff</th>
<th>Level Two Team Conference-Timing critical-recommend if not same day within 24 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interactions:</strong></td>
<td>May Include:</td>
</tr>
<tr>
<td>- Stay calm-use words carefully</td>
<td>- Behavioral health, if applicable</td>
</tr>
<tr>
<td>- Avoid “have to”, “can’t”, “it’s not our policy”</td>
<td>- Risk management</td>
</tr>
<tr>
<td>- Use “I will”, “will you”, “would you be willing”</td>
<td>- Person responsible for security</td>
</tr>
<tr>
<td>- Give clear instructions, set clear limits—“I will help but I need you to stop swearing, threatening.....”</td>
<td>- CNO</td>
</tr>
<tr>
<td>- Be polite but clear and firm</td>
<td>- DTO</td>
</tr>
<tr>
<td>- Continue to show you want to help-listen, ask questions, summarize</td>
<td>- Patient/family?</td>
</tr>
<tr>
<td>- Never touch without approval</td>
<td><strong>Actions:</strong></td>
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<table>
<thead>
<tr>
<th><strong>Actions:</strong></th>
<th><strong>Objectives:</strong></th>
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</thead>
<tbody>
<tr>
<td>- Notify leadership asap</td>
<td>- Similar to first</td>
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<thead>
<tr>
<th><strong>Goal:</strong></th>
<th><strong>Actions:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>- Escalate to level two team</td>
<td>- Instruct staff on consistent response to concerning behaviors</td>
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</table>

**Note:** Verbal expectations should be set early if there is behavioral acting out. Advance to written behavior plan when verbal redirection is not effective.
### Level Three Behaviors:

<table>
<thead>
<tr>
<th>All Staff</th>
<th>Level Three Team Conference</th>
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<tbody>
<tr>
<td><strong>Actions:</strong></td>
<td><strong>Includes:</strong></td>
</tr>
<tr>
<td>• Don’t confront</td>
<td>• All prior members</td>
</tr>
<tr>
<td>• Don’t physically try to stop</td>
<td>• CEO</td>
</tr>
<tr>
<td>• Activate violence response plan if necessary</td>
<td><strong>Objectives:</strong></td>
</tr>
<tr>
<td></td>
<td>• Review situation</td>
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<tr>
<td></td>
<td>• Determine options for patient</td>
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</tbody>
</table>

IV. Ensure that Electronic Event Report (RL Solutions) has been completed for threatening or violent behaviors.

V. Additional consultation with Corporate Risk Staff or Legal may be desired.

For a copy of any of the worksheets in this presentation, please go to the following link: HealthSouth’s intranet site/Corporate Services/Risk Management/Resources/Violence Prevention White Paper: Recommendations and Resources
PROCESS FLOW CHART FOR DISRUPTIVE PATIENTS/FAMILY

1. Staff recognizes & attempts resolution

2. Resolution reached with patient/family?
   - Yes → STOP
   - No → First Level:
     - Care Conference with Case Managers, nurse manager/charge nurse, lead therapist, Physician and/or APN

3. Resolution?
   - Yes → Team members identified to deliver plan of care to patient/family
   - No → Second Level:
     - Team conference (original group plus a selection of the following) as needed:
       - BHS, if applicable
       - CNO
       - Risk Staff
       - DTO
       - Patient family?
       - Person responsible for security

4. Resolution?
   - Yes → Team members identified to deliver plan of care to patient/family
   - No → Behavioral contract needed?
     - Yes → Team members identified to deliver behavioral contract to family
     - No → Third Level:
       - Second level team
       - CEO

5. Resolution?
   - Yes → STOP
   - No → Fourth Level:
     - May need to contact Corporate Legal / Risk
SAMPLE VIOLENCE PREVENTION PLAN

Purpose
The purpose of the HEALTHSOUTH Valley of the Sun Rehabilitation Hospital Violence Prevention Plan is to identify procedures for preventing, responding to, assessing, reporting, and documenting threatening or violent behavior in the workplace and communicating the information appropriately.

Philosophy and Definitions
HealthSouth is committed to the safety and security of its employees, patients, practitioners, students and visitors. Any acts of workplace violence will not be tolerated.

For the purposes of this policy, violence is broadly defined as including, but not necessarily limited to, behavior involving employees, visitors, physicians or patients which:

- Causes or threatens to cause harm to anyone;
- Disrupts the operation of the hospital;
- Creates an atmosphere of intimidation or fear for hospital employees, medical staff members or allied professionals; or
- Interferes with an individual’s ability to work/practice competently.

Threats, verbal harassment or sexual harassment, in addition to actual physical harm, are considered acts of violence.

The workplace includes, but is not limited to the building, parking lots, patient/potential patient homes and traveling to and from work assignments.
Goals and Objectives
The goals and objectives include, but are not limited to:

- Improving awareness of potential violence without creating an atmosphere of suspicion or fear;
- Creating a work environment in which employees feel comfortable bringing concerns at any level to their supervisors or Senior Managers;
- Providing education to staff, supervisors and Senior Managers about their role in the prevention, assessment and response to violent situations;
- Maintaining an ongoing program to achieve a violence-free work environment;
- Working with community organizations to identify shared risks.

