

Partnership for Patients



ALASKA STATE HOSPITAL &
NURSING HOME ASSOCIATION



Washington State
Hospital Association

Preventing HealthCare Workplace Violence Toolkit[®]



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EXECUTIVE SUMMARY

Leadership and Culture

Workplace violence in the hospital setting can be a daunting topic that must address multiple risks across the complex system of healthcare. This toolkit describes the multifaceted factors that contribute to “aggressive behavior” and the best practices of an aggressive behavior response program. Throughout each section of the toolkit, *Hospital Highlights* can be found with real examples of how hospitals in Washington and throughout the country have implemented effective best practices to combat this issue. Below are the key elements of a comprehensive aggressive behavior response program that will be addressed:

- Compliance
- Engagement
- Organizational Structure
- Integrating Quality Management
- Marketing Safety
- Information Technology
- Incident Reporting
- Assessing the Risk
- Training & Communications
- Prevention & Control
- Incident Response
- Post Incident Follow Up
- Addressing Mental Health Challenges
- Recordkeeping & Sustainability

Background

Aggressive Behavior in Hospitals

In Washington and across the country healthcare workers are disproportionately exposed to being injured while on the job due to their exposure to a number of workplace hazards. One of the hazards coming to the forefront is aggressive behavior which refers to any physical or verbal assault occurring in the hospital setting. What makes the topic of aggressive behavior even more difficult to address is the historical mindset of healthcare professionals who view exposure to aggressive behavior as simply “part of the job”. Addressing this evolving and increasing risk posed to hospital workers requires a single organizational focus when it comes to the function of safety management. This single organizational focus now is being addressed by the CMS initiative *Integration of Worker, Patient & Visitor Safety*.

Defining the Issue of Aggressive Behavior

Since the early 2000’s, collaborative efforts between workers, executives, regulatory agencies, associations, academia and numerous other stakeholders have resulted in resources and guidance on how to develop and administer a workplace violence program in hospitals. For Washington, safety came to the forefront in 1999 when the Department of Labor and Industries (L&I) issued a healthcare violence rule under chapter 49 of the RCW^{4,5}.

L&I’s analysis of workers’ compensation claims in Washington showed healthcare employees face the highest rate of workplace violence and the actual incidence is likely to be greater than documented because of failure to report or maintain records of incidents. The rule requires hospitals to conduct a security and safety assessment, have a process for reporting incidents, maintain a workplace violence plan and provide training for staff. However, incident rates have continued to remain high across the continuum of healthcare.

In 2015, the American Nurses Association (ANA) released a “no tolerance” statement in regards to aggressive behavior⁷. Following suit, OSHA released two publications that same year regarding preventing violence in the workplace^{7,8}.

Workplace Violence Prevention Toolkit and Bundle

Goals, Definitions and Measures

Goal: To reduce the incidence of employee injuries related to aggressive behavior and assaults by **20%** by September 23, 2017.

Measurement	Outcome	Numerator	Denominator
Number of workers' compensation claims per 100 full-time workers (WA Labor and Industries, Alaska Dept. of Labor)	From worker's comp claims.	Number of approved workers' compensation claims.	Total number of hours worked by all employees.
Measurement	Process	Numerator	Denominator
Violence Prevention Program in place	Percent of hospitals with Workplace Violence Prevention (WPV) programs.	Total number of hospitals with WPV programs.	Total number of hospitals.

INTERVENTIONS TO PREVENT Workplace Violence

Compliance

Interventions

A comprehensive written *Workplace Violence Plan* is required of Washington hospitals by RCW 49.19 and state psychiatric hospitals by RCW 72.23.400. See [Tool 1](#) for the specific plan requirements mandated by RCW 49.19.

The Joint Commission's Sentinel Event Alert, *Issue 45* requires health care facilities to comply with the following criteria for the security of patients, staff and visitors¹⁰:

- Create and maintain a written plan that addresses how the institution will provide security
- Conduct risk assessments to determine potential for violence

- Provide strategies for prevention
- Establish a response plan enacted when an incident occurs

Additional Joint Commission standards that directly and indirectly apply to aggressive behavior response are below:

1. RI.01.06.03

- a. Patient's right to be free from neglect, exploitation and verbal, mental, physical and sexual abuse

2. LD.03.01.01

- a. Leaders create and maintain a culture of safety and quality throughout the hospital

3. EC.02.01.01

- a. The hospital manages safety and security risks

4. LD.04.04.05

- a. The hospital has an organization wide, integrated patient safety program within its performance improvement activities

5. EM.02.02.05, EP3

- a. The Emergency Operations Plan describes how the hospital will coordinate security activities within community security agencies

See [Tool 1](#) for additional information about Joint Commission recommendations and standards as well as information on OSHA's Safety and Health Management System and how it compares to Joint Commission standards.

Engagement

1. Executive Engagement

Program development must begin with a clear commitment from the executive team through the designation of an executive champion who supports the position that aggressive behavior will not be tolerated. The entire organization must have a clear message that within the hospital everyone can trust that their safety is of primary concern and that any barriers to the contrary will be quickly addressed for staff, visitors and patients without fear of reprisal. Time and resources for training, investigations, assessments and post-incident follow up will likely need to be allocated and supported by the executive team.

To maintain executive engagement and continuously evaluate program outcomes, hospitals have begun utilizing *Worker Safety Executive Dashboards* which are typically combined with patient safety reports of hospital acquired conditions or infections and evaluated at the same time as part of the organizations prioritized quality and safety agenda¹¹. See [Tool 2](#) for an example worker safety dashboard currently being provided to WSHA members participating in the WSHA Workers' Compensation Benchmarking initiative.

2. Staff Engagement

One main challenge to address when discussing aggressive behavior in healthcare is underreporting of incidents. This requires an organizational culture that promotes reporting and engagement of frontline staff,

supervisors and managers. In addition, it is essential that staff be involved in interdepartmental task forces to promote sharing across interdisciplinary fields; this is detailed in the next section ‘Organizational Structure’.

When asked why incidents are not reported, healthcare professionals typically respond that reporting takes too much time, they will be perceived of as a troublemaker, or there is little confidence something will be done with the report. Employee engagement can also be facilitated by surveys. Adding staff safety questions to an existing survey, such as the Agency for Healthcare and Quality (AHRQ) patient safety survey, hospitals are able to glean staff concerns about reporting and safety culture. However, a survey may not meet the needs of some organizations and the use of focus groups or open dialogue during staff meetings or shift change can be an effective approach to get detailed feedback.

Hospital Highlight:

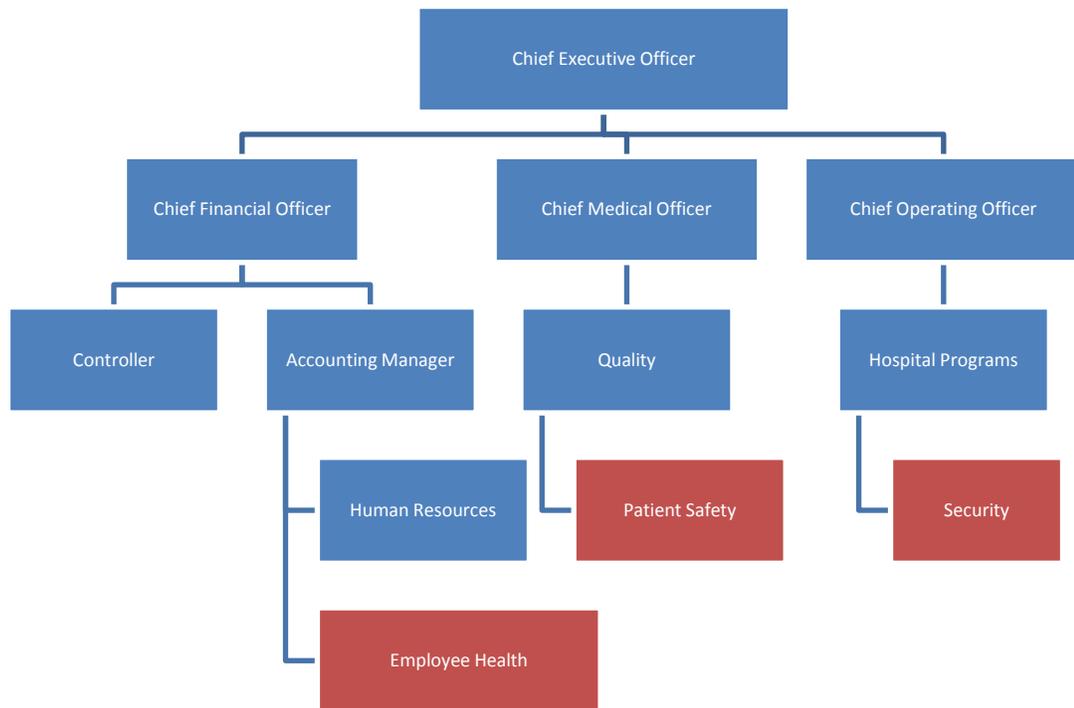
An example of engagement comes from Holy Cross Hospital in Fort Lauderdale, FL, a 557 bed facility, which has been recognized by OSHA for their efforts in addressing aggressive behavior resulting in only a few OSHA recordable incidents each year. In order to address aggressive behavior, the organization has worked to create an environment of civility between staff that patients can mirror. At the beginning of each shift, managers read aloud to all employees their *Healthy Work Environment Pledge* in order to set the tone of each day. The pledge focuses on treating everyone with compassion and to communicate respectfully and openly. For a copy of the pledge, see [Tool 2](#).

