Workplace Violence Prevention and Related Goals

The Big Picture

A workplace violence prevention program can complement and enhance your organization's strategies for compliance, accreditation, and quality of care.

Workers in hospitals, nursing homes, and other healthcare settings face significant risks of workplace violence. Leading healthcare organizations have shared some of their solutions and shown that one does not need to tackle workplace violence in isolation. This document illustrates how a workplace violence prevention program can complement and enhance your organization's strategies for compliance, accreditation, and quality of care.

Regulatory Compliance

Federal Requirements

Although OSHA has no specific standard on the prevention of workplace violence, an employer has a general duty to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." This requirement comes from Section 5(a)(1) of the *Occupational Safety and Health Act of 1970* (OSH Act).

In addition to the federal OSHA program, 26 states, Puerto Rico, and the U.S. Virgin Islands have OSHA-approved State Plans. Of these State Plans, 22 (21 states and Puerto Rico) cover both private and state and local government workplaces. The remaining six State Plans (five states and the U.S. Virgin Islands) cover state and local government workers only. These state plans must be "at least as effective" as Federal OSHA (Section 18(c) of the OSH Act).

Section 11(c) of the OSH Act provides protection for employees who exercise a variety of rights guaranteed under the Act, such as filing a safety and health complaint with OSHA. In states with approved state plans, employees may file a complaint under the OSH Act with both the state and Federal OSHA. More information can be found at www.whistleblowers.gov.

In 2015, OSHA published an update to its *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* (see "Resources" at the end of this publication). These voluntary guidelines provide a compendium of research-based strategies to help prevent violent injuries to healthcare workers, and they emphasize the value of a comprehensive written workplace violence prevention program.

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State Requirements

As of August 2015, nine states require certain healthcare facilities to have some type of workplace violence prevention program. As these requirements are established by state law, they are enforced by the states and not by OSHA.

In 1993, California became the first state to require healthcare facilities to develop and maintain a violence prevention program. Subsequent state laws incorporated elements of the initial California state law. Currently, California is working on updating state requirements.

The requirements in these states differ. State laws in California, Washington, New York, New Jersey, and Connecticut require healthcare employers to provide comprehensive workplace violence prevention programs. In New York, the law applies to public workplaces but not to the private sector. In the other states, laws are directed toward specific healthcare settings such as acute psychiatric care, long-term and residential care, or ambulatory surgical centers. States with workplace violence prevention legislation can be models for other states that are considering their own legislation.

> Washington State's efforts to reduce workplace violence in the healthcare industry have led to lower injury rates and workers' compensation costs. From 1997 to 2007, the state's average annual rate of workers' compensation claims associated with workplace violence in the healthcare and social assistance industry was 75.5 per 10,000 full-time equivalent workers (FTEs). From 2007 to 2013, the rate had fallen to 54.5 claims per 10,000 FTEs—a decrease of 28 percent. This improvement coincides with Washington's 2009 rule that required hazard assessments, training, and incident tracking for workplace violence.
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> Source: Foley, M., and Rauser, E. 2012. Evaluating progress in reducing workplace violence: Trends in Washington State workers' compensation claims rates, 1997–2007. *Work*. 42: 67–81. (Updated data provided by the authors in 2015.)

Washington (Title 49, Chapter 49.19)
Who is covered: Hospitals, home health, hospice, home care agencies, community mental health programs, and evaluation and treatment facilities
Penalties for perpetrators: Yes
Washington's law requires facilities to perform a hazard assessment and record review, then develop a violence prevention plan. Training must be provided regularly to all affected employees identified in the violence prevention plan, and it must occur within 90 days of an employee's start date. Records must be available for incidents occurring during the last five years.

Oregon (2013 ORS, Vol. 14, Chapter 654)
Who is covered: Hospitals, ambulatory surgical centers, and home healthcare services
Penalties for perpetrators: No
Oregon's law requires periodic hazard assessments and record reviews, which must feed into a violence prevention plan. The plan must take into account the physical attributes of the facility, staffing, personnel policies, first-aid and emergency procedures, reporting of violent acts, and employee education and training. Employees have the right not to treat a patient who has assaulted them if the employer denies the employee's request to have a second employee present. An employee in home healthcare may refuse to treat a patient unless the employer provides the employee with a two-way communication device. Training must occur within 90 days of an employee's start date and is provided as needed thereafter. Records must be kept for five years.

