

UNDERSTAND
IDENTIFY

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

- A GUIDE FOR HOSPITALS -



TENNESSEE
HOSPITAL
ASSOCIATION

DEVELOP
IMPLEMENT

ACKNOWLEDGEMENTS

This guide provides recommendations, tools and case examples to aid hospitals in the development of a comprehensive workplace violence prevention program. The Tennessee Hospital Association (THA) acknowledges the following organizations whose workplace violence-related resources provided valuable inspiration and direction for the development of this guide.

American Organization of Nurse Executives

Emergency Nurses Association

Occupational Safety and Health Administration

Ontario Hospital Association

Oregon Association of Hospitals and Health Systems

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TABLE OF CONTENTS

- 4 -

UNDERSTANDING WORKPLACE
VIOLENCE IN HEALTHCARE

- 9 -

IDENTIFYING VULNERABILITIES
AND RISK FACTORS

- 11 -

DEVELOPING A WORKPLACE VIOLENCE
PREVENTION PROGRAM

- 38 -

IMPLEMENTING THE WORKPLACE
VIOLENCE PREVENTION PROGRAM

- 40 -

ADDITIONAL RESOURCES

- 43 -

CONCLUSION

UNDERSTANDING WORKPLACE VIOLENCE IN HEALTHCARE

INTRODUCTION

In a February 2020 article in Occupational Health & Safety, the following alarming facts were presented.¹

- Violence and assault against healthcare workers are on the rise, especially against nurses
- Serious harm from workplace violence is four times more common among healthcare workers than workers in private industry
- The cost to help an injured healthcare worker or hire a replacement can be more than \$100,000
- Violence against healthcare workers is significantly underreported
- A growing number of states are passing laws requiring organizations to establish workplace violence prevention plans

While most hospitals have strategies in place to address workplace violence, the THA Board of Directors believed additional focus was needed and directed the Association to develop a hospital workplace violence prevention toolkit. This document is the response to that directive, and provides tools and resources to establish and/or strengthen a hospital's workplace violence prevention program.

DEFINITION

The Occupational Safety and Health Administration (OSHA) defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site."² Similarly, the National Institute for Occupational Safety and Health (NIOSH) defines it as "any physical assault, threatening behavior, or verbal abuse occurring in the work setting."³ The World Health Organization (WHO) extends the definition to violence against a worker that is "related to their work, including commuting to and from work."⁴

THERE ARE FOUR TYPES OF WORKPLACE VIOLENCE:

TYPE I

The perpetrator has criminal intent and no relationship with the hospital or its employees

TYPE II

A customer, client or patient becomes violent when receiving care or services

TYPE III

An employee commits violence toward another employee

TYPE IV

Violence perpetrated against an employee, patient, or family by someone with whom they have a personal relationship (e.g., domestic violence)

Type II is the most common type of violence reported by healthcare workers and, therefore, is the primary focus of this toolkit.

UNDERSTANDING WORKPLACE VIOLENCE IN HEALTHCARE



RISK FACTORS

According to OSHA, certain workers are at greater risk of experiencing workplace violence. These include those that exchange money with the public; those working with volatile or unstable people; those working alone or in isolated areas; and those working at night or in high crime areas.⁵ While violence can occur anywhere in the hospital, the Centers for Disease Control and Prevention (CDC) cites psychiatric units, emergency departments, waiting areas and geriatric/long-term care units as those with highest risk.⁶ Patient characteristics most associated with violent behaviors include:

- Substance abuse, including alcohol
- Cognitive impairment
- Anger about clinical relationships or situations
- Pain
- History of violence
- Being within the criminal justice system
- Certain psychiatric or medical diagnoses

There also are environmental factors that increase the risk of workplace violence, which the CDC has organized into four categories:⁷

- Factors that provide opportunity to gain access or avoid detection, such as unmonitored entrances, insufficient lighting or blind corners.
- Factors that increase stress such as confusing signage, long wait times, language/culture differences, difficulty parking or accessing a building, insufficient heat or air conditioning, bad weather conditions, high noise levels, limited access to food or beverages, pain or uncertainty about care and outcomes.
- Items that could be used as weapons such as unsecured furniture, fixtures, decorative items, or office or medical supplies.
- Things that limit staff ability to appropriately respond to violent incidents such as lack of training, being understaffed or lack of security systems, alarms or devices.

UNDERSTANDING WORKPLACE VIOLENCE IN HEALTHCARE

COSTS

Workplace violence is costly to hospitals, both directly and indirectly. Direct costs include medical bills, compensation for time away from work, litigation, settlement costs and vocational rehabilitation, if required.⁸ Indirect costs are more difficult to calculate and include lost productivity, overtime, administrative time, increased insurance premiums, legal fees, regulatory agency involvement, morale, reputation risk and media attention.^{9,10} OSHA cites the cost of recruiting, hiring, orienting and training a replacement nurse as ranging from \$27,000 to \$103,000.¹¹

Though it infrequently occurs, OSHA can fine hospitals for not taking reasonable steps to protect workers from exposure to workplace violence.¹² There also can be costs for repairing or replacing damaged medical equipment or furniture, or establishing additional security.

An important but less obvious cost of workplace violence is poor patient outcomes. Caregiver fatigue and stress is associated with increased risk of medication errors, hospital-acquired infections, poor patient satisfaction and caregiver turnover.¹³ An organization's safety culture and the work environment of nurses correlates with patient outcomes.¹⁴

WHY WORKPLACE VIOLENCE IS UNDERREPORTED

In 2015, Workplace Health and Safety shared results from a large health system's examination of workplace violence reporting practices. In its study, 88 percent of healthcare workers that had experienced a workplace violence event in the prior year had not reported it.¹⁵ Reporting was more likely if the employee required medical treatment or lost time from work and if the employee was younger, had fewer years of work experience and had a higher level of education and licensure. A similar study in a single healthcare organization showed less than 60 percent of workers reported physical violence and less than 50 percent reported non-physical violence. In a study of nursing students, 45 percent reported experiences with verbal abuse, but only four events had been documented into an event reporting system. In all three studies, it was noted that informal, verbal reports of the occurrences may occur, but formal reporting in an event-reporting system was significantly lacking. Similarly, a survey of over 3,700 nurses found reporting rates of 6.5 percent for verbal violence and 10 percent for physical violence.¹⁶

There are several reasons healthcare workers may not report violent incidents, including the belief that reporting would not change anything, it is not necessary to report violence that was not intentional or did not result in harm, it happens so frequently leaders already are aware of the problem, there would be negative repercussions for reporting, they might be negatively perceived by management, the reporting process is cumbersome or they might be blamed for the incident.¹⁷ Weak or non-existent policies, inadequate training, lack of clearly defined rules of conduct and management failure to take action are additional complicating factors.¹⁸

UNDERSTANDING WORKPLACE VIOLENCE IN HEALTHCARE

FEDERAL LAW

OSHA officials apply the [General Duty Clause](#), Section 5(a)(1) of the Occupational Safety and Health Act of 1970, for inspections and citations that pertain to workplace violence.¹⁹ The General Duty Clause requires employers to provide a work environment free from hazards that cause or are likely to cause death or serious physical harm.²⁰

The [Workplace Violence Prevention for Health Care and Social Service Workers Act](#) is proposed federal legislation that would require hospitals to develop and implement a comprehensive workplace violence prevention plan. Hospitals would be required to investigate workplace violence incidents, risks or hazards as soon as practicable; provide training and education to employees who may be exposed to workplace violence; meet record-keeping requirements; and prohibit acts of discrimination or retaliation against employees that report workplace violence incidents, threats or concerns.²¹ The bill was introduced to the House in February 2021 and was approved on April 16, 2021.

In [29 CFR § 1904.39](#), OSHA also requires reporting of a workplace-related fatality within eight hours of the death and workplace-related hospitalizations, amputations or loss of an eye within 24 hours, including those that resulted from workplace violence. A fatality is considered workplace-related if it occurred within 30 days following a workplace-related event.