Hospital Highlight:

Providence Health Care, the third largest not-for-profit health system in the country, demonstrated successful employee engagement through the use of a survey. A survey was created and distributed to staff in order to gain insight into the current perceptions and attitudes surrounding violence in the workplace. In order to gain a true understanding of the current state, the survey questions strived to address the five key building blocks to an effective program: management commitment and employee involvement; incidents and reporting; hazard prevention and control; training; and violent actions – perception and experience²³.

Organizational Structure

The Joint Commission’s 2012 publication titled, *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation*, it calls for an integrated approach between departments to combat the issues of violence and security¹². For a single focus on safety, organizations should consider how Security, Quality and Employee Health are structured within the organization and how they interact.



The chart above is an example of a typical hospital organizational chart. The result of this structure is a disconnected worker safety and patient safety departments. This can make efforts to establish a single organizational focus on safety very difficult and is a main point of frustration with professionals addressing the risk of aggressive behavior in healthcare. Structuring the patient and worker safety functions under one executive is one way to facilitate the integration of operations and the coordination of efforts. For example, if employee health was bundled under quality, patient safety and employee health efforts could work in tandem to promote general safety efforts throughout the organization. No one organizational structure has proven to be effective due to the unique operations, capabilities and risks present in each hospital environment.

If re-organization of your hospital structure is unrealistic, another way to align departments is through interdepartmental taskforces. The use of organizational has proven to be effective in developing a single organizational focus on safety as well as to address aggressive behavior incidents. Hospitals focusing on increasing the dialogue about aggressive behavior by increasing reports of incidents, some by more than 100%, have worked to coordinate efforts between Employee Health and Quality¹¹. The investigation of incidents and injuries is just one example of a function performed by both departments and when not integrated can be performed very differently with varying terminology and distinct reporting systems resulting in information and process silos. For addressing aggressive behavior, the following departments should be considered for inclusion in any taskforce or workgroup:

- Employee Health
- Security
- Nursing
- Physicians
- Pharmacy
- Human Resources
- Finance
- Clinical Specialty Departments
- Information Technology
- Marketing
- Facilities
- Admissions/Dietary

See [Tool 2](#) for additional information about organizational structure.

Integrating Quality Management

To facilitate improvements in clinical practices as well as to address issues such as reducing wait times, Quality departments have been actively adopting management system principles from other industries that are based on the concepts of High Reliability Organizations (HRO). HROs focus on preventing system or process failures as well as effectively responding and rapidly learning when failures do happen. HROs have shown to be an effective approach to address patient safety initiatives, including aggressive behavior risks in hospitals. However, those responsible for worker safety such as Employee Health or other departments such as Facilities, Human Resources or even Security may not be as well versed in the HRO concepts or utilizing the same principles to address safety management program improvements. See [Tool 2](#) for additional information about HROs and the integration of worker and patient safety.

Marketing Safety

Hospitals with effective aggressive behavior programs typically utilize the internal expertise of the marketing department to help with program roll out and sustainability. Marketing the message of how and why there is a new organizational focus on aggressive behavior is crucial to the program's success. Staff should be provided the context as to what constitutes aggressive behavior, why it will no longer be tolerated, and the support that will be provided by the organization to address the issue.

Examples of Marketing to Administer an Aggressive Behavior Program:

- Clear and easily understood educational messages directed at patients and visitors
- Signage or handouts persuading staff to change their reporting behavior (intentional or unintentional incidents)
- Videos showing staff and executives supporting the new aggressive behavior initiatives

Hospital Highlight:

Mt. Carmel Hospital in Columbus, Ohio worked with Security to develop playing cards for their canine security team that are handed out to patients and during community events to convey the security presence at the facility while also connecting with the community¹¹. The marketing department also helped with a staff engagement initiative to name one of the dogs which also helped promote the overall program to the staff.

Information Technology

For those working to improve how hospitals prepare for and respond to aggressive behavior, the challenges presented by the IT landscape of their organization can be multi-faceted but also presents an opportunity to effectively leverage communication systems to alert workforce of risks and promote progress.

IT Issues in Reporting Incidents:

- Utilizing different computerized reporting and incident management systems for patient incidents, staff incidents and security incidents.
 - Inconsistency of information reported by each system makes assessing the risk difficult and inaccurate.
- Mismatched or conflicting definitions of what constitutes “aggressive behavior”.
 - Challenging to pinpoint the issue and determine a solution.

IT Best Practices for Reporting Incidents:

- Improve and modify existing systems in place to accommodate reporting and incident management across the organization.
- Adopt a new commercially available software platform designed to integrate across departments.
 - When evaluating new systems, ensure that information can be readily extracted to be used for assessing the risk or the effectiveness of the intervention.
- Implement a single intranet-based resource tied to the incident management system used to report categorized patient, visitor or staff related incident or injury.
 - This system eliminates paper reporting forms which helps to combat staff feedback that incident reporting is too time consuming.

Hospital Highlight:

Providence Health Care in Washington created a process that put an individual in the Security Department as the point person to review reports for workplace violence events coming from two electronic systems that were unable to interface²³. If an employee experienced a physical assault, the Security Department point person would contact the administrator on call who would then notify the senior leader for that area. The senior leader would then reach out to that employee to determine the employees support needs and follow-up accordingly. See the [Post Incident Follow Up](#) section for additional information on this key program component.

Incident Reporting

According to the rule RCW 49.19 in place for Washington hospitals, an incident reporting system must capture “Violent Act Records”. [Tool 1](#) specifies the exact data fields that must be captured. Another aspect to incident reporting is a standardized and well communicated definition of “aggressive” and “violent” behavior across the hospital. Hospitals that have created standardized definitions have shown to increase reporting. Other organizations have chosen to go a step further in defining incident reporting by capturing “near miss” or “good catch” incidents to better understand events or encounters that may not require medical treatment but still need to be captured in the reporting system for analysis and prevention⁸.

Hospital Highlight:

The 2015 -2016 Ohio Hospital Association's project in worker and patient safety integration yielded an increase of over 100% in reporting aggressive behavior incidents before an injury occurred by participants¹¹. All participants in the project documented that a consistent definition communicated during rounding or shift meetings was essential to the effort. Provided below is the definition utilized by Ohio hospitals for reporting events prior to injury.

Ohio Hospital Association Aggressive Behavior – Near Miss Definition

Near-misses should be reported when a patient or visitor intentionally commits a physical assault, threatens or verbally abuses a hospital employee where no physical injury occurred. Unintentional actions by patients or visitors (i.e., dementia, TBI, diabetic seizure, etc.) still present a risk of injury and should be captured as near misses but noted as unintentional. Examples include but are not limited to physical assaults, threatening behavior or verbal abuse.

In addition to having the appropriate information technology systems in place and capturing the appropriate information, hospitals must directly address the three primary known barriers of aggressive behavior incident reporting which as stated previously are: (1) reporting takes too much time, (2) staff will be perceived negatively, and (3) staff have little confidence the report will be addressed.

Barriers to Reporting of Aggressive Behavior Incidents

1. “Reporting takes too much time”

- A centralized computer reporting system can improve the ease of reporting (discussed in previous section).
- Incident reporting hotlines that capture the essential information telephonically to initiate a report.
- Marketing and training efforts to patients, staff and visitors that proactively reporting incidents and hazards is an essential component to the organizational focus on safety.