Procedures

- Reporting – There is a non-retaliatory policy for anyone reporting violence as defined above.
  - Non-Employees
    - Non-employees may report to any employee any incident which is a threat or a potential threat to the safety and security of any party who is linked to the hospital.
  - Employees
    - HealthSouth employees shall notify their supervisor and/or Senior Manager of any threat that they have witnessed, received, or have been told that another person has witnessed or received. In addition, HealthSouth employees are required to report any behavior which they consider threatening or violent.
  - Supervisors
    - A Senior Manager, Human Resources Director or Safety Officer should be notified by the employee and/or the supervisor of the incident in addition to responding to the event.
Responding to Workplace Violence

It is not possible to list all potential scenarios. The person who identifies the incident will have to determine if the situation is emergent.

- **Emergencies**
  For immediate assistance in an emergency (assault, direct threat of violence, bomb threat, suicide attempt, or incidents involving hostages or weapons) or any crime in progress, dial 9, 9-1-1 if possible. Personal and patient safety is most important. Provide the police with as many details as possible. Contact a Senior Manager or Administrator on Call when circumstances allow. If circumstances allow, codes which may be paged to alert staff are:
  a. Code White (hostage)
  b. Code Silver (active shooter)
  c. Lockdown (internal or external incident)

- **Non-Emergency Threat Assessment**
  The supervisor or notified Senior Manager will do an immediate assessment, and if 9-1-1 is not required, the appropriate personnel will be alerted and action will be determined. Code Orange (psychological incident) triggers a team response to the area.

  Actions may include but are not limited to:
  a) Counseling and/or disciplinary action
  b) De-escalation techniques;
  c) Involving other parties as appropriate (i.e., the supervisor of a contracted vendor, or the practice manager of a doctor’s group).
Prevention

- Annual Review
  a) The CEO/designee will coordinate with the Safety Officer to do an annual review of workplace violence to identify existing or potential violence hazards. The work site review should include, but is not limited to, inspecting security measures and reviewing EOC, Risk and OSHA events to search for trends in prior occurrences of violence. OSHA guidelines may be used for guidance for a workplace analysis to assist in identifying hazards.
  b) Following a violent incident, the Safety Officer and/or Director of Quality/Risk will conduct a risk assessment to determine if changes to the plan or the procedures are required.
  c) The results of these hazards analyses will be used to determine the appropriate preventive actions to be taken and reviewed through the committee structure.

- Security measures include, but are not limited to:
  a) Background checks for employees and practitioners
  b) Badge identification
  c) Video Surveillance
  d) Coded entrance access
  e) Timed locks for specific doors
  f) Parking lot lights and parking policies
  g) Providing support in the home visit arena to ensure employee safety
  h) Participating in community organizations (AzHHA, AzCHER, etc.) to help identify and reduce potential risks and to plan for response
SAMPLE VIOLENCE PREVENTION PLAN (CONCLUDED)

○ **Education and Training**
  Training in violence prevention will be provided at initial hire and reviewed on an annual basis. Training will include reporting procedures, codes, and other aspects of the Violence Prevention Program. As with all annual re-orientation, HR will maintain a record of employee training.

○ **Recordkeeping**
  Recordable employee injuries that occur as a result of workplace violence should be reported in compliance with standards for OSHA Recordkeeping and Posting.

  Senior Managers/CEO will provide information so that Records can be kept of when, where, and how threatening or violent incidents occurred. This will help provide information for analysis. Depending on the event, information may be stored with the Safety Officer, Human Resources or Quality/Risk.

❖ **Post-incident action**
  ○ **Hospital response**
    Response may include, but is not limited to, suspension and/or termination of any business relationship, and disciplinary action up to and including termination of any employee who has violated the policy. Additionally, criminal prosecution may be pursued against person/persons involved.

  ○ **Corporate Role**
    Leadership must report to Corporate Risk Management any threats, threatening behavior or violent acts, as soon as possible. Corporate Risk Management will notify Human Resources and Internal Audit.

    Corporate leadership will assist the hospital to provide victims and co-workers traumatically affected by the incident with medical attention and psychological support.
SAMPLE VIOLENCE PREVENTION POLICY

POLICY
HealthSouth is committed to the safety and security of its employees, patients, students, practitioners and visitors. Any acts of workplace violence against employees, patients, volunteers, visitors or other individuals by anyone will not be tolerated.

For the purposes of this policy, violence is broadly defined as including, but not necessarily limited to, behavior involving employees, visitors, physicians or patients which:
- Causes or threatens to cause harm to anyone;
- Disrupts the operation of the hospital;
- Creates an atmosphere of intimidation or fear for hospital employees, medical staff members or allied professionals; or
- Interferes with an individual’s ability to practice competently.

Threats, verbal harassment or sexual harassment, in addition to actual physical harm are considered acts of violence.

The workplace is defined as the hospital, the surrounding area, including the parking lots, and patient’s homes if visited within the scope of an employee’s work.