TENNESSEE LAW

Tennessee Occupational Safety and Health Act of 1972, [T.C.A. 50-3-105\(1\)](#) uses similar language to the General Duty Clause of the federal Occupational Safety and Health Act of 1970, stating Tennessee employers will provide a place of employment that is free from hazards that cause or are likely to cause death or serious physical harm.²² TOSHA's [guidance](#) to investigators on reports of workplace violence is available online and provides insights into what would qualify as a hazard that could lead to a fine.

[T.C.A. 20-14-102](#) allows employers or employees who have suffered violence or threats of violence at the workplace to seek a temporary restraining order and injunction against the perpetrator.

[T.C.A. 39-13-116](#) assigns the following mandatory penalties for assault against a first responder or nurse while such provider is acting in the discharge of their official duties:

- Assault (Class A misdemeanor): fine of \$5,000 and minimum sentence of 30 days incarceration.
- Aggravated assault (Class C felony): fine of \$15,000 and minimum sentence of 90 days incarceration.

UNDERSTANDING WORKPLACE VIOLENCE IN HEALTHCARE

HOSPITAL ACCREDITATION

The Joint Commission, in its [Sentinel Event 59](#) – Physical and Verbal Violence Against Healthcare Workers, lists the standards that pertain to workplace violence. New and revised workplace violence prevention requirements went into effect January 1, 2022, and the following resources were provided by The Joint Commission to aide hospitals with compliance:

- [Updated R3 Report](#)
- [Compendium of Resources](#)
- [Pre-Publication Requirements: Critical Access Hospitals](#)
- [Pre-Publication Requirements: Acute Care Hospitals](#)

DNV GL Healthcare integrates [OSHA 3148-04R](#) and Section 99, Chapter 13 of the National Fire Protection Association guidelines in annual surveys. Hospitals are expected to conduct risk assessments, establish a workplace violence program and train staff in accordance with the program.

SUMMARY

Given the prevalence, severity and cost of workplace violence, not to mention the growing regulatory climate and attention from unions and media, there has never been a better time to put a workplace violence prevention program in place. While no single strategy will prevent workplace violence, a multi-strategy, organization-wide approach increases protection. Comprehensive programs include the common core elements of leadership commitment, worker participation, worksite analysis and hazard identification, hazard prevention and control, safety training, recordkeeping and program evaluation.



UNDERSTANDING WORKPLACE VIOLENCE IN HEALTHCARE

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IDENTIFYING VULNERABILITIES AND RISK FACTORS

INTRODUCTION

An effective workplace violence prevention program is built around a healthcare organization's unique characteristics, vulnerabilities and risk factors. Not only is a baseline assessment important for planning the program, ongoing assessment ensures a nimble response to new risk factors and an efficient use of personnel and resources.

Keeping in mind that workplace violence includes both verbal and physical aggression and can occur from coworkers, business associates and personal acquaintances, as well as patients and visitors, a facility assessment should be broad and can include:

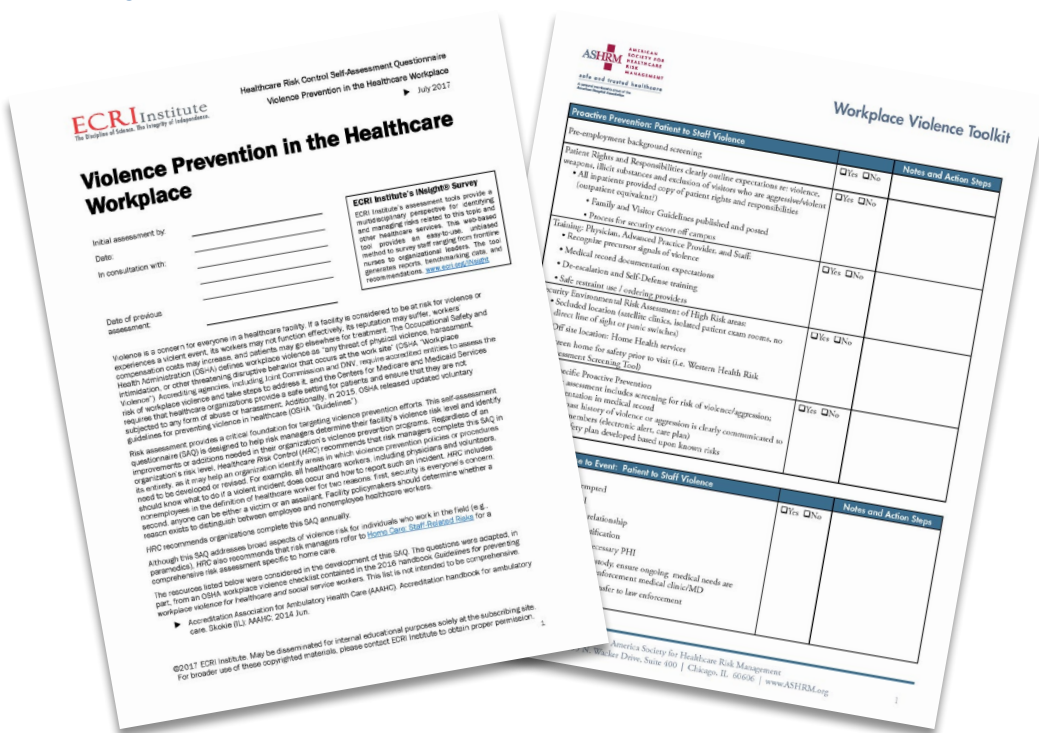
- Safety culture
- Policies and procedures (personnel management, security, disruptive behavior)
- Details from reported events
- Physical environment and grounds
- Patterns and prevalence of community violence
- Patient admissions for violence-related injuries (type and mechanism of injury)
- Relationship with local law enforcement
- Employee perspectives
- Safety and security-related equipment
- Training
- Costs

Assessments can be conducted by hospital staff, outside experts or a combination of both, and the frequency of assessment should be determined by the organization based on its size, complexity, number of risks, severity of risks and progress in developing its workplace violence prevention program. A hospital may choose to assess safety culture annually, for example, but review information from safety events monthly or quarterly.

SELF-ASSESSMENT TOOLS

The following self-assessment tools vary from one another. They can be adapted to meet the needs of different types of hospitals:

- American Society of Healthcare Risk Managers – [Workplace Violence Toolkit](#)
- Chubb Healthcare – [Hospital Violence Prevention Self-Assessment Tool](#)
- ECRI Institute – Violence Prevention in the Healthcare Workplace – [Self-Assessment Questionnaire](#)
- Minnesota Hospital Association – [Preventing Violence in Healthcare Gap Analysis](#)
- New York State Department of Labor – Workplace Violence Prevention Program [Workplace Security Checklist](#) | [Employee Questionnaire](#)
- Oregon Association of Hospitals and Health Systems: [Workplace Violence Program Gap Analysis Tool](#) | [Employee Survey](#) | [Safety and Security Checklist](#) | [Analyzing Injury Data and Direct Injury Costs](#)
- OSHA [Workplace Violence Checklist](#)
- National Institute for Occupational Safety and Health [Checklists for Organizations](#).



ADDITIONAL ASSESSMENT RESOURCES

The Tennessee Center for Patient Safety, a department of THA, offers the Agency for Healthcare Research and Quality (AHRQ) Culture of Safety survey free to member hospitals. Direct inquiries to Jennifer McIntosh, data manager, at jmcintosh@tha.com.

ORGANIZATIONS THAT CONDUCT ASSESSMENTS

[Hospital Shared Services](#) | [Mitigation Dynamics](#) | [Kroll](#) | [Threat Analysis Group, LLC](#)

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

BUILDING A TEAM

A workplace violence prevention program should be tailored to the size, complexity and unique risks and vulnerabilities of an organization. It is best developed and overseen by a multi-stakeholder team that is supported by engaged leadership who champion the program, help prioritize interventions and allocate appropriate financial and personnel resources.