2. “Staff will be perceived negatively”

- Review OSHA Rule taking effect January 2017 that includes Anti-Retaliation Protections for workers.¹⁴
- Effective aggressive behavior programs encourage reporting of incidents and hazards before an injury occurs.
- Determine a follow-up process after an incident is reported – this can be incentive based that aligns with the organization's values.

3. “Staff have little confidence the report will be addressed”

- Education and training of new employees must focus on shifting a paradigm that aggressive behavior is **not** viewed as just “part of the job” and is not accepted at this organization.
- Involve tenured nursing staff and other disciplines in taskforces and program development discussions to champion the program.
- Be prepared to know the experience you want a staff member to have when they report an incident for the first time. More information about proper response is in the section [**Post Incident Follow Up.**](#)

Assessing the Risk

The rule in Washington RCW 49.19 directs organizations to begin their efforts by assessing the risk, further defined in [Tool 4](#) along with additional resources for assessing risk. Without the proper planning and structure, the exercise of assessing the risk will not be as fruitful. Program development may simply need to begin with opening the dialogue regarding reporting and staff support¹¹.

Hospital Highlight:

For Providence Health Care in Washington, the planning and structuring of the assessment became the most important part of developing their workplace violence program. Following the survey to understand employee engagement concerns regarding workplace violence, senior executives led a work session with staff to review the survey results and determine next steps. Objectives were identified during the session to keep the team on track, those objectives are below:

- Review current policies and procedures pertaining to workplace violence in PHC
- Identify gaps in current workplace violence program and best practices for workplace violence prevention systems
- Brainstorm and recommend solutions to close gaps in PHC's workplace violence prevention program
- Build an ongoing framework for continuous improvement of PHC's workplace violence prevention program

By working through these objectives throughout the day, staff and senior leadership were able to build a framework for their workplace violence program (See [Tool 4](#))²³.

Risk Assessment: Components to Include

A proper assessment of the risk is an essential to any program. It is important to address in the risk assessment scenarios of intentional and unintentional harm. A risk assessment should include but is not limited to the following¹⁶:

- Complete review and analysis of incident records
- Classification of the types of incidents experienced
- Anticipation of the types of incidents that could occur
- Review of current operational practices and systems utilized
- Frontline staff input from all disciplines (at the minimum from affected disciplines)
- Physical security analysis of the facility and grounds
- Patient and visitor input
- Past five year review of information including: injury records, job hazard analysis, staff and patient surveys⁹

Risk Assessment: Settings and Risk Factors to Consider

Many organizations use the practice of pin mapping via electronic systems to provide a visual representation of the types of violence and locations which may result in patterns or additional insights that can be used when designing prevention, control or response interventions. Settings and risk factors to consider may include but are not limited to the following:

- Patients with histories of aggressive or violent behavior
- Transporting patients
- Barriers to escaping from a room or area
- Socio-economic conditions of the area: pervasiveness of illicit drugs, prevalence of weapons
- Lack of training by staff
- Frequent understaffing or turnover: fatigued staff, lack of security or mental health staff
- Infrequent communication with patients and families

Risk Assessment: Continuous Review

- Goals of the program should be captured on the executive dashboard for monthly or quarterly review
- Regular reassessments of the environment of care should occur quarterly or bi-annually
- Utilization of existing rounding practices, shift huddles, daily staff calls can serve as frequent assessment review

Prevention and Control

To prevent and control incidents of aggressive behavior, hospitals should directly address the findings from the assessment phase described in the [Assessing the Risks](#) section. Prevention and control techniques can generally be categorized as (1) facility design interventions, (2) operational interventions and (3) people-based interventions.

Facility Design Interventions

- a. Physical Changes:
 - i. Panic buttons; cameras; lighting; fencing; secured doors; secured areas; room layout; silenced alarm systems; safe rooms for staff; rooms to segregate groups; metal detectors; weapon. Security equipment; bullet or shatter proof barriers; secured furniture; signage showing zero tolerance for aggressive or violent behavior.
- b. Environmental Changes
 - i. Soothing wall colors; noise reduction; designated meditation rooms for staff, patients and visitors.
- c. Security Changes
 - i. Having visitors sign-in; use of badges for entry into secured areas; requiring visitors to wear identification tags; visible security presence.

Hospital Highlight:

A canine program that has been successfully deployed at Mt. Carmel Hospital in Columbus, Ohio where canines and trained handlers deter aggressive behavior while also identifying illicit drugs and explosive material on top of also providing patient therapy. The presence of the dogs is well known by the community because they also regularly attend public outreach events.

Operational Interventions

- Decreasing wait times.
 - Improves patient perception of quality of care and is effective in deterring aggressive behavior.
- Openly discuss and solicit information about aggressive behavior concerns from staff members.
 - Use existing daily shift huddles, hand-off practices, rounding efforts and patient and family engagement practices.
- Trauma Informed Care (OSHA's *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*).
 - Treatment technique instituted in inpatient psychiatric units as a way to reduce patient violence and the need for seclusion and restraint.
- Escorting staff to parking lots at dawn, dusk and at night.
- Not allowing staff to work alone when signs of aggression are observed.
- Flag patients (or family members) that have recently or previously exhibited aggressive behavior.
 - System should have the capability to flag the patient for real time communication of risk to staff.
- Using specific color gowns or color coded magnetic door strips to convey the aggressive behavior risk to staff before entering the room.

Hospital Highlight:

St. Agnes Hospital in Baltimore, MD, implemented an operational intervention to notify their most frequent returning patients exhibiting aggressive behavior that it would not readmit them, obviously excluding the emergency department.⁸

Hospital Highlight:

Providence Health Care utilized the Electronic Medical Record (EMR) of patients and identified patients presenting a potential risk across the care continuum. Once identified, the risk associated with those patients could then be communicated by using a visual cueing strategy, for example, color-coding an alert at the entrance of the patient room to denote at risk for violence. In addition, an ethics team was developed to review and provide advice on ethical issues as new strategies were developed.²³

People Based Interventions

- Healthcare professionals should be trained in defensive skills.
 - Help ensure a measured response to meet the level of aggression exhibited by the patient or visitor.
- Improved new employee orientation to include safety orientation training.
 - Length of employment is strongly correlated to experiencing an aggressive or violent incident.
- Input and involvement from exposed staff.
- Ensuring nursing to patient staffing ratio is sufficient for the unit.
- Presence and capabilities of Security staff or Law Enforcement.
- Proper training of temporary and contract staff – held accountable for compliance.
- Implementation of the “tap out” practice.
 - Employee observing a co-worker who may be escalating a situation can “tap out” their co-worker to remove them from the situation and let a calmer person ready to apply de-escalation skills take over.

- Importance of sleep and a work-life balance for employees.
 - Sleep is being studied as a contributing factor to aggressive behavior in healthcare and has been shown to be a contributing factor for adverse patient events and even turnover.¹⁹
 - Washington Department of Labor and Industries and SHARP research team through their PASS project are studying the topics of patient conflict and violence, co-worker conflict, and the connection with work-life stress.²⁰

[Tool 6](#) provides additional information and resources regarding prevention and control techniques.

Training and Communications

Training must be based on the results of assessing the risk as discussed previously as well as the prevention and control measures deployed to address the risk assessment. In Washington, Violence Prevention Training is required for all employees and must be completed within 90 days of hire for all new employees by RCW 49.19. See [Tool 1](#) for required components.

Types of Violent Behavior:

Hospitals should be sure to include all forms of aggressive or violent behavior in their training plans, below are some examples:

- Co-worker incidents.
- Staff-on-patients or Staff-on-visitors.
- Visitors/family-on-staff.
- Visitor-on-patient or Visitor-on-visitor.
- Domestic related incidents.

Strategies for Training:

It is important to train both clinical and nonclinical staff because all employees face the risk of being exposed to an aggressive or violent incident.

- Provide classroom or online training followed up by hands-on training at departmental level.
- Role playing to address aggressive or violent situations that can arise.
- Training on-the-go or just-in-time training.
- When conducting training address the mindset that aggressive behavior is just part of the job.
- Training programs focus: de-escalation techniques, violence predicting factors, response teams, proper use of restraints, hands-on physical skills training.
- Training should be an opportunity to explain the importance of capturing incidents that may be intentional or unintentional (refer to [Incident Reporting](#) section).