PROCEDURES
Proactive Risk Assessment
The CEO/designee should coordinate with the Quality Council/Safety Committee to do an annual review of workplace violence to identify existing or potential violence hazards. The work site review should include, but is not limited to, inspecting security measures and reviewing past records to search for trends in prior occurrences of violence if applicable.

The results of this hazards analysis will be used to determine the appropriate preventive actions to be taken and reviewed thru the committee structure.
Reporting
There is a non-retaliatory policy for anyone who reports violence or potential violence.

Non-Employees
Non-employees may report to any employee any activity, action or verbal interchange which they have witnessed or been a part of which they perceive as workplace violence or potential workplace violence as defined above.

Employees
Employees will report information to their supervisor/Senior Manager about any information they have received, witnessed, or been a part of which they perceive as workplace violence or potential workplace violence as defined above.

Supervisors/Leadership
Supervisors and Senior Managers must keep open, non-retaliatory communication with staff so that potential threats can be de-escalated and that actual events have responses that are appropriate to the situation. Documentation of events will be reviewed and analyzed for improved response.

Corporate
Senior Managers must report information to Corporate Leadership who will provide support to develop strategies and responses to violence in the workplace.

Immediate Response to Workplace Violence
Emergencies
Personal and patient safety are most important. If possible, dial (9) 9-1-1 for immediate assistance in an emergency (assault, direct threat of violence, suicide attempt, or incidents involving hostages or weapons) or any crime in progress, and describe the situation in detail.

If the situation requires notification of the entire hospital, and you are able to do so safely, dial 80 and repeat an overhead page alert. Some identified Codes are:
Code Orange (psychological situation); Code White (Hostage situation); Code Silver (Active Shooter situation)

When circumstances allow, provide information to Senior Management.
SAMPLE VIOLENCE PREVENTION POLICY (CONCLUDED)

Threat Assessment
In a non-emergent situation, Senior Management will initiate an investigation regarding any threats, threatening behavior or violent acts on HealthSouth property and respond to workplace violence. Options include but are not limited to: counseling, de-escalation techniques, disciplinary action by the appropriate hospital leadership, pursuing criminal charges and severing of the business relationship.

Corporate Reporting
The CEO/designee will report the incident to Corporate Risk Management as soon as possible. Support for post-event response, including counseling, pressing criminal charges, processing insurance claims, etc. will be provided.

Education and Training
Training in violence prevention will be completed upon hire, and re-education will be done annually. HR will maintain records of the training.

Recordkeeping
Any recordable employee injuries that occur as a result of workplace violence should be reported in compliance OSHA standards.

Depending on the nature of the event or potential event, records may be stored in EOC, Quality/Risk or Human Resources. The CEO/designee will review all records in the annual analysis of workplace violence.

Post Response
Victims will be provided medical and psychological care to deal with any physical or mental effects resulting from the event. Corporate Risk will provide support and resources to assist in this effort.
ACTIVE SHOOTER POLICIES

The next two policies are examples of active shooter policies. There may be several differences between the two, however there is one very important difference that needs to be addressed.

For many years the industry standard was to overhead page a “code”, such as “code silver” when there is an active shooter (such as in sample policy #1). However, the current trend is to use plain language for overhead paging, such as “Active shooter-cafeteria” (such as in sample policy #2).

The use of plain language is recommended by:

• US Department of Health and Human Services
• Homeland Security
• National Incident Management System
• Institute of Medicine
ACTIVE SHOOTER POLICIES

The rationale for the preferred use of plain language as described by the Florida Hospital Association includes:

- Employees who are new or work at multiple locations may not recall unique code nomenclature;
- People understand the information received without further extensive explanation;
- People know what actions are required based on the information received.

All HealthSouth Hospitals should review this information and consider their patient population, geographic location and other resources to determine which method is most appropriate for a specific hospital.
SAMPLE ACTIVE SHOOTER POLICY #1

PURPOSE
The purpose of this policy is to communicate HealthSouth’s procedures for responding to an “active shooter” or any other such threat of violence posed in the workplace. In the event that a person or group of persons enter the hospital or any of HealthSouth’s corporate offices and begins to fire weapons, an immediate and controlled response can result in a reduced loss of life and injury. The goal of this policy is to expedite the conclusion of the incident in the safest manner possible.

The procedures contained within this document are in line with security best practices and follow the guidelines established by the Department of Homeland Security.

DEFINITIONS
For the purpose of this policy, an active shooter is considered to be an individual actively using a weapon with the intent of causing death or serious bodily injury (i.e., while “shooter” is a term that is used in the policy, the policy applies regardless of the weapon or threat imposed).

SCOPE
All hospital and corporate office employees, volunteers, patients and visitors.

ROLES AND RESPONSIBILITIES
It is the responsibility of the hospital CEO to ensure compliance with this policy within [Hospital].

POLICY
[Hospital] is committed to the safety and security of its employees, patients, volunteers and visitors. Any acts of workplace violence against employees, patients, volunteers, visitors or other individuals will not be tolerated.
In the event of a person or persons actively firing a weapon or otherwise posing a threat, hospital personnel will, when safely possible, follow the guidelines and procedures outlined in this policy.