California (State Health and Safety Code and SB-1299)
Who is covered: General acute care, acute psychiatric, and certain other types of hospitals
Penalties for perpetrators: Yes
California's law requires a designated committee to develop a safety plan, which must be updated based on findings from an annual facility assessment. This plan should take into account physical layout, staffing, security personnel, policy and training related to appropriate responses, and coordination with local law enforcement. Facilities must track incidents of violent behavior and evaluate trends. Affected employees and collective bargaining agents must be engaged in worksite analysis. Safety and health training is required.

Illinois (405 ILCS 90/)
Who is covered: Mental health and developmental disability facilities
Penalties for perpetrators: Yes
Illinois' law requires a violence prevention plan to be implemented based on findings from a risk assessment and record review. The plan must be reviewed at least once every three years and must take into account the facility's physical layout, personnel policies, first-aid and emergency procedures, reporting of violent acts, and employee education and training. All affected employees must be trained within 90 days of their start date, and they must receive periodic refresher training. The facility must keep records of workplace violence incidents.

New York (Labor Law Article 2)
Who is covered: Public facilities with at least 20 full-time permanent employees, including state-run healthcare and social service facilities
Penalties for perpetrators: Yes
New York's law requires a risk assessment of the workplace, which includes consideration of hazards such as working late, working alone, and exchanging money. Each facility must have a violence prevention plan that addresses the identified hazards. Employees are required to complete training at the start of employment and annually thereafter. Each facility must have a system for reporting incidents. Strong requirements for employee involvement have served as a model for other states' laws.

Maine (Sec. 1. 22 MRSA §1832)
Who is covered: Hospitals
Penalties for perpetrators: No
Maine's law requires a safety and security plan to be implemented annually, and hospitals must have a process to receive and record incidents or threats of violent behavior.

Connecticut (Public Act No. 11-175)
Who is covered: Hospitals, long-term and residential care, behavioral health, outpatient and ambulatory care, home care, and other facilities with 50 or more full- or part-time employees
Penalties for perpetrators: Yes
Connecticut's law requires a workplace safety committee with equal representation among management and employees. The committee must meet quarterly, conduct an annual risk assessment, and implement a violence prevention plan. An employee has the right to request accompaniment when caring for a patient who previously assaulted them, or they may ask to be reassigned. Employers must keep detailed incident records and must report assaults to authorities within 24 hours (with some exceptions).

New Jersey (P.L. 2007, Chapter 236)
Who is covered: Hospitals and nursing homes
Penalties for perpetrators: Yes
New Jersey's law requires a violence prevention committee to conduct an annual risk assessment and develop a violence prevention plan. At least half of the committee must be direct caregivers. The assessment must consider the facility's layout, crime rate in surrounding areas, lighting in surrounding areas, communication and alarm devices, and staffing; it must include a records review and a review of existing policies. The plan must specify risk reduction strategies and must establish a post-incident response system. Employees must receive annual training in identifying precipitating factors of violence and appropriate responses. Records of violent events must be kept for five years.

Maryland (Senate Bill 483)
Who is covered: Hospitals, state residential facilities, and nursing homes licensed for 45 beds or more
Penalties for perpetrators: No
Maryland's law requires each facility to conduct an annual assessment and have a workplace safety committee. Hospitals and state residential facilities' committees must have equal representation among management and employees, their employees must receive regular training, and they must have a system for reporting, responding to, and tracking incidents.

Sources:
- Penalties for perpetrators are based on a review of two sources as of August 2015:
  - American Nurses Association. Workplace violence. http://nursingworld.org/workplaceviolence.
  - Emergency Nurses Association. 50 state survey: Criminal laws protecting health professionals. https://www.ena.org/government/State/Documents/StateLawsWorkplaceViolenceSheet.pdf.

  States are labeled "Yes" if their laws explicitly impose penalties for assaulting a healthcare worker. Oregon is listed as "No" because its law is limited to emergency medical service workers. Altogether, more than 30 states provide some type of penalty for assaulting a healthcare worker.
- Other information is based on a review of state laws and regulations.

Accreditation

Many healthcare organizations pursue accreditation by an independent accreditation body, The Joint Commission being the largest. While The Joint Commission's healthcare standards and accreditation process have long focused on protecting patient safety, many of the standards and management systems designed to ensure patient safety can also be adapted and applied to worker safety. In addition, efforts to improve worker safety often have the result of improving patient care. Joint Commission–accredited healthcare organizations often already have building blocks in place to reduce workplace violence and other worker safety risks.