Researchers from the Washington Department of Labor and Industries SHARP program are developing skills and tools for supervisors. The findings highlight the notion that even leaders themselves may experience poor psychological health²¹. They also found an increase to supervisors' aggressive patient safety behavior gradually improved the perception of others of a violent climate²². Training resources and examples are provided in [Tool 5](#).

Incident Response

Due to the complexity of the issue of aggressive behavior, no single incident response protocol has been identified as being the most effective. Incident response protocols begin with identifying the emergency call codes the facility will use to initiate a response. In 2008, the WSHA worked with member hospitals as well as the Oregon Association of Hospitals & Health Systems and the Oregon Patient Safety Commission to develop standardized emergency codes for the region. As a result of this work, Code Gray was adopted for “Combative Person” and Code Silver adopted for “Person with Weapon/Hostage Situation”. Since then several hospitals have found the need to subcategorize the Code Gray type of incident. Having a single code for different case scenarios can lead to frustration if responders are not able to discern if a team response is necessary for an extremely aggressive person that has turned into an assailant versus a situation requiring assistance in de-escalating a patient that is verbally abusive but physically unable to become an assailant.

Hospital Highlight:

At Holy Cross Hospital, the multidisciplinary team recognized that a single code for combative person did not capture the wide range of aggressive behavior situations that could be encountered by staff. Due to the ambiguity around the code, staff was found to be excessively responsive or insufficiently at other times. As a result, more specific and detailed sub-codes were developed to indicate the specific degree of assistance needed. Three codes were developed which are “Code Assist”, “Code Strong” and “Code Strong with Intensivist.” Holy Cross has trained over 1,000 employees, clinical and nonclinical, within their organization.

- **Code Assist** calls for a uniformed security officer’s presence to deter and prevent aggressive behavior. Officers are trained to clearly communicate with the aggressive individual and make the patient aware that if they consistently refuse treatment with inappropriate behaviors, the hospital may discharge them as they are no longer providing the care needed.
- **Code Strong** is called if de-escalation efforts to make the patient more comfortable do not address the situation and results in a team response made up of first responders, the nurse supervisor and engineering staff who are available throughout the day. The team enters if the behavior does not stop and clears the area of items that could be used for weapons. They then quickly execute a pre-rehearsed and coordinated routine to secure the head, arms and legs. Code Strong team individuals were required to attend an 8 hour training session.
- **Code Strong with Intensivist** is called if behavior is escalating exponentially and the code can only be initiated by a registered nurse. This code follows the same response protocol as the Code Strong but also includes an intensive care physician who can order STAT sedation for the patient or physical restraints, in medically indicated for safety. In addition, the Pharmacy and Therapeutics and Medical Executive Committees developed laminated pocket cards for intensive care physicians which described suggested medications to support potentially violent patients. See Tool 6 for an example of the pocket card. Holy Cross also saw the need to better identify and communicate the potential for aggressive behavior to staff. As a result, they established their Violence Prevention Advisory (VPA) Committee. The goal of this group was to tag the EMR of potentially violent patients and make the information known to any member of the team providing care or entering the room. The EMR system is connected to other systems that are accessible and visible to staff and alert them to the potential risk. See [Tool 6](#) for Holy Cross Hospital’s “Risk of Violence Response Algorithm.”

Post Incident Follow Up

How an organization responds and supports staff after an aggressive behavior incident reflects its commitment to establishing and sustaining a culture of safety. Staff must be provided with timely medical and if necessary psychological and emotional support. Many hospitals now require a post incident support meeting or debrief that is free of blame and focused on how the incident occurred and how effective the individuals were in responding. Staff who witness assaults should also be included in post incident debrief.

Many of the same concepts incorporated following a medical error can be applied to the post incident follow-up for aggressive behavior. Known as “second victims”, the organization’s focus should be on recognizing the staff injury and immediately providing support to staff, in addition to patients and families involved in the event¹². Communicating to staff what services are available and what to anticipate if an event were to happen encourage and help staff to come forward in a timely manner. A referral to the hospital’s Employee Assistance Programs (EAPs) may be appropriate, as an example, for additional follow-up and promotion of well-being.

Hospital Highlight:

At the Metro Boston Mental Health Unit (MBMHU) of the Lemuel Shattuck Hospital in Jamaica Plain, Massachusetts, a violence prevention program was developed and included two initiatives to help staff deal with aggressive incidents.¹²

Safety and Respect Group: Staff and patients meet twice each week to increase awareness of the impact of violence and to suggest, teach, role-play and support alternatives to violence. In addition, the Safety and Respect group processes violent events in order to increase appreciation for the impact of violence in a therapeutic environment.¹²

Assault Staff Action Program (ASAP): The ASAP is an ongoing statewide Massachusetts program that is operated at all Department of Mental Health inpatient facilities. At MBMHU, its purpose is to render “emotional first-aid” to assaulted staff, which includes debriefing, support and follow-up. While there are several staff at this facility who provide these services, their numbers have not been able to keep up with the demand, so MBMHU is working to recruit and train additional responders.¹²

Addressing Mental Health Challenges

Due to insufficient funding and limited primary care providers, patients with violent histories and assaultive tendencies are seeking care more and more in emergency departments forcing many hospitals to develop interim solutions to address the day to day challenges. Unfortunately, in many instances, acute care hospitals are not structured or equipped to treat patients with behavioral health needs for the long term and as a result, precious resources are oftentimes pulled from other patients also in need of acute care.

Interim Solutions to Address Mental Health in Washington:

- Hire additional psychiatric advanced registered nurse practitioners and social workers.
 - Helps provide resources to both mental health patients as well as those caring for them.

- Mental Health Integration Program (MHIP) through the University of Washington.
 - Purpose of MHIP is to integrate high quality mental health screening and treatment into primary care settings serving safety net populations.
 - MHIP uses a patient registry (CMTS) to track and measure patient goals and clinical outcomes.
- WSHA continuing to push for more treatment options other than available State Hospitals.
 - Goal of creating a more regional model of care with more community-based facilities.

Hospital Highlight:

Olympic Memorial Center, an 80 bed facility located in Port Angeles, Washington, has begun its own journey in improving mental health care within its community. Olympic Medical Center created a Patient/Visitor Behavior Agreement, with an accompanying step-be-step escalation process, for any patients with a history of Code Gray, any known disruptive behaviors, or with recent/current drug/alcohol use.²⁴ The goal of the Behavior Agreement is to be proactive and set clear expectations prior to an incident occurring. The team also created an ***Involuntary Treatment Act*** (ITA) Inpatient Algorithm for staff to understand the processes and paperwork involved with a high-risk patient assigned to either the medical/surgical floor or ICU.²⁴ Included in the algorithm is a Behavioral Health Checklist tool and Behavioral Health Handoff Communication form. See [Tool 7](#) for more detailed information and form examples.

Recordkeeping and Sustainability

According to the rule in RCW 49.19, Washington hospitals are required to keep records of violent acts. The required components can be found in [Tool 1](#). In particular, hospitals must ensure that “good catch” or “near miss” incidents are also recorded for proper management and accurate risk assessments. OSHA recordkeeping requirements also apply but are specific to the OSHA recordkeeping criteria which will not include all incidents. Documentation of risk assessments should also be maintained along with training records. Confidentiality of staff information should be ensured and guaranteed throughout the process.

Sustainability may require a measured approach with departmental changes to test success followed by a wider organizational role out. Below are some best practices in regards to program sustainability:

- Use of Worker Safety Dashboards – provides organizational accountability and transparent performance.
- Ongoing staff training, on orientation and annually thereafter.
- Recruitment of tenured staff to champion organizational changes for staff.
- Internal marketing efforts to fortify programs.
- Employee recognition for program contributions and efforts.
- Peer sharing between hospitals within health systems and throughout the community.

Tools and Resources

Tool 1: Compliance

Link to <http://app.leg.wa.gov/rcw/default.aspx?cite=49.19>

RCW 49.19 – Safety Health Care Settings Workplace Violence Requirements

Safety and Security Assessment

Before the development of the Workplace Violence Plan, each health care setting shall conduct a security and safety assessment to identify existing or potential hazards for violence and determine the appropriate preventive action to be taken. The assessment shall include, but is not limited to, a measure of the frequency of, and an identification of the causes for and consequences of, violent acts at the setting during at least the preceding five years or for the years records are available for assessments involving home health, hospice, and home care agencies.