The multi-stakeholder team will vary between facility types, but should include individuals that are knowledgeable about and/or can represent perspectives of the following:

- Physical environment and grounds
- Security
- Emergency preparedness
- Human resources
- Safety culture/Professional behavior
- Staff training
- Regulatory/Accreditation
- Nursing
- Physicians
- Patient admissions
- Patient advocacy/Customer relations
- Clinical leadership
- Financial leadership
- Safety event reporting

The team should be familiar with the results of facility risk assessments and play an active role in selecting and testing interventions and developing related policies or procedures. The team also should assist with evaluating uptake, staff competency and effectiveness of the interventions.



DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

ONLINE TRAINING

The planning team may benefit from introductory training in workplace violence, process improvement or both. Free online education options are available.

OSHACADEMY

OSHAcademy's [Preventing Workplace Violence](#) is a free online course on steps organizations should consider when developing a workplace violence prevention plan.

OREGON ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS

[Section 2, Step 4](#) of the Oregon Association of Hospitals and Health Systems' workplace violence toolkit provides recommendations and instruction on establishing a workplace violence prevention committee.



DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

TOOLKITS AND GUIDES

In developing a workplace violence prevention program, the multi-stakeholder team may find it helpful to refer to toolkits and guides in addition to this one. Several are listed below:

- Oregon Association of Hospitals and Health Systems [Workplace Violence Prevention Toolkit](#).
- OSHA [Caring for our Caregivers – Preventing Workplace Violence: A Roadmap for Health Care Facilities](#).
- Association of Nurse Executives and Emergency Nurses Association [Toolkit for Mitigating Violence in the Workplace](#).
- American College of Emergency Physicians [Emergency Department Violence: An Overview and Compilation of Resources](#).
- U.S. Department of Labor [Workplace Violence Prevention Program](#).
- USDA [Handbook on Workplace Violence Prevention and Response](#)
- Massachusetts Hospital Association Security Guidance: [Developing Healthcare Safety and Violence Prevention Programs within Hospitals](#).
- South Carolina Hospital Association: [Hospital Safe Zones](#)



FRAMEWORK DOCUMENT

Having a written description of the workplace violence prevention program, while not a regulatory requirement in Tennessee, is an increasingly popular requirement by other states and is considered a best practice. The written document should describe the basic framework and operations of the program and the strategies utilized to prevent violence. Reviewing the language of state regulations related to written workplace violence plans provides helpful insight into what a written plan should include:

[California](#) | [Oregon](#) | [Washington](#) | [New York](#) | [New Jersey](#) | [Connecticut](#)
[Nevada](#) | [Pennsylvania](#) | [Minnesota](#)

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

STRATEGIES TO PREVENT WORKPLACE VIOLENCE

The workplace violence prevention plan should include methods for evaluating its effectiveness. Some strategies will be costly and time-consuming, so it is important to quantify their impact. Ongoing monitoring of the program will identify drift in performance or changes in effectiveness that increase risk and require new interventions. [Section 8](#) of the Oregon Association of Hospitals and Health Systems workplace violence prevention toolkit provides considerations and possible metrics for program evaluation, including a [Program Measurement Plan template](#).

In addition to program metrics, the use of ongoing risk assessment, routine event review, debriefing after behavioral response team activations and discussions about safety during leader rounds help maintain and improve the program. The multi-stakeholder team that designs the workplace violence prevention program can continue as an ongoing oversight and review committee, analyzing data and findings from assessments to keep the workplace violence program relevant and effective.

The following list of strategies is a collection of interventions recommended by national safety organizations or subject matter experts. The strategies have been organized into the following categories:

- Safety Foundation
- Physical Environment
- Security-Related
- Human Resource/Personnel Management
- Patient-Related

If a hospital is seeking a resource that is not addressed in this guide, contact [Rhonda Dickman](#) at THA, 615-401-7404.



DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

SAFETY FOUNDATION

A successful workplace violence prevention program requires a strong foundation. Across the organization, there must be knowledge of workplace violence and the factors that lead to its occurrence and mitigation. There must be an established system for the recognition, response and reporting of events. Further, there must be a culture that supports reporting, investigation and consistent action against the behaviors and risk factors associated with aggression and violence. Strategies include:

LEADERSHIP SUPPORT

Hospital leaders, from the Board of Directors to department-level managers, must be committed to the workplace violence prevention program. The American College of Healthcare Executives, in its policy position on workplace violence, states that “healthcare executives have a professional responsibility to treat and take steps to mitigate violence and to advocate for cultures of safety.”¹ In addition to helping with program development and resource allocation, leadership support includes consistency in applying interventions, being visible (i.e. safety rounds), supporting event reporters and victims, coaching to best practices, modeling desired behaviors and reviewing program performance.

SAFETY CULTURE

A healthy safety culture has zero tolerance for workplace violence, including unprofessional and disruptive behavior. Workplace violence is perpetuated when it is accepted as ‘part of the job,’ and leaders do not act against it.^{2,3} In a zero-tolerance environment, all threats and incidents are taken seriously and have consequences, whether by a worker, physician, patient or visitor.⁴ However, caution should be taken to avoid a policy that is so inflexible it hinders reporting of aggressive incidents, limits how a hospital can address unique situations, or creates legal issues when bringing disciplinary action against a perpetrator.⁵ While zero tolerance can be powerful in advancing safety culture, hospitals should carefully consider how they will define, investigate and enforce it within their organization and clearly communicate it in policy. Legal counsel review of the final policy is recommended. Supervisors at all levels must understand their role in implementing the policy and receive necessary training and support.

Communicating a zero-tolerance policy to patients and visitors (signage)

- [MedStar Montgomery Medical Center](#)
- [CHI Franciscan Health](#)
- [Non-identified hospital](#)
- [St. Louis University Hospital](#)
- [Aurora Health Care](#)
- [Conway Regional](#)
- [Amita Health](#) *Please note: this poster received some social media criticism for including the line “Failure to respond to staff instructions” as an example of aggressive behavior.*
- [Bronson Hospital](#)
- International examples: [NHS Zero Tolerance – 1](#) | [NHS Zero Tolerance - 2](#)

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

JUST CULTURE

A healthy safety culture is one in which workers at all levels feel safe and supported when voicing concerns, including their own mistakes or inabilities.⁶ In a just culture, workers know they are accountable for their actions, but they will not be blamed for system faults. Systems are in place to support compliance with the workplace violence prevention plan, and are easy to use, readily accessible and well-understood by workers.

- American Nurses Association [position statement](#) on Just Culture.
- [Just Culture algorithm](#) from the National Patient Safety Foundation
- [Just Culture Guide](#) from the AHRQ Patient Safety Network.
- [Just Culture Toolkit](#) Scenarios from the Association of Perioperative Registered Nurses, an interactive training tool.
- The [Just Culture Company](#) offers in-person and online certification training programs.

POSITIVE WORK ENVIRONMENT

A positive work environment reduces worker-perpetrated aggression. While no environment will be considered ideal by all workers, certain characteristics reduce negativity and promote a healthy, professional atmosphere.⁷ These include:

- Promotion of sincere, open and timely communication between managers and employees
- Opportunities for professional development
- Availability of a non-judgmental forum for sharing complaints and concerns that provides timely feedback
- Concern for employee wellness and quality of life
- Impartial and consistent discipline for employees who exhibit improper conduct and poor performance
- American Association of Critical Care Nurses (AACN) [Establishing and Sustaining Healthy Work Environments, 2nd Edition](#)

**A POSITIVE WORK ENVIRONMENT
REDUCES AGGRESSION**

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

PROFESSIONAL BEHAVIOR

- Passionate About Creating Environments of Respect and Civilities (PACERS) [Civility Toolkit](#) empowers healthcare leaders in identifying, intervening and preventing workplace bullying.
- The American Board of Pediatrics [Teaching, Promoting, and Assessing Professionalism Across the Care Continuum](#) is directed toward physicians but outlines principles that apply to all healthcare professionals.
- The [Vanderbilt Center for Patient and Professional Advocacy](#) offers training in professional accountability.
- Tennessee Medical Foundation [Handling Distressed Physician Behavior](#) describes how hospitals can identify, understand and address contentious physician behaviors. The principles it brings forward can be applied to any healthcare professional.
- Dartmouth-Hitchcock [policy on disruptive behavior](#).