The greatest opportunity of surviving an active shooting incident or other incident is to evacuate the site of danger. Employees, patients, volunteers and visitors will make all efforts to safely relocate from the affected areas. The gathering area for [Hospital] for anyone able to safely exit the building will be [DESIGNATED SITE]. When possible, a Command Center will be established at the designated location and staff will adhere to procedures as outlined in this policy.
SAMPLE ACTIVE SHOOTER POLICY #1 (CONTINUED)

PROCEDURES
When it is known or reasonably believed that there is imminent danger or a threatening situation exists, staff will contact 911 or local law enforcement immediately. Any employee upon becoming aware that an active shooter or violence situation exists and when safety permits will attempt to provide a safe perimeter for employees, patients, volunteers and visitors and will attempt to communicate the situation to others by [enter site specific steps such as overhead paging, panic buttons, etc. When making an announcement, state “Code Silver” and describe the location. Repeat this two times as safety permits.] At no time will an employee of [Hospital] be required to intentionally place themselves in harm’s way.

Employees in the affected area should quickly determine the most reasonable way to protect their own life followed by protecting the lives of patients and visitors. Note: Patients and visitors are likely to follow the lead of employees during an active shooting situation.

Evacuate:
If there is an accessible escape path, attempt to evacuate the area. Assess your situation and location and consider the following:
- Have an escape route in mind
- Evacuate regardless of whether others agree to follow
- Leave your belongings behind
- Help others escape, if possible
- Prevent individuals from entering an area where the active shooter may be
- Keep your hands visible
- Follow the instructions of any police officers
- Do not attempt to move wounded people
- Call 911 when you are safe
- REQUIRED: Report to the designated site as quickly as possible.
**SAMPLE ACTIVE SHOOTER POLICY #1 (CONTINUED)**

**Hide out:**
If evacuation is not possible, or if you consider the risk too great to evacuate, find a safe place to hide where the active shooter is less likely to find you.

Your hiding place should:
- Be out of the active shooter’s view (such as in a room, ducking under a patient bed or below therapy gym equipment, inner-office bathroom or closet, or under a desk)
- Provide protection if shots are fired in your direction (i.e., an office with a closed and locked door)  
  [insert site specific suggestions based upon areas in your hospital]
- Not trap you or restrict your options for movement.

To prevent an active shooter from entering your hiding place:
- Lock the door
- Blockade the door with heavy furniture (e.g., desk, patient bed with wheels locked)  
  [insert site specific suggestions based upon areas in your hospital]

If the active shooter is nearby:
- Lock the door
- Silence your cell phone and/or pager
- Turn off any source of noise (e.g., radios, televisions)
- Hide behind large items (e.g. cabinets, desks)
- Remain quiet
- If possible, dial 911 to alert police to the active shooter’s location. If you cannot speak, leave the line open and allow the dispatcher to listen
SAMPLE ACTIVE SHOOTER POLICY #1 (CONTINUED)

**Take action against the active shooter:**
As a last resort, and only when your life is in imminent danger, attempt to disrupt and/or incapacitate the active shooter by:
- Acting as aggressively as possible against him/her
- Throwing items and improvising weapons
- Yelling
- Committing to your actions

**Employees outside the affected area** should quickly determine their level of safety and their ability to perform any of the following:

**Communicate**
Make overhead announcement.
- The intercom system at [Hospital] can be accessed by [hospital specific directions]
- Announce “Code Silver” and the location. Repeat twice if safety permits
- Upon hearing “Code Silver,” inform patients and visitors of the situation and the need to evacuate or hide out

**Call 911**
Give as much detail as you can to 911:
- Number of shooters and/or shots fired
- Clothing worn by the shooter(s)
- Gender of shooter(s)
- Type of weapons (e.g., knife, hand gun, rifle/shotgun, smoke/fire)
- Current or last known location of shooter(s) within the building; (Be as specific as possible remembering that law enforcement does not know your building.)

**Direct patients and visitors**
- Reassure patients and visitors who may seem distressed; keep all visitors and patients as calm as possible during this time
- Identify the safe area they are to report to and give specific directions on how to get there; remember the safe area may be an area located in another building or business.
SAMPLE ACTIVE SHOOTER POLICY #1 (CONTINUED)

**Barricade/restrict access**
Movement by the shooter should be reduced as much as possible.
- Close and lock doors.
  - Office doors
  - Department doors
  - Hallway/corridor doors
- Move furniture in front of doors for additional security
  - Office doors
  - Department doors
  - Hallway/corridor doors
- Prevent individuals from entering an area where the active shooter may be
  [insert site specific suggestions based upon areas in your hospital]

**Evacuate**
- Evacuate regardless of whether others agree to follow
- Leave your belongings behind
- Help others escape, if possible
- Prevent individuals from entering an area where the active shooter may be
- Keep your hands visible
- Follow the instructions of any police officers
- Do not attempt to move wounded people
- Call 911 when you are safe.
- Report to the designated area as quickly as possible.
Upon arrival of Law Enforcement:
Law Enforcement will assume command of the situation. Law Enforcement’s purpose is to stop the active shooter as soon as possible:

- Officers will proceed directly to the area in which the last shots were heard. **They will not stop to help injured persons.**
- Officers may be carrying a variety of weapons: handguns, shotguns, rifles.
- Officers may be armored: bulletproof vest, helmets and/or shields
- Remain calm and follow officer’s instructions.
- Put down any items in your hands.
- Immediately raise your hands and spread fingers.
- Avoid making quick movements toward officers, such as attempting to hold on to them for safety.
- Avoid pointing, screaming and/or yelling.
- Do not stop to ask officers for help or direction when evacuating. Proceed in the direction from which the officers are entering the premises.
- A number of law enforcement agencies such as local and regional SWAT Teams may respond to this situation. Law enforcement officers from outside agencies will not recognize employees of the hospital. It is imperative that all employees are wearing their hospital Identification card at all times.
Command Center
A Hospital Command Center will be established as quickly as possible at the pre-designated area on or off campus. This will serve as the primary Command Center until law enforcement arrives. Law enforcement will establish the most appropriate location for their Command Center. Should law enforcement determine the location for their Command Center is to be located in another area; the Hospital Command Center will become the Secondary Command Center. Duties and activities to take place at the Hospital Command Center include but are not limited to:

- Establish an Incident Commander.
- Provide a safe perimeter for staff and visitors to the best of their ability and await the arrival of law enforcement.
- Collect as much critical information about the situation/event regarding the active shooter and victims.
- Provide information to law enforcement upon their arrival.
- Coordinate with law enforcement and provide assistance as needed both during and following the situation.
- Conduct head counts of employees, patients and known guests.
- Await the “All Clear” from law enforcement. Upon receiving an “All Clear,” determine what areas of the hospital are permissible for employees and patients to return to.
- To the best of their ability, control all traffic in and out of the hospital. Any suspicious activity should be reported immediately to law enforcement.
- Inform employees to cooperate fully with Law Enforcement and relay any information they may possess.
- Notify the Corporate Risk Management Office. For the after-hours call schedule see the Risk Management Home Page or call 205-410-2777 and the appropriate Corporate Departments will be notified.
- Inform employees not to speak to the media. Refer all media inquiries to:
  - Corporate Communications Department
  - HealthSouth Corporation
  - 3660 Grandview Parkway, Suite 200
  - Birmingham, AL 35243
  - Media Hotline: 205-410-2777
  - Fax: 205-969-4993
- Utilize counselor/ministers, if available, to assist with emotional and/or religious concerns. [insert site specific info. here]
SAMPLE ACTIVE SHOOTER POLICY #2

Purpose
To delineate procedures and provide a set of guidelines to be followed during a situation involving an individual firing a weapon and actively engaged attempting to kill people in a confined area on hospital property.

Policy
[Hospital] will design and implement a set of response procedures to be followed by hospital staff in the event of an active shooter emergency on hospital property.

General
These procedures are intended to define immediate response actions to be taken by staff at and away from the immediate location of the shooter in order to protect themselves and others from life threatening consequences.

Mitigation:

- [Hospital] as part of its ongoing education and training program instructs personnel in established response procedures to be followed in the event of active shooter emergency. Effectiveness of such training is measured by staff interviews during environmental rounds and by staff performance during drills or by post-event analysis of actual plan implementations. This performance measurement information is reported regularly to the Environment of Care Committee. As opportunities for improvement are identified, specific issues are addressed, and staff education and training is modified or enhanced as indicated.
- The hospital lobby is staffed approximately twelve hours a day, and a video surveillance system records activity at all first-floor exterior exit doors and in several areas on the second floor 24/7. All other exterior doors are kept locked at all times.
SAMPLE ACTIVE SHOOTER POLICY #2 (CONTINUED)

Preparedness:

- When an active shooter emergency situation arises, responding staff need sufficient resources in order to adequately respond to the situation. Appropriate immediate action can save lives, and communication with local law enforcement is essential.
- Staff are instructed that the Police Department shall be contacted without hesitation by any person safely able to do so in the event of an active shooter situation.
- Panic buttons are in place at the nurses’ station and reception desk and these are tested on a monthly basis.
- [Hospital] is equipped a public address system accessible from any telephone to be used to alert staff using PLAIN LANGUAGE – coded announcements shall not be used when announcing an active shooter emergency.
- In addition, [Hospital] has also developed violence prevention policies and procedures, and a Code Silver protocol (See EOC.EM.403.00) to provide staff with guidelines to follow in the event of a hostage scenario or other potentially threatening situation which may or may not involve a weapon.