See [Tool 4](#) for more details and resources regarding the Safety and Security Assessment requirements.

Workplace Violence Plan

The plan shall address security considerations related to the following items, as appropriate to the particular setting, based upon the hazards identified in the Safety and Security Assessment.

- (a) The physical attributes of the health care setting;
- (b) Staffing, including security staffing;
- (c) Personnel policies;
- (d) First aid and emergency procedures;
- (e) The reporting of violent acts; and
- (f) Employee education and training.

Violence Prevention Training

Each health care setting shall provide violence prevention training to all its affected employees as determined by the plan. The training shall occur within ninety (90) days of the employee's initial hiring date unless he or she is a temporary employee. For temporary employees, training would take into account unique circumstances. The training may vary by the plan and may include, but is not limited to, classes, videotapes, brochures, verbal training, or other verbal or written training that is determined to be appropriate under the plan. The training shall address the following topics, as appropriate to the particular setting and to the duties and responsibilities of the particular employee being trained, based upon the hazards identified in the assessment required:

- (1) General safety procedures;
- (2) Personal safety procedures;
- (3) The violence escalation cycle;
- (4) Violence-predicting factors;
- (5) Obtaining patient history from a patient with violent behavior;
- (6) Verbal and physical techniques to de-escalate and minimize violent behavior;
- (7) Strategies to avoid physical harm;
- (8) Restraining techniques;
- (9) Appropriate use of medications as chemical restraints;
- (10) Documenting and reporting incidents;
- (11) The process whereby employees affected by a violent act may debrief;

- (12) Any resources available to employees for coping with violence; and
- (13) The health care setting's workplace violence prevention plan.

Violent acts—Records.

Each health care setting shall keep a record of any violent act against an employee, a patient, or a visitor occurring at the setting. At a minimum, the record shall include:

- (1) The health care setting's name and address;
- (2) The date, time, and specific location at the health care setting where the act occurred;
- (3) The name, job title, department or ward assignment, and staff identification or social security number of the victim if an employee;
- (4) A description of the person against whom the act was committed as:
 - (a) A patient;
 - (b) A visitor;
 - (c) An employee; or
 - (d) Other;
- (5) A description of the person committing the act as:
 - (a) A patient;
 - (b) A visitor;
 - (c) An employee; or
 - (d) Other;
- (6) A description of the type of violent act as a:
 - (a) Threat of assault with no physical contact;
 - (b) Physical assault with contact but no physical injury;
 - (c) Physical assault with mild soreness, surface abrasions, scratches, or small bruises;
 - (d) Physical assault with major soreness, cuts, or large bruises;
 - (e) Physical assault with severe lacerations, a bone fracture, or a head injury; or
 - (f) Physical assault with loss of limb or death;
- (7) An identification of any body part injured;
- (8) A description of any weapon used;
- (9) The number of employees in the vicinity of the act when it occurred; and
- (10) A description of actions taken by employees and the health care setting in response to the act. Each record shall be kept for at least five years following the act reported, during which time it shall be available for inspection by the department upon request.

OSHA's Safety and Health Management Systems and Joint Commission Standards - Comparison

https://www.osha.gov/dsg/hospitals/documents/2.2_SHMS-JCAHO_comparison_508.pdf

The Joint Commission Suggested Actions Regarding Workplace Violence Program Development

As provided in the Sentinel Event Alert, Issue 45

- 1.) Work with the security department to audit your facility's risk of violence. Evaluate environmental and administrative controls throughout the campus, review records and statistics of crime rates in the area surrounding the health care facility, and survey employees on their perceptions of risk.
- 2.) Identify strengths and weaknesses and make improvements to the facility's violence-prevention program.
- 3.) Take extra security precautions in the Emergency Department, especially if the facility is in an area with a high crime rate or gang activity. These precautions can include posting uniformed security officers, and limiting or screening visitors (for example, wand for weapons or conducting bag checks).
- 4.) Work with the HR department to make sure it thoroughly prescreens job applicants, and establishes and follows procedures for conducting background checks of prospective employees and staff. For clinical staff, the HR

department also verifies the clinician's record with appropriate boards of registration. If an organization has access to the National

Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank, check the clinician's information, which includes professional competence and conduct.

- 5.) Confirm that the HR department ensures that procedures for disciplining and firing employees minimize the chance of provoking a violent reaction.
- 6.) Require appropriate staff members to undergo training in responding to patients' family members who are agitated and potentially violent. Include education on procedures for notifying supervisors and security staff.
- 7.) Ensure that procedures for responding to incidents of workplace violence (e.g., notifying department managers or security, activating codes) are in place and that employees receive instruction on these procedures.
- 8.) Encourage employees and other staff to report incidents of violent activity and any perceived threats of violence.
- 9.) Educate supervisors that all reports of suspicious behavior or threats by another employee must be treated seriously and thoroughly investigated. Train supervisors to recognize when an employee or patient may be experiencing behaviors related to domestic violence issues.
- 10.) Ensure that counseling programs for employees who become victims of workplace crime or violence are in place. Should an act of violence occur at your facility – whether assault, rape, homicide or a lesser offense – follow-up with appropriate response that includes:
 - a. Reporting the crime to appropriate law enforcement officers.
 - b. Recommending counseling and other support to patients and visitors to your facility who were affected by the violent act.
 - c. Reviewing the event and making changes to prevent future occurrences.

Tool 2: Engagement and Organizational Structure

Example of Washington State Hospital Association, Workers' Compensation Benchmarking Program, Worker Safety Executive Dashboard

Provided by Lucia Austin-Gil, Sr. Director of Patient Safety and Brad Hunt, RiskControl360

 WSHA - Worker Safety Executive Dashboard 2013 - 2016 Q2 Data				
Hospital & Rates	2013	2014	2015	2016 - Q1 Q2
	1/13 - 12/13	1/14 - 12/14	1/15 - 12/15	Annualized
ABC Hospital System				
Total Workers' Compensation Claims	81	56	52	32
Total Claim Costs	\$834,946	\$402,448	\$427,265	\$135,410
Total Hours Worked	1,820,004	1,905,955	1,938,003	2,005,846
Frequency Rate	8.90	5.88	5.37	3.19
WSHA Frequency Benchmark	9.07	8.10	6.69	5.19
Severity Rate	\$91,752	\$42,231	\$44,093	\$13,502
WSHA Severity Benchmark	\$80,990	\$64,893	\$37,238	\$18,141

Holy Cross Hospital's Daily Organization "Healthy Work Environment Pledge"

Provided by Pat Schuldenfrei, EdD, RN, CPHQ, Patient Safety Officer, Chair, Committee to Prevent Patient Violence

HWE Pledge
I will maintain healthy working relationships with every member of our team.
I will talk to you ASAP if I am having problems with you.
I will not discuss it with another person unless I need advice on how to communicate with you effectively.
I will maintain respect and integrity with all team members regardless of rank, culture or level of education.
I will avoid gossiping, back-stabbing and blaming.
I will commit to communication with Christ-like compassion and caring with my team members.
I will accept you as you are today and forgive past problems.
I am committed to the solution rather than constant complaints about the problems.
I will appreciate and value your contribution.
I will remember we are human and mistakes are opportunities for forgiveness and growth.
Derived from: Manthey M., (2010), Commitment to my Co-workers