TRAUMA-INFORMED CARE

Sensitivity to the effect of prior life traumas on an individual's current response to injury, illness or stress is useful in preventing aggression and violence. Trauma-informed care delivery helps patients feel safe and respected, easing anxiety and promoting healing.

- [Trauma-informed Care Implementation Resource Center](#).
- [ACEs \(Adverse Childhood Events\) Aware](#).
- The Healthcare Toolbox [free online training](#) on trauma informed care with pediatric patients.
- [Trauma Informed Care Training Center](#) with online and in-person training options.

VICTIM SUPPORT

Hospitals with a strong safety foundation have resources in place to help workers who are victims of workplace violence, both immediately after an event and in the time period following an event.

- [Getting Back to Work After a Workplace Violence Event](#) – article from Society for Human Resource Management.
- [Assaulted or Battered Employee Policy](#) - sample policy from Edith Nourse Rogers Memorial Veterans Hospital, Bedford, MA.
- [How to Get Employees Back on Track After Workplace Violence](#) – blog on the website of human resource vendor, Insperity.
- International Public Safety Association [Mental Health Continuum Model](#) – a process for assessing how staff are coping.

When a violent patient or family member assaults a healthcare professional, the question may arise whether legal charges should be brought against the person. While a legal framework exists in Tennessee, the choice to bring charges can be difficult, and it is not common practice. Advocates such as [ZDoggMD](#) and the [#SilentNoMore](#) Foundation promote pressing charges as a means of changing the culture that accepts aggression against health professionals. Workers have

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

two options: to pursue criminal charges or sue the offender for personal injury. To pursue criminal charges, the assault should be reported to law enforcement. If the hospital has law enforcement staff, they should be notified; otherwise, a call should be made to local police. To pursue suing for personal injury, a personal injury attorney is needed.^{8,9}

If planning to press charges, the worker should be sure to submit an adverse event report and seek medical attention according to hospital policy and procedure. This will provide necessary documentation to support their case.

EVENT REPORTING PROCESS/SYSTEM

Hospitals should decide what information they wish to collect related to workplace violence and provide an easy, accessible process for reporting the desired information. Commonly collected information includes date, time and location of the event; type of perpetrator; type of event; the nature and severity of worker harm; what was happening prior to the event; and staff response to the event. Reporting mechanisms can include hotlines, paper tools or electronic event reporting systems. Complicated, time-consuming or difficult-to-access reporting mechanisms will hinder reporting.¹⁰

- The Joint Commission [Sentinel Event Alert 59 – Workplace Violence](#) recommends hospitals review each workplace violence event to determine contributing factors and that hospitals monitor the effectiveness of workplace violence prevention initiatives. Event reporting systems and processes that allow for capture of that information at the time of occurrence can ease later data collection and analysis burdens.
- American Nurse Association position paper [Reporting Incidents of Workplace Violence](#).

STRATEGIES HOSPITALS HAVE USED TO IMPROVE STAFF REPORTING OF EVENTS:¹¹⁻¹⁴

- Provide a clear statement of the organization's position on workplace violence.
- Clearly define workplace violence and the types of events and threats that should be reported.
- Examine existing reporting procedures to determine if changes are needed.
- Encourage employees to report incidents or related concerns and explain the reporting process.
- Report safety events during daily safety huddles.
- Security officer rounding and participation in clinical staff meetings.
- Hospital leader meetings with unit managers to gather more information around events and communicate concern for staff involved.
- Utilize the marketing department to provide information for staff regarding reporting, such as signage, handouts and videos.
- Utilize data from event reports to improve the workplace violence prevention plan.
- Communicate to staff the actions taken in response to information gained from event reports i.e., installing panic alarms, increasing security patrols in the parking area, etc.

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

RELATIONSHIP WITH STATE AND LOCAL LAW ENFORCEMENT

Healthcare and law enforcement intersect in many ways, but a positive relationship is of special importance in the context of workplace violence, especially for hospitals that do not have in-house security or frequently care for patients with a high risk of violence.

- [Minnesota Hospital Association Health Care and Law Enforcement Collaboration Roadmap](#)
- Recorded webinar from American Hospital Association's Hospitals Against Violence initiative, entitled "[Partnering with Law Enforcement](#)"
- Hospitals and law enforcement can work collaboratively to reduce violence in their community.
CDC: [Cardiff Violence Prevention Model](#)
- The lack of mental health crisis services across the U.S. has resulted in law enforcement officers serving as first responders to most crises. [Crisis Intervention Team \(CIT\)](#) programs are an innovative, community-based approach to improve the outcomes of these encounters, bringing hospitals, mental health providers and law enforcement together for training and development of collaborative partnerships. A March 2019 report, [Advancing Crisis Intervention Teams in Tennessee](#) provides additional guidance.

AWARENESS OF COMMUNITY VIOLENCE, CRIME AND CIVIL UNREST

Hospitals can better anticipate the types of violence that may occur within their facilities by knowing the types of violence and crime that are prevalent in their community. Crime statistics can be obtained from the following online sources.

- Tennessee Bureau of Investigations: [Crime Insight](#)
Optional view: [Filterable tables from raw data set](#)
- Tennessee Bureau of Investigations: [Annual Crime Reports](#)
- Tennessee crime statistics: [City-Data.com](#)
- Federal Bureau of Investigations: [2011 National Gang Threat Assessment](#)

To prepare hospitals for the impact of civil unrest, ASPR-TRACIE (Assistant Secretary for Preparedness and Response - Technical Resources, Assistance Center, and Information Exchange) compiled the following resources for hospitals.

[ASPR-TRACIE Technical Assistance](#) document that includes guidelines on medical management of victims.

[Ten "musts" for nurses when planning for a crisis](#) from Nursing Administration Quarterly.

Hospital examples of preparedness:

- [How Vancouver hospitals prepared for the Stanley Cup riot](#)
- [A long night in the Emergency Department](#)
- [Baltimore's Unrest: Perspectives From Public Health and Emergency Physician Leaders](#)

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

VISITOR PROCEDURES

Managing hospital visitors is an important consideration for patient recovery and safety as well as worker safety; therefore, hospitals should carefully review their visitation policies and visitor management practices.¹⁵ A variety of electronic visitor management systems exist and can aid hospital security with visitor screening, authorization, badging and tracking.

Common visitor management practices include:

- Establishing set visiting hours.
- Limiting the number of visitors.
- Screening visitors before entering the facility, which may include bag searches, passing through a metal detector and/or viewing visitor identification.
- Requiring that all visitors wear visitor identification (badge, sticker, band) while they are in the facility. Some hospitals will provide long-term visitors, such as parents of critically ill children, a different type of identification that simplifies screening procedures.¹⁶
- Giving visitors instructions on visitor expectations.
 - University of Pittsburg Medical Center Pinnacle Health: [Patient and Visitor Code of Conduct](#)
 - Northwell Health Mather Hospital: [Code of Conduct](#)
 - University of Maryland Medical Center: [UMMC Visitor Code of Conduct](#)
- Having clear directional and instructive signage.
- Maintaining visitor watch lists for high-risk visitors, such as those with a prior history of violence or former employees who are not to be in the facility.
- Developing a disruptive visitor policy and procedure.