The Joint Commission's accreditation manual has several standards related to workplace violence, spread across four chapters of the manual.[1] The manual lists the accreditation requirements specific to workplace violence in different healthcare organizations, including hospitals, doctors' offices, nursing homes, office-based surgery centers, behavioral health treatment facilities, and providers of home care services. Particularly relevant standards include:

- Environment of Care (EC)

- Emergency Management (EM)

- Leadership (LD)

- Performance Improvement (PI)

For example, developing a strong safety culture, addressed in Joint Commission Standard **LD.03.01.01** for hospitals ("Leaders create and maintain a culture of safety and quality throughout the hospital"), is a key aspect of ensuring both worker and patient safety.[2] A strong safety culture includes managing and mitigating the risk of harm as reflected in Standard **EC.02.01.01** ("The hospital manages safety and security risks"). It also includes empowering staff to report incidents without fear of reprisal, which is included in Standard **LD.04.04.05** ("The hospital has an organization wide, integrated patient safety program within its performance improvement activities"). Reporting enables healthcare organizations to track and analyze incidents to inform both proactive and reactive risk reduction. Standard **EM.02.02.05, EP 3** ("The Emergency Operations Plan describes how the hospital will coordinate security activities with community security agencies [for example, police, sheriff, National Guard]") provides another connection, as it requires preparation for emergencies such as an active shooter situation. Although these three examples come from The Joint Commission's hospital standards, safety expectations are also in place for other settings such as long-term care, ambulatory care, behavioral health, and home care.[3]

"The organizational culture, principles, methods, and tools for creating safety are the same, regardless of the population whose safety is the focus."

– The Joint Commission. *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation.*

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[1] Joint Commission. 2015. *2015 Comprehensive Accreditation Manual for Hospitals (CAMH)*. 2015. Oakbrook, IL: Joint Commission Resources.

[2] Joint Commission. 2015. *2015 Comprehensive Accreditation Manual for Hospitals (CAMH)*. 2015. Oakbrook, IL: Joint Commission Resources.

[3] Standards reprinted here with The Joint Commission's permission.

Workplace Violence Prevention and Related Goals: The Big Picture

The Joint Commission's *Improving Patient and Worker Safety: Opportunity for Synergy*, *Collaboration and Innovation*[4] highlights additional synergies between patient and worker health and safety activities. To successfully integrate patient and worker safety, the document recommends:

- Encouraging leaders to make patient and worker safety core organizational values.

- Identifying opportunities to integrate patient and worker safety activities across departments and programs.

- Understanding and measuring performance on safety-related issues.

- Implementing and maintaining successful worker and patient safety improvements.

The Joint Commission shares recommendations, policies, procedures, and other information to help facilities prevent workplace violence. For example, it adopted a formal Sentinel Event Policy in 1996 to help hospitals that experience serious events learn from those events and implement actions to prevent future events.[5] A sentinel event is a patient safety event that results in any of the following: death, permanent harm, or severe temporary harm and intervention required to sustain life. In 2014, The Joint Commission added to its list of events considered sentinel: rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital.[6] Reporting a sentinel event to The Joint Commission is optional, but it can provide crucial data to help The Joint Commission and others identify causes, track trends, extract lessons learned, and ultimately contribute to better prevention strategies. The Joint Commission's sentinel event data collection and analysis processes protect the confidentiality of the patient, the caregiver, and the hospital.

A comparison between broader safety and health management system elements and the elements of performance found in related Joint Commission standards can be found in OSHA's *Safety and Health Management Systems and Joint Commission Standards*.[7]

OSHA and The Joint Commission have established an alliance to provide healthcare workers and others in the healthcare industry with information, guidance, and access to training resources to help protect employees' health and safety. Free resources, including many articles, are available at www.jcrinc.com/about-jcr/osha-alliance-resources.

Similar connections between accreditation and worker safety can be found in standards from other accrediting organizations, such as the Healthcare Quality Association on Accreditation (HQAA), Accreditation Association for Ambulatory Health Care (AAAHC), Accreditation Commission for Health Care (ACHC), and Commission on Accreditation of Rehabilitation Facilities (CARF). For example, CARF accredits programs primarily in the areas of aging, behavioral health, substance abuse treatment, and child and youth services. Its Standard 1.H.13 refers to "comprehensive health and safety inspections" conducted by the external authorities, including OSHA. The standard requires a healthcare facility to submit a written report to CARF that identifies health and/or safety areas inspected, issues that were discovered during the inspection, and an action plan for improvement. The 2015 *CARF-CCAC Standards Manual* is available for download at bit.ly/1JBpOXD.