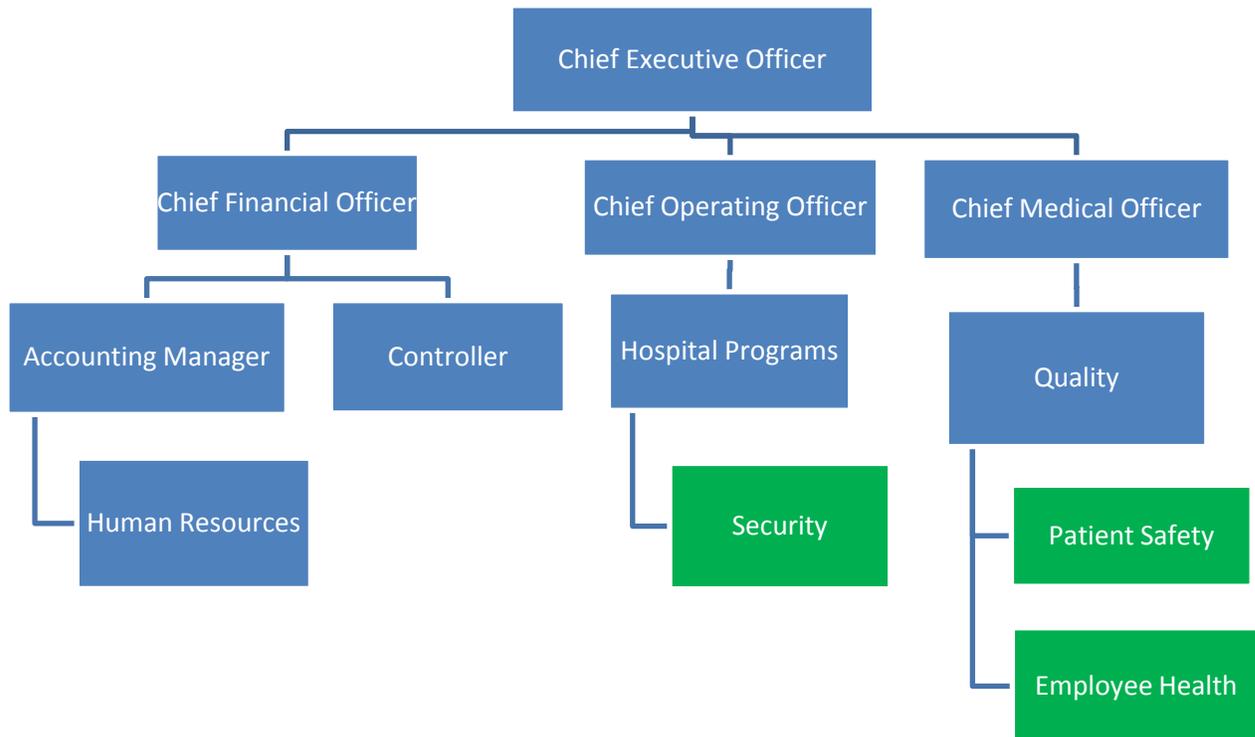
Support for an Integrated Approach to Safety Management

The Joint Commission - Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation. Monograph discussing the connections between patient safety and worker safety.

<http://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf>

Reporting Structure Example to Facilitate the Organizational Management of Safety

Below is an example of an organizational structure that integrates all safety functions.



The Joint Commission and High Reliability Organizations

Chapter 1 of The Joint Commission's 2012 publication titled *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation* explains the benefits to improve safety for both patients and workers by utilizing High Reliability Organization processes and principles. [Click Here and Go To Chapter 1](#)

High Reliability Organizations: Five Operational Processes

As provided in OSHA's *Workplace Violence Prevention and Related Goals – The Big Picture*. Dec 2015.

Sensitivity to operations: Workers in HROs are mindful of procedures and interactions between team members. This heightened situational awareness sensitizes them to minor deviations and enables them to respond appropriately.

Reluctance to simplify: When outcomes deviate from established plans, HROs question conventional explanations for why things went wrong and explore the entire potential scope of the problem.

Preoccupation with failure: No matter how enviable their track records, HROs never let success breed complacency. They focus unceasingly on ways the system can fail, and encourage staff to always listen to their “inner voice of concern” and share it with others.

Deference to expertise: Team members and organizational leaders in HROs defer to the person with the most knowledge relevant to the issue they are confronting. This may involve deviating from the traditional physician, nurse, and technician hierarchy.

Resilience: HROs acknowledge that, despite considerable safeguards, errors will sometimes occur. By anticipating and planning for such situations, they can contain and minimize the adverse consequences.

Tool 3: Example Programs

Washington State Department of Labor and Industries

Workplace Violence Awareness and Prevention for Employers and Employees. This resource includes:

- Sample Workplace Violence Prevention Program
- Sample Forms
- Sample Training Techniques
- Sample Policy on Domestic Violence in the Workplace
- Selected Laws and Regulations
- Other Resources on Workplace Violence
- Technical Assistance and Training

<http://www.lni.wa.gov/IPUB/417-140-000.pdf>

Minnesota Department of Health

Metropolitan Hospital Compact: Management of Violence in the Healthcare/Workplace Setting Template. This resource includes example:

- Example policy statements
- Definitions
- Response procedures
- Communication guidelines
- Investigation Considerations
- Post Incident Critical Event Review (CER)
- Policy Review
- Record Keeping/Data Analysis
- Employee Resources
- Executive Engagement
- Education Plan
- Threat or Event Assessment Tool
- Incident Response Form
- Event Response Team Members
- Domestic Violence Assessment
- Violence in the Workplace Response Algorithm
- Hospital Violence Data Tracking
- Code Silver Policy
- Workplace Violence After Care Checklist
- Prevention and Mitigation Strategies

<http://www.health.state.mn.us/patientsafety/preventionofviolence/mcviolenceprevtoolkit.pdf>

WorkSafe Victoria

Prevention and management of aggression in health services. This resource includes the following tools:

- Organizational self-assessment
- Staff survey
- Design and aggression
- Violence and the design process
- Violence prevention policy
- High-risk screening
- Violence hazard identification and risk assessment
- Behavior assessment
- Client alert
- Warning notice
- Conditions and agreement
- Exposure to aggression risk calculator
- Aggression risk calculator
- Post-training evaluation tool – short term
- Post-training evaluation tool – medium to long term
- Competency-based assessment

https://www.worksafe.vic.gov.au/_data/assets/pdf_file/0012/10209/Aggression_in_health_care.pdf

Civil Service Employees Association, Local 1000, AFSCME, AFL-CIO

Workplace Violence Employee Survey - <https://cseany.org/wp-content/uploads/2013/02/Survey.pdf>

Workplace Violence Incident Report Form - <https://cseany.org/wp-content/uploads/2013/02/Incident-Report.pdf>

Tool 4: Assessing the Risk

Washington State Requirements per RCW 49.19

The assessment must identify existing or potential hazards for violence and determine the appropriate preventive action to be taken. The assessment shall include, but is not limited to, a measure of the frequency of, and an identification of the causes for and consequences of, violent acts at the setting during at least the preceding five years. Here are common risk factors to consider for an assessment as provided by OSHA.

- Working directly with people who have a history of violence, people who abuse drugs or alcohol, gang members, or distressed relatives or friends of patients or clients.
- Lifting, moving, and transporting patients and clients.
- Working alone in a facility or in patients' homes.
- Poor environmental design of the workplace that may block employees' vision or interfere with their escape from a violent incident.
- Poorly lit corridors, rooms, parking lots, and other areas.
- Lack of a means of emergency communication.
- Prevalence of firearms, knives, and other weapons among patients and their families and friends.
- Working in neighborhoods with high crime rates.
- Other risk factors are more organizational in nature, including:
 - Lack of facility policies and staff training for recognizing and managing escalating hostile and assaultive behaviors from patients, clients, visitors, or staff.
 - Working when understaffed in general—and especially during mealtimes, visiting hours, and night shifts.
 - High worker turnover.
 - Inadequate security and mental health personnel on site.
 - Long waits for patients or clients and overcrowded, uncomfortable waiting rooms.
 - Unrestricted movement of the public in clinics and hospitals.
 - Perception that violence is tolerated and victims will not be able to report the incident to police and/or press charges.
 - An overemphasis on customer satisfaction over staff safety.

ECRI Institute

Western Health Risk Assessment Screening Tool -

<https://www.ecri.org/components/HRC/Pages/SafSec3.aspx?tab=4>

Civil Service Employees Association, Local 1000, AFSCME, AFL-CIO

Workplace Violence Inspection Checklist - <https://cseany.org/wp-content/uploads/2013/02/Inspection-Form.pdf>

Washington Department of Labor & Industries SHARP Program

Workplace Violence Studies - [L&I SHARP - Healthcare Workplace Violence Publications](#)

- The Washington State Psychiatric Hospital Work, Stress, and Health Project: Final Report to the Washington State Department of Social and Health Services and Eastern State Hospital (2013)
- Stopping the pain: The role of nurse leaders in providing organizational resources to reduce disruptive behavior. (2013)
- Workplace Bullying and Disruptive Behavior: What Everyone Needs to Know (2013)
- Evaluating progress in reducing workplace violence: Trends in Washington State workers' compensation claims rates, 1997 - 2007. (2013)

National Institute for Occupational Safety and Health

NIOSH Occupational Violence Information – [NIOSH Violence Page](#)

NIOSH – Violence: Occupational Hazards in Hospitals - [2002 Publication](#)

Occupational Safety and Health Administration

OSHA – Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers. Pages 30 through 40 contain checklists for evaluating risk factors and inspecting work areas. [Click Here and Go to Page 30](#)

OSHA Workplace Violence Assessment Checklist - [OSHA Checklist](#)

OSHA Hospital eTool for Hospital Violence - [Violence Section of OSHA eTool](#)

Providence Health Care

A Planned Approach to Workplace Violence in Health Care: Beginning the Journey – Conceptual Framework created during the one-day work session with senior leadership and staff. The Conceptual Framework helped to categorize ideas and create an action plan moving forward.