Consideration should be given to visitor comfort, an important tool for reducing stressors that could trigger aggression. Reviewing visitor complaints or other forms of feedback can be helpful as can observing waiting areas, noting how visitors experience the environment and talking with them about their needs. These include:

- Physical needs: access to bathrooms, food and beverages, directions to smoking areas
- Physical comfort: seating comfort and proximity to others, noise levels, room temperature
- Conveniences: phone charging stations, ATMs, shuttle to parking areas, directional signage
- Communications: posting average wait times, providing updates on their loved one
- Spiritual support: chaplain services, chapel

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

Other non-employee individuals routinely enter hospitals and can be potential security threats, including contractors, vendors, delivery persons, employee family members and agents of accrediting or regulatory agencies. Screening procedures and requirement of visitor badges must be considered for these populations.

RESOURCES RELATED TO VISITOR MANAGEMENT

- International Association for Healthcare Security and Safety: [Effectiveness of Visitor Management in Hospitals](#)
- Open Journal of Nursing Article (2013): [Violence against healthcare staff by patient's visitor in general hospital in Greece: Possible causes and economic crisis](#)
- PowerPoint presentation by chair of IAHS Council on Guidelines (2018): [Violent Patient/Visitor Management](#)
- Hospitals may wish to consult with a visitor management system company. A few examples include:
[Veristream](#) | [Symplr](#) | [Lobbytrack](#) | [IdentiSys](#) | [FAST-PASS 7](#)

STAFF TRAINING AND COMPETENCY

A trained, competent staff is a vital tool in mitigating workplace violence. Hospitals should develop a customized staff training plan that outlines the type and frequency of training for all staff and for those in special roles. It should describe how staff competency will be measured and maintained and should be evaluated regularly. Key findings from the hospital's risk assessment will be helpful in developing the staff training plan. Hospitals also may find value in consulting with a workplace violence training expert. At a minimum, all staff should have training in the definition of workplace violence, professional behavior, the hospital's plan to prevent and respond to workplace violence, and their role in that plan.

WHO NEEDS WHAT TRAINING?

The free online OSHAcademy course [Preventing Workplace Violence Section 4 – Education and Training](#) walks planning committees through key considerations for developing a staff training plan.

The Oregon Association of Hospitals and Health Systems workplace violence toolkit provides sample staff training plans.

[6a Education and Training Plan](#) | [4a Communications Plan](#)

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

TRAINING METHODOLOGIES

A combination of training methodologies is more effective than a single methodology alone.¹⁷ Online courses, classroom trainings, table-top exercises, simulation and role-playing are techniques used in workplace violence training programs. Online courses, combined with table-top exercises, may be sufficient for staff with limited exposure risk. Classroom training with hands-on exercises and role-playing may be more effective for those with higher exposure risk.

Using presenters from hospital security, human resources and the employee assistance program enables workers to become familiar with the individuals who can help them in relation to violent situations and may lead them to seek help sooner when needed.¹⁸

Refresher training on key components of the hospital's workplace violence prevention plan should be provided at a frequency determined by the hospital based on its risk assessment findings. Mock drills serve as an excellent means of assessing and maintaining staff competency.

- ASPR TRACIE [mock drill exercise template](#) and resources
- While designed for a school campus rather than hospital environment, the Caltech [Workplace Violence Exercise guide](#), nevertheless, provides useful guidance on conducting mock drills.

ORGANIZATIONS THAT PROVIDE TRAINING

- The National Institute for Occupational Safety and Health (NIOSH) offers a free online course [Workplace Violence Prevention for Nurses](#)
- [Crisis Prevention Institute \(CPI\)](#) – a range of training options from de-escalation to advanced physical intervention. Online options available.
- [Welle](#) (previously Non-Abusive Psychological Physical Intervention) – a training program tiered to needs of different staff. Online options are available.
- [ALICE \(Alert, Lockdown, Inform, Counter, Evacuate\)](#) - active shooter training for organizations. Online option is available.
- [TEAM \(Techniques for Effective Aggression Management\)](#) – training options from verbal de-escalation to physical countermeasures. Online options and an ED-specific training program are available.
- [AVADE Workplace Violence Prevention](#) – a range of training options from de-escalation to security-specific (defense baton, pepper spray defense). Online options are available.
- [RIGHT RESPONSE](#) - de-escalation training.
- [Handle with Care](#) – verbal and physical intervention training.
- [MOAB](#) – a range of training options from verbal de-escalation to advanced physical and security-specific (law enforcement level) training.
- [International Association for Healthcare Security and Safety](#) – training for security officers from basic to supervisory level. Certification program and online training options available.

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

- [Personal Safety Group](#) offers training on situational awareness and personal safety for workers who telecommute, conduct home visits and/or travel for work.
- [Satori Alternatives to Manage Aggression](#) offers a range of training programs from de-escalation to advanced physical techniques that incorporates principles of trauma-informed care.
- The National Alliance on Mental Illness (NAMI) Tennessee has [training programs](#) that help professionals work with individuals who suffer from mental illness.

[CODE the movie](#) shares experiences of correctional officers and inmates under their supervision who have mental illness. While designed for correctional officers, the content provides useful insights for healthcare professionals and hospital security officers.

NAMI Tennessee provides [inservices](#) on how to work with patients with mental illness. The association also offers a number of helpful [fact sheets](#).

SYSTEM FOR NOTIFYING EMPLOYEES OF SECURITY THREATS

Hospitals must establish systems for violence-related communications and notifications. Staff witnessing a threat or event must be able to call for help and alert those at risk of danger. Further staff notifications may be necessary. The following are methods some hospitals have used:

- Personal alarms worn by staff
- Panic buttons
- Public addresses/overhead codes
- Silent alerts
- All-staff computer screen alerts
- Pager/phone/tablet push notifications
- Two-way radio notifications
- Integrated systems that allow for mass notifications through a variety of these methods

There are not standard hospital emergency codes in the state of Tennessee. Rather than instituting a color or name for an emergency code, some hospitals are moving toward plain language codes to help staff implement proper response more quickly without having to remember what the code name means or refer to a code guide.

- ASPR TRACIE [Resources on Plain Language Emergency Alerts for Hospitals](#).
- If your hospital chooses not to implement plain language codes, the following [Guide to Emergency Codes](#) by National Health Care Provider Solutions outlines commonly used codes within the U.S.

When a patient has been identified as high risk for violence, the risk should be communicated to staff working with the patient. Information on communicating the risk is provided further in this section under Patient-Related Interventions.

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

PHYSICAL ENVIRONMENT

A significant factor in the safety or risk related to workplace violence is the physical environment of the organization, both internally and externally. A thorough risk assessment will evaluate lighting, walkways, parking areas, traffic, landscaping, wayfinding signage and building access, as well as the configuration of rooms, departments, hallways, nursing stations and all public-facing areas. It is within the physical environment that violence-preventing engineering controls are considered, such as the locations and types of alarm systems, panic buttons, metal detectors, electronic doors, coded key cards, hallway mirrors, security cameras, space enclosures, service-counter depth and furniture selection and placement.

The physical environment should be evaluated from several perspectives.

- What is the experience of the person spending time in the environment?
- Does the environment reflect the mission and vision of the organization?
- Does the environment support safe and effective patient care?
- Is the environment a safe space for workers?

The International Association of Healthcare Security and Safety's document, *Security Design Guidelines for Healthcare Facilities*, is a comprehensive guide to creating a safe physical environment. The May 2020 edition can be purchased on the [website](#). An [older version](#) (2012) is available at no cost.

Hospitals may wish to invite local law enforcement to do an environmental safety walk-through with hospital leadership, security and physical plant directors. Law enforcement can point out areas of concern and recommend changes to the environment or discuss ways to work within the environment to optimize safety. They also can be helpful in identifying safe rooms and escape routes in the event of an active shooter.