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[4] Joint Commission. 2012. *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation*. www.jointcommission.org/improving_Patient_Worker_Safety.

[5] Joint Commission. 2014. Sentinel event policy and procedures. www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/default.aspx.

[6] Reprinted here with The Joint Commission's permission.

[7] OSHA. 2013. *Safety and Health Management Systems and Joint Commission Standards*. www.osha.gov/dsg/hospitals/documents/2.2_SHMS-JCAHO_comparison_508.pdf.

Patient Safety

Increasingly, healthcare facilities are integrating their *patient safety* and *worker safety* programs and managing them together using a common framework. Doing so makes sense, because many of the risk factors that affect patient safety also affect workers. For instance, a violent confrontation or intervention can result in injuries to both workers and patients, and caregiver fatigue, injury, and stress are tied to a higher risk of medication errors and patient infections.[8]

In addition, the tools used to monitor, manage, and improve patient safety have proven equally effective when applied to worker safety. For example, if your facility is Joint Commission accredited, you may be able to adapt existing compliance monitoring tools and infrastructure to address occupational safety. Several hospitals use their "environment of care" rounds to monitor for conditions that could affect either patient or worker safety.

Strategies to improve patient safety and worker safety can go hand-in-hand— particularly those that involve nonviolent de-escalation and alternatives such as sensory therapy. The nationwide movement toward reducing the use of restraints (physical and medication) and seclusion in behavioral health—which is mandated in some states—along with the movement toward "trauma-informed care," means that workers are relying more on approaches that result in less physical contact with patients, intervening with de-escalation strategies *before* an incident turns into a physical assault, preventing self-harm by patients, and ultimately equipping patients with coping strategies that can help them for life. The results can be a "win-win" for patient and worker safety.

A Culture of Safety

An organization's culture is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to objectives such as quality and safety. Many leading healthcare organizations are reducing injuries to both patients and workers by fostering a "culture of safety" characterized by an atmosphere of mutual trust, shared perceptions of the importance of safety, confidence in the efficacy of preventive measures, and a no-blame environment. Typical attributes of a culture of safety include:

- Staff and leaders who value transparency, accountability, and mutual respect

- Safety as everyone's first priority

- Not accepting behaviors that undermine the culture of safety

- A focus on finding hazardous conditions or "close calls" at early stages before injuries occur

- An emphasis on reporting errors and learning from mistakes

- Careful language to facilitate conversation and communicate concerns

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[8] Rogers, A.E., Hwang, W.T., and Scott, L.D. 2004. The effects of work breaks on staff nurse performance. *Journal of Nursing Administration*. 34(11): 512–519.

"Workplace safety is inextricably linked to patient safety. Unless caregivers are given the protection, respect, and support they need, they are more likely to make errors, fail to follow safe practices, and not work well in teams."

—National Patient Safety Foundation, Lucian Leape Institute. *Through the Eyes of the Workforce: Creating Joy, Meaning, and Safer Health Care*

"Safety is safety. We don't differentiate between patient and associate safety. We practice and encourage safety behaviors for both patients and associates. The behaviors we promote are exactly the same."

—Kate Henderson, Vice President and Chief Operating Officer, UMC Brackenridge

"Where some hospitals would limit their approach to medication, we use a more holistic approach. We work with patients as individuals, to find out what has a calming effect on them, and help them put that into practice. The result can be a positive change that lasts the rest of their lives."

—Cindy Chaplin, RN, BSN, Nurse Educator, Massachusetts Nurses Association Local Unit Chairperson, Workplace Violence Task Force Co-Chair, Providence Behavioral Health Hospital (Holyoke, Massachusetts)

High Reliability Organizations: Five Operational Processes

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.

Many healthcare organizations have strengthened their cultures of safety by embracing two sets of principles:

- **High reliability organization (HRO)** principles arose from air traffic control, nuclear power, and other industries characterized by complex systems with innate risks that must be managed effectively to avoid catastrophe. The Joint Commission has endorsed the use of similar principles to transform healthcare into a high reliability industry.[9] The Joint Commission promotes an environment of "collective mindfulness" in which employees look for and report small problems or unsafe conditions before they pose a substantial risk, and when they are easy to fix. The identification and careful analysis of errors can reveal weaknesses in protocols or procedures that can be remedied to reduce the risk of future failures.