Conceptual Framework

1. Prevention strategies

- Department assessment
- Patient Identification
- Safety strategies

2. Intervention Strategies

- Caregiver training strategies – risk stratified
- Security response expectations/support

3. Post incident Strategies

- Caregiver follow-up
- Reporting, review, data collection and organizational follow-up

4. Structure

- Committee Structure
- Communication plan

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Tool 5: Training and Communication

National Institute for Occupational Safety and Health

Free NIOSH Training – Workplace Violence Prevention for Nurses (CDC Course No. WB1865 - NIOSH Pub. No. 2013-155) - [NIOSH Free Training](#)

International Labour Organization, International Council of Nurses, World Health Organization, & Public Services International

Framework Guidelines for Addressing Workplace Violence in the Health Sector: The Training Manual

http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---safework/documents/instructionalmaterial/wcms_108542.pdf

Washington Department of Labor & Industries

L&I – Workplace Violence Prevention: [Module 1](#)

L&I – Workplace Violence Prevention: [Module 2](#)

Department of Labor and Industries – Critical Incident Stress Debriefing (CISD) Overview - [Click to Start Class](#)

Occupational Safety and Health Administration

OSHA Workplace Violence Prevention - Health Care and Social Service Workers – Power Point - [OSHA Healthcare PowerPoint Violence](#)

Tool 6: Prevention, Control and Response

Washington State Hospital Association

Standardization of Emergency Code Calls - [WA Code Standardization](#)

Emergency Nurses Association

Workplace Violence Toolkit - [ENA Violence Toolkit](#)

Minnesota Department of Health

Prevention Violence in Health Care Toolkit

<http://www.health.state.mn.us/patientsafety/preventionofviolence/toolkit.html>

North Carolina Department of Labor, Occupational Safety and Health Division

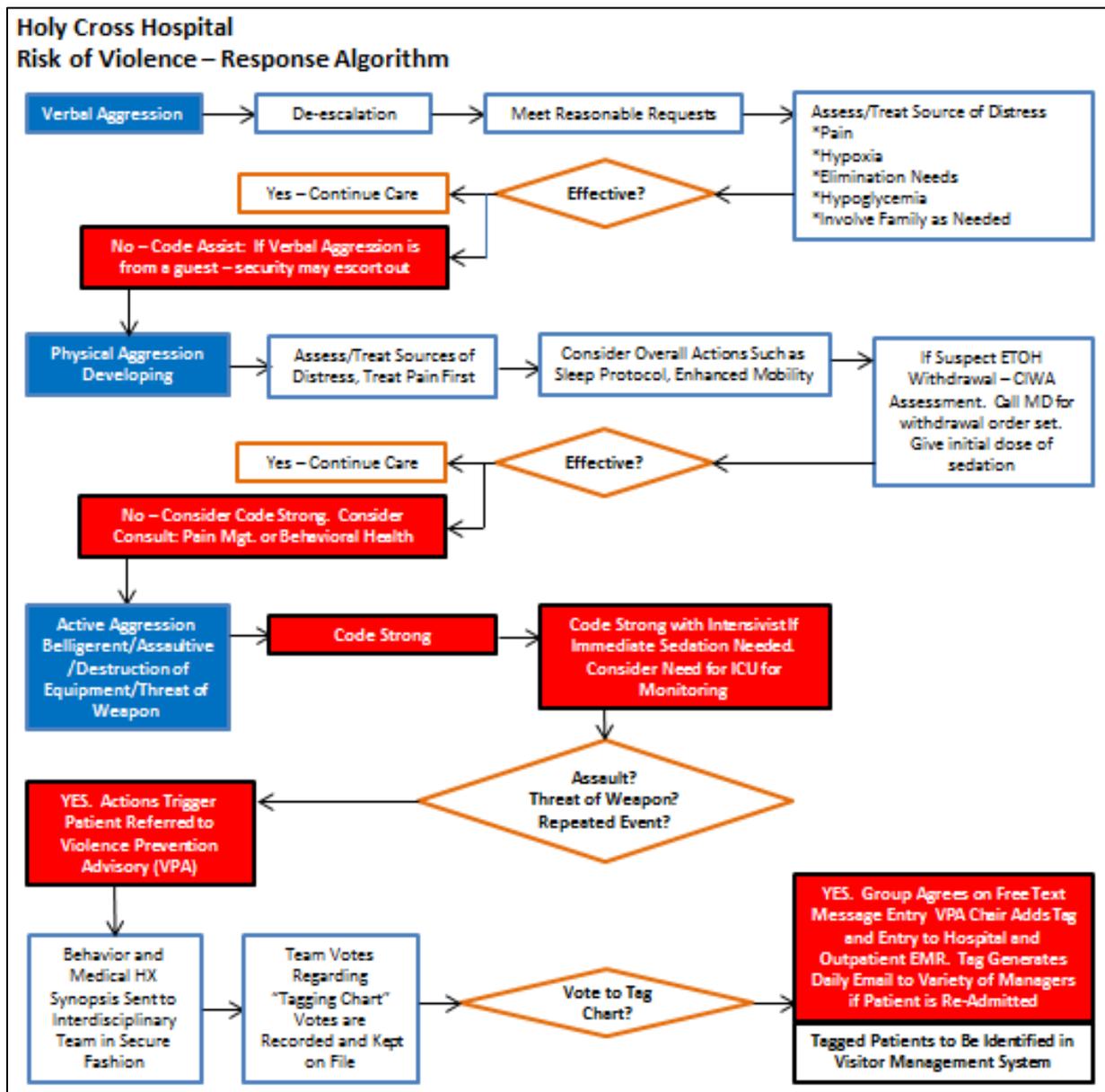
Workplace Violence Prevention Guidelines and Program for Health Care, Long Term Care and Social Services Workers - <http://www.nclabor.com/osha/etta/indguide/ig51.pdf>

Facilities Guidelines Institute

Common Mistakes in Designing Psychiatric Hospitals: An Update

<http://www.fgiguide.org/resource/common-mistakes-in-designing-psychiatric-hospitals-an-update/>