Organizations or consultants that conduct hospital workplace violence risk assessments and/or training often can provide information about engineering controls and technologies that could address the hospital's areas of vulnerability.

Commercial landscaping companies may offer recommendations or provide designs to improve the safety of the hospital exterior while retaining a welcoming appearance.

ADDITIONAL RESOURCES REGARDING THE PHYSICAL ENVIRONMENT:

- American College of Emergency Physicians - [Design Considerations for A Safer Emergency Department](#).
- Journal of Emergency Nursing – [Preventing Emergency Department Violence Through Design](#).
- Healthcare Facilities Management – [Hospital Designs to Bolster Security](#).
- Recorded webinar by the Center for Health Design - [Security Implications of Physical Design Attributes in the Emergency Department](#).

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

- California Department of Industrial Relations [Guidelines for Security and Safety of Health Care and Community Service Workers](#), Section III – Program Elements, item B – Hazard Prevention and Control.
- Whole Building Design Guide – [Landscape Architecture and the Site Security Design Process](#).
- MD News – [Cost Effective Improvements to Hospital Parking Lot Security](#).
- Available for purchase from the International Association for Healthcare Security and Safety - a guide on integrating security principles into new construction or renovations – [IAHSS Security Design Guidelines for Healthcare Facilities](#)
- IPVM [Hospital Video Surveillance Guide](#)
- University of Iowa Operations Manual – [Chapter 45: Video Surveillance](#), a sample policy.

SECURITY-RELATED

Hospital security personnel are a vital part of workplace violence prevention and response efforts. Typical work responsibilities, depending upon the size of the hospital, include the following:¹⁹

- Assessing security risks and vulnerabilities
- Customer service
- Maintaining an orderly environment
- Preventative patrol
- Incident reporting and investigation
- Response to requests for service
- Parking and traffic control
- Educating staff on security procedures and personal safety
- Background investigations on job applicants
- Response to internal and external emergencies
- Enforcement of rules and regulations
- Facility access control
- Assisting with registering, screening, badging and directing visitors
- Liaison with law enforcement and other government agencies
- Management of electronic security systems
- Other support services

In an article for AHSE Health Facilities Management, healthcare security expert, Thomas Smith CHPA, CPP, recommended hospitals have security-related policies that address the following:²⁰

- When and to whom events are reported
- How events are investigated
- Process for escalating events internally and externally to law enforcement and/or proper regulatory bodies as appropriate

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

- Procedures for securing high-risk areas
- Use-of-force, including guidelines that ensure regulatory compliance
- Amount and type of training for security personnel and workers in high-risk areas

SECURITY-RELATED BEST PRACTICES RESOURCES

Resources from the International Association for Healthcare Security and Safety:

- [Basic Training for Healthcare Security Personnel](#) includes training manuals for security officers and instructors.
- The [Healthcare Safety Certificate Program](#) for healthcare security professionals – a core resource for the Certified Healthcare Protection Administrator (CHPA) certification.
- [Security System Monitoring in Health Care Facilities](#)
- [Violence in Healthcare and the Use of Handcuffs](#)
- [Lessons Learned & Best Practices for Managing Forensic Patients in Healthcare Facilities](#)
- [Behavioral Health Patient Boarding in the ED](#)
- [Weapons Use Among Hospital Security Personnel](#)
- [Best Practices of Hospital Security Planning for Patient Surge](#) – a comparative analysis of three national systems (pre-COVID).

[ASIS International](#) offers certifications in core and advanced security practices. It also provides services to members, including online education offerings on a variety of security-related topics and access to published security [standards and guidelines](#).

New Jersey Emergency Management [Security Readiness Assessment Tool](#)

Journal of Healthcare Protection and Management (2019) – [A Refined Model for Estimating the Industry-Average Number of Security Staff for Hospitals](#)

ASHE Health Facilities Management – [2018 Hospital Security Survey](#)

Patient Safety and Quality Healthcare (2010) – [Workplace Safety: Hospital Security Impacts Patient Satisfaction](#)

Journal of Healthcare Protection and Management (2019) – [Elevation of the Healthcare Security Leader](#)

Workplace Health & Safety article (2016) [Security Personnel Practices and Policies in the U.S.](#)

A recent innovation in hospital security is the use of K9 officers. Unlike traditional police dogs, the dogs used for hospital security are highly trained to provide a calming presence, as well as detect firearms or illegal substances, distinguish violent from non-violent situations and intervene when needed as part of the overall security response. One of their greatest strengths is their

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

ability to reduce violence by serving as visual deterrents and a de-escalating presence. Hospitals with K9 officers are using them to patrol parking areas, waiting rooms and hospital departments with high risks of violence; examine unattended packages; help with crowd control; and respond to security calls, as well as take part in community outreach and public relations projects.²¹

Hospitals considering K9 officers should know there are costs and commitments involved, which require careful consideration. Talking with hospitals that have implemented K9 officers is advised. In Tennessee, two hospitals have K9 security officers.

- University of Tennessee Medical Center, Knoxville. Contact [W. Keith Neeley](#), Vice President, Facility Operations,
- Maury Regional Medical Center, Columbia. Contact [Mike Short](#), Administrative Director, Safety, Security, Transport, and Environmental Services

ADDITIONAL RESOURCES INCLUDE THE FOLLOWING:

- Journal of Healthcare Protection Management article (2015): [Seven Steps for Starting and Building an Effective Hospital Security K9 Program](#).
- American Society for Industrial Security ASIS online article: [K9 Teams Press "Paws" on Healthcare Violence and Crime](#).
- Security Magazine article (2014): [Working with Canines in Healthcare](#).
- Nurse.org article (2019): [This is Why K9s Are The Newest Team Members At Hospitals](#).
- CDC Guidelines for Environmental Infection Control in Healthcare Facilities (2003), [Section H. Animals in Healthcare Facilities](#).

HUMAN RESOURCES/ PERSONNEL MANAGEMENT

Human resources (HR) professionals are key stakeholders in hospital workplace violence prevention programs. In addition to participating in the design and review of the hospital's overall plan, HR professionals must institute safe personnel management practices.

- Compensation & Benefits Daily Advisor (2014): [Violence in the Workplace – 12-Point Action Plan](#)
- International Risk Management Institute: [Preemployment Screening and Workplace Violence Prevention](#).
- Greater Cleveland Partnership: [Workplace Violence: 36 Warning Signs to Watch For](#).
- ESI Employee Assistance Group (2013): [Planning Terminations that Involve Potentially Violent Employees](#).
- Society for Human Resource Management toolkit (SHRM Members Only) [Managing Difficult Employees and Disruptive Behaviors](#).

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

Hospital workers should be encouraged to follow practices for personal safety. Human resources may wish to include tips for personal safety and situational awareness in the employee handbook, provide instruction in new hire orientation, and post tips near time clocks or in staff break rooms. These can include after-hours escorts to vehicles; staying alert when walking to/from the parking area; wearing name badges on break-away lanyards or clips and so forth.