- **"Just Culture"** involves creating an atmosphere of trust, encouraging and rewarding people for providing information on how errors occurred, so the sources of error can be analyzed. This can result in changes that improve safety. As Lucian Leape, MD, explains: "Approaches that focus on punishing individuals instead of changing systems provide strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes."[10]

In hospitals and other healthcare organizations, HRO and "Just Culture" can benefit both patients and workers, with the goal of improving safety for all.

Example: "Tapping Out"

Sometimes a healthcare worker finds him- or herself in a verbal power struggle with an agitated patient, or finds that he or she is getting frustrated and not making progress. At **Providence Behavioral Health Hospital** in Holyoke, Massachusetts, other colleagues are encouraged to recognize this type of situation and "tap in" by telling the first worker something like "You have a phone call—and it's your supervisor." Sometimes all it takes is a new face to get a patient to calm down, and the emphasis on caring language allows the first worker to exit the situation gracefully. This type of focus on collaboration and respectful language is a hallmark of a "culture of safety."

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[9] See, for example, www.jointcommission.org/highreliability.aspx.

[10] Leape, L. 2000. Testimony, United States Congress, United States Senate Subcommittee on Labor, Health and Human Services, and Education. January 25, 2000.

Example: "Culture of Safety" at Ascension Health

Ascension Health is the nation's largest Catholic and not-for-profit health system, with more than 150,000 employees (associates) at 1,900 locations, including more than 100 hospitals. Although all of these hospitals have dedicated safety professionals available, they cannot be everywhere at all times, nor can they expect to be experts in all the operations of a modern hospital. Recognizing this, several Ascension hospitals have adopted HRO principles to provide all associates with tools, resources, authority, and accountability that make it possible for everyone to integrate associate safety into their daily activities, just like they do for patient safety.

Key components of Ascension's program include:

• Empowering associates

• Making safety routine and visible

• Training

• Management visibility and commitment

For example, **University Medical Center Brackenridge** (UMC Brackenridge) in Austin, Texas, provides high reliability safety training to 100 percent of staff and on-site contractors. Safety coaches throughout the hospital receive additional training. Training tools include videos, staff testimonials, and role-playing in an on-site simulation laboratory.

At **St. Vincent's Medical Center** in Bridgeport, Connecticut, each day begins with a "safety huddle" led by a senior executive. Representatives from all departments, including both clinical and non-clinical services, are required to attend. Together they review any patient or associate safety events or concerns, recognize "good catches" (near-misses), and share updates on the status of safety-related projects or initiatives. These daily exchanges, fostered in an open, no-blame environment, help create an atmosphere of trust and cooperation. Several other Ascension hospitals use a similar approach.

Ascension Health's hospitals teach associates to intervene in situations using the "language of care." For example, any associate can stop the process by saying "I have a concern"—akin to the idea that any employee in a factory can stop the assembly line if he or she sees something wrong. Other examples:

• It's not a "near-miss"; it's a "good catch."

• With patients, "We're doing [x] for your safety."

Additionally, nurses—or even pastoral care staff—may take the lead in responding to certain security events, in partnership with security staff, so as to keep the focus on caring for the patient.

To remove barriers to reporting, Ascension Health has adopted computer-based reporting systems that emphasize reporting of "good catches" to provide opportunities to proactively reduce hazards. An associate who reports a concern will likely be engaged in follow-up discussion, root cause analysis, and response. **Saint Agnes Hospital** in Baltimore, Maryland, increased reporting by 75 percent using this approach. At UMC Brackenridge, senior administrators show their appreciation by writing a thank-you note to any associate who makes a "good catch."

Any UMC Brackenridge associate who makes a "good catch" receives a thank-you note from the leadership team.

Safety and Health Management Systems: A Comprehensive Approach

A workplace violence prevention program can fit effectively within a broader safety and health management system, also known as an injury and illness prevention program. Under this type of program, employers and employees continually monitor the workplace for hazards and then cooperate to find and implement solutions. All of this happens within a Plan-Do-Study-Act management system framework that should be familiar to healthcare administrators. A comprehensive safety and health management system can effectively manage a wide range of worker safety risks in healthcare, including workplace violence; patient handling (e.g., lifting); bloodborne pathogens; slips, trips, and falls; and more. This approach can go hand-in-hand with HRO principles and practices.