Response Procedure:

Initial staff response to any active shooter situation is to accept that the situation is real and based on proximity to the shooter, make a conscious effort to take the steps outlined below using the acronym “NEST”: **

N – “Not-Nothing”
- Don’t freeze - get past your disbelief
- Alert others – use panic buttons, telephones, or other available means.
- If/when feasible, access PA system and announce “Active Shooter – (give location)”. Repeat three times.
- Assess the situation – What’s happening? – Where’s the shooter?
- Dial 9-911 and communicate the following:
  - Location of the shooter
  - Number of shooters, if more than one
  - Physical description of shooter(s) – sex, race, clothing type and color
  - Number of weapons held by the shooter(s) and type of weapon, if known
  - Number of potential victims at the location
E – “Evacuate”
- Do not go toward the threat.
- If there is an accessible escape path:
  - Have an escape route and plan in mind.
  - Evacuate regardless of whether others agree to follow.
  - Leave belongings behind.
  - Get as far away as possible.
  - Assist patients and others without jeopardizing personal safety.
  - Do not attempt to move wounded victims.
  - Keep hands visible and elevated when exiting.

S – “Shelter in Place”
- If evacuation is not possible, find a place to hide out where the shooter is less likely to find you:
  - Choose a place that is out of the shooter’s view – behind a locked door if possible
  - Barricade the door with beds (wheels locked) or heavy furniture.
  - Make the room appear empty - turn off lights.
  - Silence cell phones/pagers.
  - Hide behind large items (cabinets, desks) – do NOT stand behind the door.
  - Place signs on exterior windows when possible – communicate location and need for assistance.
- Remain calm and quiet until police arrive
- Continue to assess the situation

T – “Take Action”
- As a last resort, when your life is in imminent danger, act to avoid harm:
  - Attempt to disrupt incapacitate the shooter.
  - Be as aggressive as you can and commit to your actions.
  - Throw items and improvised weapons - furniture, fire extinguishers, heavy objects.
  - Run toward the perpetrator – yell, scream.
Recovery:

- When the determination has been made that the threat has been eliminated, an “All Clear” is to be announced by the Switchboard Operator. The affected area will be treated as a crime scene under the control of law enforcement until an investigation had been completed, which might last for multiple days or longer.

- The Incident Commander will assure that the following are considered as soon as possible after the threat has been terminated:
  - Immediate medical attention for patients, visitors, and staff who have been injured
  - The collection and preservation of evidence by the police
  - Families should be re-united with their loved ones as soon as practical.
  - Emotional support for patients, visitors, staff, and families who have been affected by the incident.
  - Repair of any physical damage to the area
  - Actions needed to return the unit/area to full operational status

- Staff involved in the emergency response are to report to the command center for debriefing and are given specific recovery operation assignments. At a minimum the following assignments shall be considered:
  - Remove all perimeter barriers that may have been utilized.
  - Remove any temporary signage.
  - Direct evacuated personnel back into the building.
  - Arrange for replacement supplies that may have been used.
  - Return emergency equipment including keys, to the command center tool box.

Other specific needs will be addressed at this time. When individual assignments have been completed, staff will report back to the Command Center and are finally released to resume normal duties. The Safety Officer or Risk Manager will prepare an after-action report on plan implementation including evaluation of effectiveness of response, lessons learned, and opportunities for improvement. Any recommendations for process improvements are to be referred Environment of Care Committee.

** Used with permission from the individuals who authored the content and Sixth Leaf, LLC.
Name (Optional) ________________________________________________

Please assess your department/unit over the last year. Circle TRUE (T), FALSE (F) or DON'T KNOW (?). Thank you for your honest assessment.

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<thead>
<tr>
<th>Hazard Prevention and control (continued)</th>
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<td>31.</td>
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**Training**

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<tbody>
<tr>
<td>32.</td>
<td>Employees have received training on the company's workplace violence prevention program.</td>
<td>F</td>
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<tr>
<td>33.</td>
<td>Employees know how to ask for assistance by phone or by alerting other staff.</td>
<td>F</td>
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<tr>
<td>34.</td>
<td>Employees have been trained to recognize and handle threatening, aggressive, or violent behavior.</td>
<td>F</td>
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<tr>
<td>35.</td>
<td>Employees have been trained in verbal de-escalation techniques.</td>
<td>F</td>
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<tr>
<td>36.</td>
<td>Employees have been trained in self-defense/restraint procedures.</td>
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**Incidents and Reporting**

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>37.</td>
<td>This work unit/department has not experienced violent behavior and assaults or threats from hospital visitors or vendors.</td>
<td>F</td>
</tr>
<tr>
<td>38.</td>
<td>This work unit/department has not experienced violent behavior and assaults or threats from patients.</td>
<td>F</td>
</tr>
<tr>
<td>39.</td>
<td>This work unit/department has not experienced violent behavior and assaults or threats from other employee’s.</td>
<td>F</td>
</tr>
<tr>
<td>40.</td>
<td>This work unit/department has not experienced domestic violence issues.</td>
<td>F</td>
</tr>
<tr>
<td>41.</td>
<td>Employees are required to report incidents or threats of violence, regardless of injury or severity; the reporting system is clear.</td>
<td>T</td>
</tr>
<tr>
<td>42.</td>
<td>Medical and psychological counseling services were offered by the employer to employees who have been assaulted or threatened.</td>
<td>F</td>
</tr>
</tbody>
</table>
PROTECTIVE STATUS POLICY

POLICY:
The hospital will have a process in place to provide for the protection of patients and staff in relation to protective status patients.