PATIENT-RELATED

Violent behaviors indicate the individual is in distress and has exceeded his or her ability to cope with the situation. Violence can be criminally intentioned, but in the acute care setting, it is more likely caused by medical, behavioral health and/or emotional factors that the person cannot control. The hospital environment, being unfamiliar and stressful, further taxes their capacity so seemingly small things can provoke a violent response.²²

VIOLENCE RISK ASSESSMENT AND RESPONSE

Violence risk assessment tools help care providers quantify and communicate risk and integrate this knowledge into the patient's plan of care. The screening usually is added to emergency department triage and/or nursing admission assessments and can be repeated with changes in the patient's condition. Descriptions of risk assessment tools and their use can be found in the following resources:

- [Broset Violence Checklist](#) – used in the ED or inpatient setting
- **STAMP** – designed for use in the ED setting. The presence of any of the following behaviors indicate potential risk of violence.²³

Staring: prolonged or intense glaring at nurse, absence of eye contact

Tone: tone and volume of voice, sharp or caustic retorts, sarcasm, demeaning inflection, increase in volume, rapid or urgent speech, aggressive statements or threats, demanding attention, yelling, swearing, name calling, rudeness, ridicule, threat of harm, humiliating remarks, intimidation, belligerence

Anxiety: flushed appearance, hyperventilation, rapid speech, dilated pupils, physical indicators of pain, grimacing, writhing, clutching body confusion and disorientation, expressed lack of understanding about emergency department processes, tense posture, clenched fists, irritability

Mumbling: talking under their breath, criticizing staff or their institution just loudly enough to be heard, repetition of same or similar questions or requests, slurring or incoherent speech

Pacing: walking around confined areas such as waiting room or bed space, walking back and forth to the nurses' area, flailing around in bed, resisting healthcare, fidgeting

- [Aggressive Behavior Risk Assessment Tool \(ABRAT\)](#) – designed for use in medical surgical areas. Assess for the following elements. If none are present, there is a low risk for violence. If one is present, there is a moderate risk. If two or more elements are present, there is a high risk of violence.²⁴

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

- History of physical aggression
- History of signs or symptoms of mania
- Confusion or cognitive impairment
- Anxiety
- Physically aggressive or threatening (shaking fist, hitting objects)
- Agitation (pacing, disrobing, screaming, crying)
- Mumbling
- Staring, glaring or avoiding eye contact
- Shouting or demanding
- Threatening to leave
- Public Services Health and Safety Association, Canada [Violence Assessment Tool \(VAT\)](#)
- [Risk Screening for Potential of Aggressive Behavior](#)
- [Brief Rating of Aggression by Children and Adolescents \(BRACHA\)](#) for assessing violence risk in pediatric patients.²⁵
- CDC-National Institute for Occupational Safety and Health [Violence Risk Assessment Tools](#)
- The American College of Emergency Physicians [Risk Assessment Tools for Identifying Patients at High Risk for Violence and Self-Harm in the ED](#)
- International Association of Healthcare Security and Safety – [Reducing Violence Toward Healthcare Workers: The Value of At-Risk Patient Screening](#)

Information gained from the violence risk assessment should be incorporated into staff protocols that outline appropriate preventive actions at each level of risk.

Low levels of risk: Continued monitoring.

Moderate levels of risk:

- Communicate risk to the care team, management and security.
- Identify patient triggers for agitation and the strategies they use to remain calm (music, talking with someone) and incorporate that knowledge into their plan of care.
- Ensure the care team projects a calm, non-judgmental demeanor and are trained and prepared to recognize and respond to a change in behavior.

High levels of risk: (in addition to the actions for moderate levels of risk)

- Apply a flag alert to the patient record and door to their room.
- Ensure staff are not alone in the room with the patient and always maintain access to an escape route.
- To the extent possible, place the patient in a room that limits overstimulation, provides adequate personal space, and has furniture and decorative items that cannot be used as weapons.

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

- Place patient under constant observation.
- Provide panic alarms for direct care staff.
- Initiate appropriate referrals.

Active violence: Ensure safety of staff. Notify behavioral response team and/or security.

STAFF PROTOCOL DEVELOPMENT RESOURCES

- Journal of the Royal College of Physicians of Edinburgh (2017) [How to deal with violent and aggressive patients in acute medical settings](#).
- Providence Health & Services – [General Overview: Management of Difficult Behavior](#)
- Public Services Health and Safety Association, Canada [Acute Care Violence Assessment Tool Sections B and C](#)
- Sample hospital disruptive patient policy: [CHI Franciscan Health](#)
- Psychiatric Times [Practical Tips for Managing the Agitated Patient: Avoiding Violence in the Clinical Setting](#). This resource was written for the clinical setting but provides information that is useful for other care settings.
- Relias Media [Management of the Violent Patient in the Emergency Department](#)
- Tennessee Hospital Association [ED Boarding of Mental Health Patients](#).

COMMUNICATING RISK OF VIOLENCE

When a patient has a known or suspected risk for violence, the risk must be communicated to those who will come in contact with the patient. Hospitals have communicated risk through one or more of the following methods:

- Flag in the patient record
- Indicator on the patient wrist band
- Flag on the door to the patient's room
- Flag above the patient's bed
- Verbal report of risk with hand-offs
- Verbal report of risk in team huddles

Department of Veterans Affairs: [Management of Disruptive Behavior at VA Medical Facilities](#).

Public Services Health and Safety Association, Canada: [Communicating the Risk of Violence: A Flagging Program Handbook for Maximizing Preventive Care](#)

Providence Health & Services: [Epic "Risk for Violence" Flag](#)

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

BEHAVIORAL AGREEMENTS

Behavioral agreements may be helpful with patients with adequate ability and resources to manage their behavior. Agreements should not use punitive language, but objectively outline expectations for both the patient and staff and be brief, positive and clear. The number and type of warnings or reminders about behavior should be included in the agreement. For the agreement to be effective, staff must be certain to consistently uphold their part of the agreement and hold the patient accountable for their overtime and across shifts.

- End Stage Renal Disease Network – [The Behavior Contract as a Positive Patient Experience](#). Although written with dialysis clinics in mind, the principles outlined in this document are helpful in designing behavior agreements for other care settings.
- Maryland Department of Health – [Recommendations for Use of Patient Behavioral Agreements](#).

BEHAVIORAL CARE PLANS

More common in the behavioral health and long-term care settings, behavioral care plans can be useful in the acute care setting for patients with risk of violence. They provide for consistency in care delivery between care providers and increase staff confidence in caring for patients with risk of violence. The care plan serves as the central source of information on the patient's risk of violent behavior, identified triggers and preferred soothing strategies, as well as the planned interventions to prevent violence. When patients are capable, involving them in developing the care plan can build trust and clarify expectations for both the patient and the care team. Within that collaboration, care team members should feel comfortable setting boundaries and may consider use of a behavior agreement that outlines expectations and consequences.

- Public Services Health and Safety Association, Canada [Triggers and Care Planning in Workplace Violence Prevention](#)
- Community Care (long-term care) [Behavioral Support Plan Tools & Tips](#)
- Kent Challenging Behavior Network [How to Write a Behavior Support Plan](#)
- AHRQ Academy [Develop a Shared Care Plan](#)
- Northwest Aids Education and Training Center [Effective Use of Behavioral Care Plans](#)
- Journal of Psychiatric and Mental Health Nursing (2006) [Managing Aggression in a Psychiatric Hospital Using a Behavioral Plan: a Case Study](#)
- Sample behavior agreements from subject matter expert, Monica Cooke:
 - [Outpatient behavior agreement](#)
 - [Substance user behavior agreement](#)
 - [Patient behavior expectation agreement](#)

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

BEHAVIORAL EMERGENCY RESPONSE TEAMS

Similar to the model of rapid-response teams, behavioral emergency response teams (BERTs) bring specialized resources to patients who are escalating toward violence. Unlike a show of force, BERTs are multidisciplinary teams with advanced training in de-escalation and intervening with violent patients. Debriefing should be conducted after each BERT event to identify potential triggers for violence that could have been mitigated earlier or more effectively to prevent escalation to violence.

- Journal of the American Psychiatric Nurse Association (2010) – [Rapid Response for Behavioral Emergencies](#)
- Nursing Excellence 2020 Magnet-Recognized Organization Success Story – [Building a successful behavioral emergency support team](#)
- Oregon Association of Hospitals and Health Systems Workplace Violence Toolkit -- [Tool 5h – Behavioral Health Rapid Responses Teams \(BHRRTs\)](#)
- PowerPoint slides from presentation by Froedtert Hospital, Wisconsin -- [Practical Implications for Clinical Nurse Specialists in a Behavioral Emergency Response Team](#)
- PowerPoint slides from presentation by Mission Health, North Carolina – [Behavioral Emergency Response Team](#)
- Sample post-event debriefing forms
 - Oregon Association of Hospitals and Health Systems -- [5d Code Grey Debrief Form](#)
 - Comprehensive Unit-based Safety Program – [Learning from Defects Tool](#)
 - Quality Plus Solutions - [Behavioral Health Event Debriefing Worksheet](#)



DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

VICTIMS OF VIOLENCE

In addition to treating violent patients, hospitals routinely treat victims of violence. Through use of screening tools, staff training and referral pathways for further resources and support, hospitals actively can aid victims and help reduce community violence.