Almost all successful safety and health management systems include six core elements that are very similar to the elements of a workplace violence prevention program:

Safety and Health Management System Element	Overview	Workplace Violence Prevention Program Element
Management leadership	Managers demonstrate their commitment to improved safety and health, communicate this commitment, and document safety and health performance. They make safety and health a top priority, establish goals and objectives, provide adequate resources and support, and set a good example.	Management commitment and worker participation
Employee participation	Employees, with their distinct knowledge of the workplace, ideally are involved in all aspects of the program. They are encouraged to communicate openly with management and report safety and health concerns.	
Hazard identification and assessment	Processes and procedures are in place to continually identify workplace hazards and evaluate risks. There is an initial assessment of hazards and controls and regular reassessments.	Worksite analysis and hazard identification
Hazard prevention and control	Processes, procedures, and programs are implemented to eliminate or control workplace hazards and achieve safety and health goals and objectives. Progress in implementing controls is tracked.	Hazard prevention and control
Education and training	All employees have education or training on hazard recognition and control and their responsibilities under the program.	Safety and health training
System evaluation and improvement	Processes are established to monitor the system's performance, verify its implementation, identify deficiencies and opportunities for improvement, and take actions needed to improve the system and overall safety and health performance.	Recordkeeping and program evaluation

OSHA's Voluntary Protection Programs (VPP) recognize employers who have achieved excellence in occupational safety and health through adoption of a safety and health management system. Visit www.osha.gov/dcsp/vpp to learn more.

Example: Integrating Workplace Violence into a Comprehensive Safety and Health Management System

Citizens Memorial Hospital/Citizens Memorial Health Care Foundation (CMH) operates six skilled nursing homes, a hospital, and several other healthcare services in southwest Missouri. Nursing homes can pose risks for workplace violence, particularly when caring for patients with Alzheimer's disease and/or other forms of dementia, which can lead to confusion and combativeness. Other significant safety challenges at nursing homes include patient lifting. CMH began to address these issues in 1997 by setting up comprehensive safety and health management systems to drive continual improvement. All six nursing homes became VPP Star worksites and have maintained this recognition ever since.

Each of CMH's nursing homes has an employee-based safety committee that meets monthly, conducts monthly inspections, and reviews incidents. Administrators and managers (including the CEO) go on frequent rounds to build relationships with front-line staff and learn about their concerns, and they encourage employees to report all incidents and near-misses using an electronic system. All staff take a personal safety training course, and workers in the Alzheimer's and dementia special care units and certain other employees take nonviolent crisis intervention training with periodic refreshers. As a result of these efforts, CMH has kept its injury rates consistently below the national average, which is a requirement to maintain VPP Star status. It has also achieved a turnover rate well below the national average in its skilled nursing facilities.[11]

> "Keeping our employees and patients safe is at the core of who we are and what we do at CMH. Focusing on safety means our employees are prepared for the unexpected and our patients receive the high quality care they deserve."
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> —Donald J. Babb, CEO/Executive Director, Citizens Memorial Health Care Foundation

Resources

- OSHA: Worker Safety in Hospitals (www.osha.gov/dsg/hospitals)—a suite of informational products and tools to help hospitals assess workplace safety needs, implement safety and health management systems, implement workplace violence prevention programs, and enhance their safe patient handling programs. In particular, see *Preventing Workplace Violence: A Road Map for Healthcare Facilities* for a detailed discussion of the core elements of a workplace violence prevention program.

- OSHA: Workplace Violence (www.osha.gov/SLTC/workplaceviolence)—resources related to workplace violence, including OSHA's G*uidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*.

- The Joint Commission: *Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation* (www.jointcommission.org/improving_Patient_Worker_Safety).

- The Joint Commission: Patient Safety Systems (www.jointcommission.org/patient_safety_systems_chapter_for_the_hospital_program).

- The Joint Commission: *Quick Safety*, Issue 5, "Preventing Violent and Criminal Events" (www.jointcommission.org/assets/1/23/Quick_Safety_Issue_Five_Aug_2014_FINAL.pdf).

- OSHA: Injury and Illness Prevention Programs (www.osha.gov/dsg/topics/safetyhealth).

This document is advisory in nature and informational in content. It is not a standard or regulation, and it neither creates new legal obligations nor alters existing obligations created by OSHA standards or the *Occupational Safety and Health Act*.

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[11] According to the national average for 2012 from the American Health Care Association's Skilled Nursing Staffing Survey: www.ahcancal.org/research_data/staffing/Documents/2012_Staffing_Report.pdf.