PURPOSE OF POLICY:
Define a patient’s visitation procedure for voluntary and involuntary protective status. The intent is to provide the safest environment for the patient, their visitors and the staff in the case of victims of violence (VOV).

PROCEDURES:
When a patient is placed on Protective Status, voluntary or involuntary, the patient’s name does not appear on the census sheet. When someone inquires by telephone or at a front desk for the patient, the inquirer would be told, “I have no information regarding the patient, please contact the immediate family.” The employee would not see any listing on the patient.

a. No information is to be given out over the phone.

VOLUNTARY PROTECTIVE STATUS:
1. A patient may choose to be placed on Protective Status in order to conceal their presence at the hospital. This is called Voluntary Protective Status.

2. Voluntary Protective Status is different from Involuntary Protective Status in that the patient chose to be placed on Protective Status and the procedure of designating visitors is NOT required. Voluntary Protective Status is meant only to safeguard a patient’s privacy.

3. For a patient to be placed on Voluntary Protective Status, the patient should contact the Liaison or Admitting Department, who will notify administration.
IN Voluntary Protective Status

1. All incoming patients who have been victims of a violent crime will be placed on protective status to ensure the safety of patients, visitors, medical staff, and employees of the hospital.
   
a. In cases where it is difficult to determine the intentional infliction of violence, protective status should be instituted per this policy until causation is determined.
   
b. Patients under protective status are allowed only three (3) designated visitors and one personal clergy person.

Each of these individuals must show a valid photo identification upon arrival at the hospital.

This photo ID must be shown to hospital staff at every visit, upon request.

2. It is the responsibility of the Liaison or nursing staff to explain the protective status policy to the patient and request the name of three (3) designated visitors, plus a designated clergy person, if so desired.
   
a. If the patient is not alert and oriented or is unable to provide the names of three (3) designated visitors the patient’s guardian or power-of-attorney may designate a total of three (3) visitors plus one clergy visitor.
   
b. Staff should ensure that the guardian or power-of-attorney is designated as a visitor, except in the circumstance that the individual was involved in committing the assault or act of violence.

3. The staff member who obtains the name of the three (3) designated visitors will complete the following process.
   
a. Complete the designated visitor list after viewing a valid picture ID for each designated visitor.

4. Already designated visitors of any patient who has been a protective status patient while hospitalized will automatically be designated visitors.
   
a. These visitors will be included in the three (3) designated visitors plus one clergy criteria.

5. No information is to be provided on the patient unless the person produces a picture ID and is a designated visitor. No information is to be given out over the phone.
6. Staff will take a picture of each designated visitor. These pictures will be posted at the nurses’ station and will be used to verify the identity of the visitor.

7. The Liaison will inform the admitting office during intake that the patient is on Protective Status and the identity of the three (3) designated visitors and personal clergy person, if available at that time. Only designated visitors will be permitted on the nursing floor and the nursing division staff is responsible for verifying each visitor’s identity.

8. Once the patient is admitted, case management will notify the Director of Plant Operations.

9. No name will be posted outside of the patient room. The patient will be identified with PSP plus the first letter of last name.

10. The chart copy of the Designated Visitor List will be posted at the nursing station. A copy will be posted at the receptionist desk.

11. It is the responsibility of the designated visitor to show his/her ID when inquiring about a patient. No information will be provided to anyone without showing proper ID.

12. Telephone privileges may be denied to all Protective Status patients. However, there may be occasions where limited privileges (allowing patient to utilize phone in nursing area or providing a phone in the room for the purpose of one phone call and then removing phone) may be appropriate. It will be left to the discretion of the Nursing Supervisor and/or the Nurse Manager to determine whether limited phone privileges should be permitted.

13. All attempts should be made to place the Protective Status patient in a private room. Two patients on Protective Status may be placed in the same room only as a last resort.

14. Abuse of the policy will result in the withdrawal of visitation privileges and the transfer of the patient to a different room if appropriate.
EXCEPTIONS TO INVOLUNTARY PROTECTIVE STATUS:

1. Patients who are under arrest:
   
   a. If the patient is under arrest and remains at The Rehabilitation Institute of St. Louis, the St. Louis Police Department must provide continuous, 24-hour coverage of the patient.
   
   b. Patients who are under arrest are not allowed visitors. Family members are precluded from calling and finding out a condition.

   To keep the family informed of the patient’s progress; the patient may designate one person who the nurse will call each morning to provide an update.

   A call will be made to the designated person with any change in the status of the patient.

   c. In situations where patient education is not sufficient for discharge teaching, one family member or designee may be brought in as necessary prior to discharge to participate in discharge planning and teaching.

2. Patients with a police hold order:
   
   a. Protective Status patients who have a police hold order will not be treated any differently than other Protective Status patients.

   In congruence with our legal obligation, nursing or case management staff should call the security department when the patient is ready for discharge or when the discharge date is known.