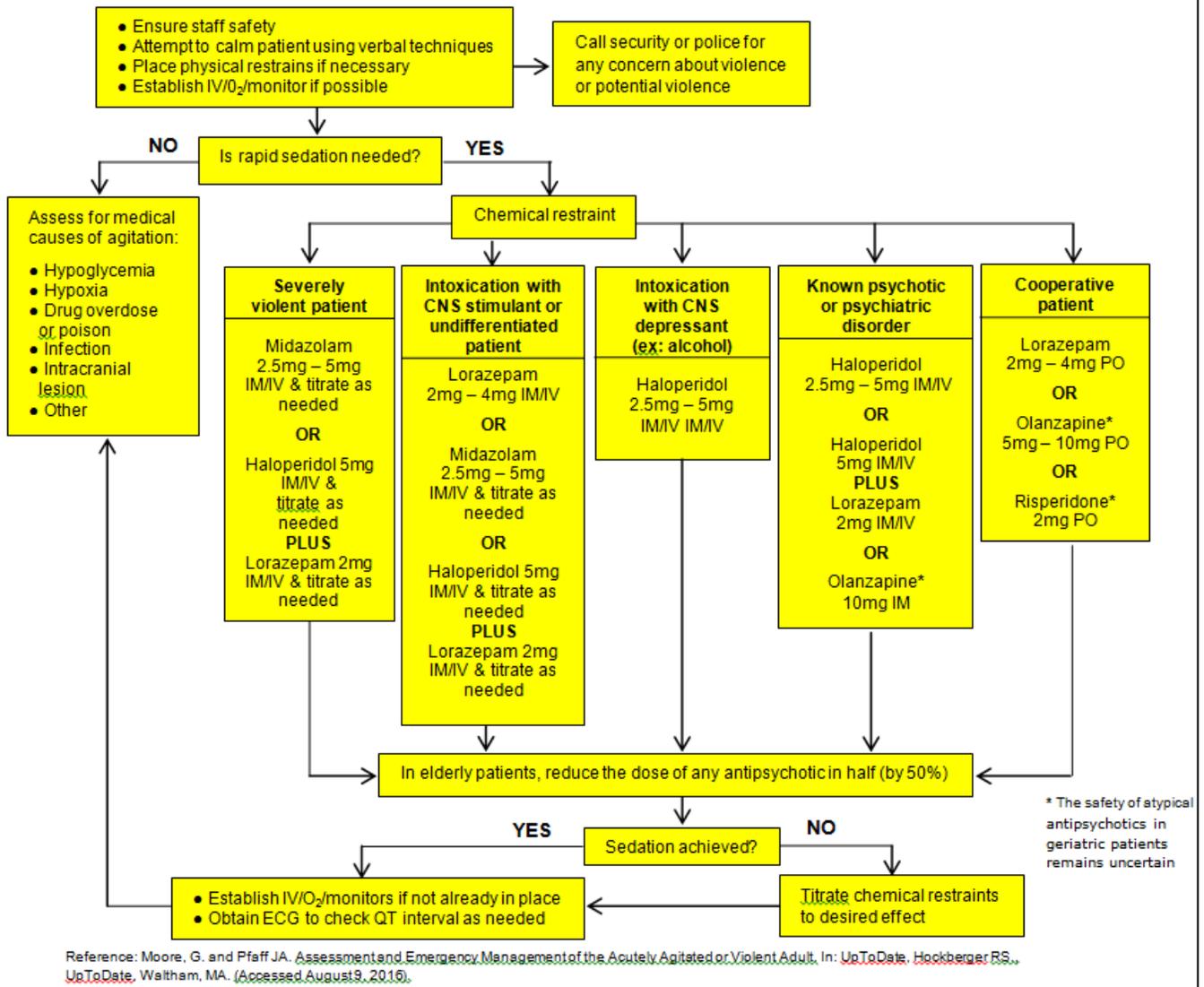
Response Algorithm Using Sub-Codes Provided by Holy Cross Hospital, Ft. Lauderdale, FL.
 Provided by Pat Schuldenfrei, EdD, RN, CPHQ, Patient Safety Officer, Chair, Committee to Prevent Patient Violence



Medication Recommendations for Potentially Violent Patients, Provided by Holy Cross Hospital, Ft. Lauderdale, FL.

Provided by Pat Schuldenfrei, EdD, RN, CPHQ, Patient Safety Officer, Chair, Committee to Prevent Patient Violence

Emergency Management of Severely Agitated or Violent Adults

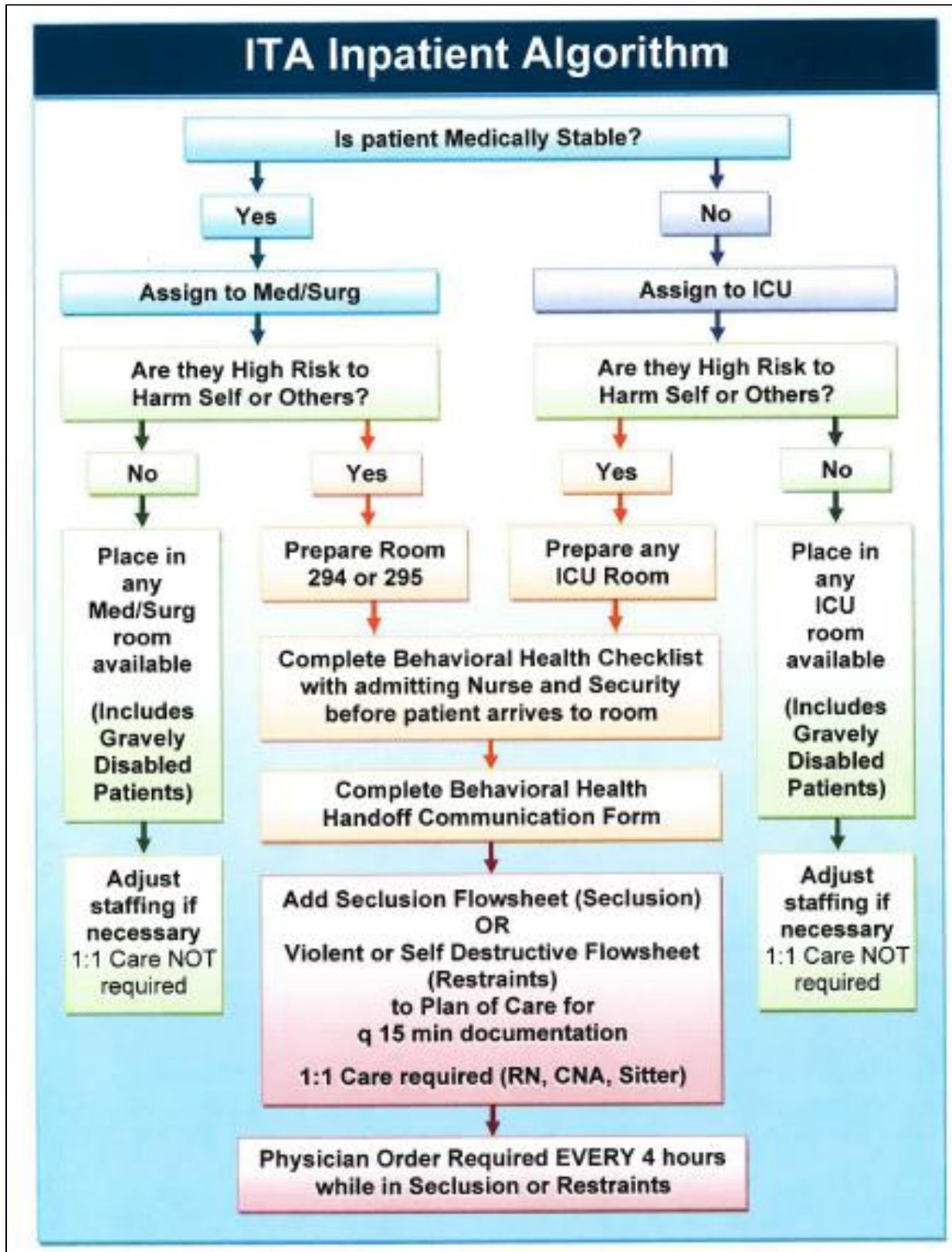


Tool 7: Addressing Mental Health Challenges

Patient/Visitor Behavior Agreement
Olympic Medical Center, Port Angeles, Washington
 Provided by Lorraine Wall, Chief Nursing Officer

PATIENT/VISITOR BEHAVIOR AGREEMENT		
<i>In order to achieve optimal health care outcomes, your health care providers would like to develop with you the following agreement.</i>		
Current Behavior Concerns: <ul style="list-style-type: none"> • 		
Behavior Goals: List goals identified by the patient and health care providers. <ul style="list-style-type: none"> • 		
Patient or Visitor Responsibilities: List specific behaviors the patient or visitor will do to reach the behavior goals. <ul style="list-style-type: none"> • 		
Health Care Team Responsibilities: List specific actions the providers will do to promote goal achievement. <ul style="list-style-type: none"> • 		
Benefits of Following the Agreement: Indicate potential gains that will be made. <ul style="list-style-type: none"> • Mutually satisfying communication. • Trust and rapport. • Decreased anxiety and tension. • Increased sense of dignity, respect, personal safety and effectiveness. 		
Potential Risks/Consequences of Not Following this Agreement: Identify possible negative outcomes that could arise or restrictions that might occur if the plan is not followed (i.e. limitations in privileges or limits on activity). <ul style="list-style-type: none"> • 		
<p>You and your health care team at future hospitalizations or visits can review this agreement. It is part of your medical record and will be available to all providers you see at Olympic Medical Center.</p>		
Patient or Visitor Signature:	Print Name:	Date:
Supervisor Signature:	Print Name:	Date:
Patient/Visitor Behavior Agreement (ADMIN 13.05.12) ADM31775 7-15		 <p>OLYMPIC MEDICAL CENTER 939 Caroline St. Port Angeles, WA 98362</p>

ITA Inpatient Algorithm
Olympic Medical Center, Port Angeles, Washington
 Provided by Lorraine Wall, Chief Nursing Officer



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5. Washington State Requirements for State Psychiatric Hospitals - [Chapter 72.23.400 RCW](#)
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