   Security will then notify the police of the patient’s release on the morning of discharge.
15. Any changes to Protective Status, including release of such status, will be determined on a case by case basis and must be communicated to:

Admitting
Security/Maintenance
Case Management
Nursing Division
Patient
Designated visitors
Clergy

16. At no time should a pass allowing the patient to leave the hospital be issued to a patient who has been a victim of violence.

17. If the medical staff deems it in the best interest of the patient, visitation privileges may be restricted.

18. If the patient is transferred back to acute care, the case manager will promptly notify the Director of Plant Operations, who will contact the security department of the acute care hospital.
PROTECTIVE STATUS POLICY (CONCLUDED)

ST. LOUIS POLICE OFFICERS WHO ARE VICTIMS OF VIOLENCE:

1. Police Officers who are VOV may be visited by other police officers in addition to the designated visitors.
   a. There may be no more than two (2) officer visitors at one time.
   b. Officers not wearing a uniform must present their police identification upon request.

2. Civilian employees of the St. Louis Police Department who are victims of violence due to work-related incidents will also be granted this exception.

The Police Officer who is conducting the investigation about the event in which the officer became a VOV is to be immediately admitted with appropriate identification, unless the medical condition warrants visitor restriction.

All other aspects of the Protective Status policy will be followed. Failure to adhere to the policy may result in visitation privileges being suspended for all police officer visitors.

All requests for information should be directed through the St. Louis Police Department.
# VIOLENCE PREVENTION PROGRAM GAP ANALYSIS

<table>
<thead>
<tr>
<th>Specific Action</th>
<th>Audit Question</th>
<th>YES</th>
<th>NO</th>
<th>If answered question “no” identify specific action plan, including persons responsible and timeline to complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Leadership recognizes violence prevention a priority</td>
<td>Violence prevention is aligned with the quality and safety plan (e.g., violence prevention is visible on meeting agendas)</td>
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<td></td>
<td>Hospital provides resources for violence prevention (e.g. time, material)</td>
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<tr>
<td>Designates responsibility for violence prevention</td>
<td>Designated individual(s) to coordinate and lead the organization’s violence prevention program (while one person is responsibility it is best practice to have an interdisciplinary team the individual works with/reports to)</td>
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<td></td>
<td>There is an interdisciplinary approach to violence prevention with input from clinical and non-clinical staff</td>
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<tr>
<td>Individual(s) responsible for overseeing an action plan for violence program planning, implementation and evaluation.</td>
<td>Interdisciplinary team oversees the action plan for the violence prevention program. (This team may be the safety committee, quality committee or subcommittees thereof.</td>
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<td>The plan includes annual education of staff</td>
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<td></td>
<td>The action plan is reviewed by the team and updated at least annually</td>
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<td>The plan considers participation/feedback from staff at all levels</td>
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<td></td>
<td>The team reviews and recommends changes to policies/procedures and training as needed</td>
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## GAP ANALYSIS

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<tbody>
<tr>
<td>Provides resources and support for violence prevention programs</td>
<td>The hospital has a process in place to report to senior leadership on the status of violence prevention efforts</td>
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<tr>
<td>Collaborates with local law enforcement</td>
<td>The hospital works with local law enforcement to develop a role for law enforcement with □ violence prevention procedures and response plans □ NA</td>
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<tr>
<td>Data Collection</td>
<td>There is a process for timely reporting of incidences of violence in the hospital and employees are trained in reporting requirements</td>
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<td></td>
<td>All data on these events is kept in a central location and data is aggregated</td>
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<tr>
<td>Data Analysis</td>
<td>A process is in place for the violence prevention team to review and analyze reported incidents of violence at least annually</td>
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<td></td>
<td>Results of the analysis is used for learning and improvement opportunities</td>
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<td>Specific Action</td>
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<tr>
<td>Clearly communicate roles for violence prevention</td>
<td>All staff understands their role regarding violence risk, recognition and intervention to prevent and mitigate acts of violence</td>
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<td>Implement strategies toward a violence free workplace</td>
<td>There is a process in place for communication to staff that violence is not an accepted part of their job</td>
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<tr>
<td>Clearly communicate expectations of reporting</td>
<td>All staff who are involved with or witnesses violent behavior are expected to report these events through RL solutions (Safety/Security form)</td>
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<tr>
<td>Communication about high risk patients</td>
<td>The hospital has a process in place to facilitate communication at the patient care level about patients/visitors at high-risk for violence, such as those who have been violent recently (e.g., daily morning huddle, shift report).</td>
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<tr>
<td>Provide violence prevention/mitigation education for all staff</td>
<td>Expectations and supporting education have been incorporated into new employee orientation</td>
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<tr>
<td></td>
<td>Ongoing violence prevention education for all staff is provided at least annually</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Ensures staff familiarity with emergency policies and procedures</td>
<td>A process is in place to ensure all staff are familiar with how and when to initiate the proper emergency response in the event of an act of violence.</td>
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<tr>
<td>Conduct post event huddles/debriefs</td>
<td>A process is in place to conduct a post-event huddle, debrief, or RCA with affected staff as soon as possible after any violent event as defined by policy</td>
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