Human trafficking is the second-fastest-growing criminal industry in the U.S., second only to drug trafficking.²⁶ In 2010, 85 percent of Tennessee counties reported cases of human trafficking, with 72 percent reporting cases of sex trafficking involving a minor.²⁷

- Tennessee human trafficking hotline: 1-855-558-6484
- U.S. human trafficking hotline: 1-888-373-7888 or text "HELP" or INFO" to 233733
- [Tennessee human trafficking resources](#)
- [National Human Trafficking Training and Technical Assistance Program](#)
- Emergency Nurses Association and International Association of Forensic Nurses Joint Position Statement [Human Trafficking Awareness in the Emergency Care Setting](#)
- Free online training for healthcare professionals on identifying and responding to human trafficking [SOAR for Healthcare](#)
- International Association of Healthcare Security and Safety – [Human Trafficking Victim Identification and Response Within the United States Healthcare System](#)

Intimate partner violence accounts for 15 percent of all violent crime in the U.S. and over 73,000 domestic violence crimes were reported to Tennessee law enforcement in 2014.²⁸

- [Tennessee resources](#)
- [National Resource Center on Domestic Violence](#)
- Emergency Nurses Association and International Association of Forensic Nurses [Joint Position Statement Intimate Partner Violence](#)

The rate of violent crime in Tennessee is significantly higher than national average, with 651.5 incidents per 100,000 persons in 2017 compared to the U.S. average of 394 incidents per 100,000 persons.²⁹

- [Tennessee crime victim support services](#)
- [Tennessee Voices for Victims](#)
- Trauma centers that care for victims of violence should closely follow the proposed [Bipartisan Solution for Cyclical Violence Act](#), which was introduced in the House in 2020 and reintroduced in 2021. The Act, which is supported by the American Hospital Association (AHA), would establish a grant program for eligible trauma centers and nonprofits to establish or expand programs that address intentional violent trauma, excluding intimate partner violence.

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

ADDITIONAL CONSIDERATIONS

PATIENT RIGHTS AND WORKPLACE VIOLENCE

In respect to workplace violence and patient rights, the [CMS Interpretive Guideline §482.13\(e\)](#) must be carefully reviewed. Policies and staff training should clearly define appropriate procedures related to restraint and seclusion, use of weapons (including pepper spray and tasers) and ceding of clinical situations to law enforcement due to the risk of life-threatening injury that cannot be clinically managed. This is of special significance to staff such as security professionals who work in both clinical and law enforcement capacities. Actions that can be taken under their clinical capacity are very different than what can be taken under their law enforcement capacity, and the transition point from clinical to law enforcement must be clearly defined in policy and included in training and competency reviews.

- American Psychological Association (2018) – [Position Statement on Weapons Use in Hospitals and Patient Safety](#)
- International Association for Healthcare Security and Safety Foundation – [Violence in Healthcare and the Use of Handcuffs](#)
- West Journal of Emergency Medicine (2013) – [Medical-Legal Issues in the Agitated Patient: Cases and Caveats](#)

ACTIVE SHOOTER PREPAREDNESS RESOURCES

- International Association of Emergency Medical Services Chiefs (2017) -- [Active Shooter Planning and Response](#)
- The Joint Commission Quick Safety (2021) – [Preparing for Active Shooter Situations](#)
- ASPR TRACIE Technical Assistance Request – [Active Shooter Drills and Evaluation](#)
- Interagency Security Committee Active Shooter Working Group (2015) – [Planning and Response to an Active Shooter: An Interagency Security Committee Policy and Best Practices Guide](#)
- U.S. Department of Homeland Security – [Hospitals and Healthcare Facilities Security Awareness for Soft Targets and Crowded Places](#)

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

SPECIAL CONSIDERATIONS FOR SMALL RURAL HOSPITALS

In 2019, THA held a town hall meeting between small, rural Tennessee hospitals and security experts from Compliance One Group on building a workplace violence prevention plan for their unique setting. In addition to adapting the concepts in this toolkit, Compliance One Group provided the following recommendations:

- Develop a strong, positive relationship with local and county law enforcement. Be sure they know the types of events your hospital is experiencing. Include them in safety meetings, facility risk assessments and strategy-planning. Seek opportunities for joint hospital-law enforcement trainings and drills.
- Frontline staff, providers and supervisors may have limited staff back-up support, particularly at night, so they must be well-trained in de-escalation techniques and the workplace violence prevention plan.
- Consultation with a security expert can be very helpful in developing a strong workplace violence prevention program and staff training plan.

RESOURCES FOR EMS, HOME HEALTH, NURSING FACILITIES AND CLINICS

As with hospitals, other care settings have risk for workplace violence. Home health workers work alone and may travel into communities with high rates of violence. EMS workers serve communities with high rates of violence and take calls to care for victims in volatile situations. Care providers in nursing facilities routinely face challenges from residents with violent behaviors related to altered mentation. Outpatient ambulatory care settings, including clinics and medical practices, are increasingly facing violence. The following resources are available for these care settings.

EMS

- Journal of Emergency Medical Services (2019) – [Protecting EMS Personnel from Assault](#).
- PowerPoint presentation from Piedmont Athens Regional – [It Could Happen to You: Workplace Violence and EMS](#).
- EMS.gov – [Fire and Emergency Medical Services Response to Civil Unrest](#).

HOME HEALTH

- International Association for Healthcare Security and Safety Foundation (2016) – [Best Practices for Preventing Violence in Home Health](#).
- HomeCare article (2020) – [How to Help Employees Avoid Workplace Violence](#).
- Public Services Health and Safety Association, Canada – [Workplace Violence Prevention Toolkit for Home Care](#).

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

NURSING FACILITIES

Many of the recommendations for hospitals apply to the nursing facility setting; however, there are unique challenges to managing aggressive resident behavior due to the prolonged period of time workers will be caring for the resident and regulations on nursing facilities related to pharmacologic treatment of aggressive behavior. The following resources may be helpful.

- iAdvance Senior Care (2013) – [Minimizing workplace violence in LTC facilities.](#)
- TEAMHealth – [7 Best Practices for Managing Difficult Behaviors in Long-Term Care](#)
- Public Services Health and Safety Association, Canada – [Long-Term Care Resources – Workplace Violence Prevention for the Healthcare Sector.](#)

CLINICS AND PHYSICIAN PRACTICES

- Physicians Practice (2015) – [OSHA Focusing on Workplace Violence in Medical Practices.](#)
- Security Magazine on-demand free webinar (2019) – [Workplace Violence Prevention in Ambulatory Care Centers and Physician Offices.](#)
- Campus Safety article (2016) – [Mitigating Workplace Violence at Ambulatory Care Sites.](#)

MANAGING MEDIA

Because a significant violent event could gain community attention, hospitals should be prepared to respond to media. The following resources may be helpful.

- Ultra-Risk Advisors (2015) – [5 Tips for Handling the Media in a Healthcare Crisis.](#)
- American Hospital Association Society for Health Care Strategy and Market Development – [Crisis Communications for Hospitals and Health Systems: A SHSMD Resource Digest.](#)
- Health Care Social Media – [A Three-Stage Approach to Handling a Healthcare Social Media Crisis.](#)

SUMMARY

Development of a well-designed workplace violence prevention program that addresses the needs and gaps identified through risk assessment, and is measured, thoroughly trained, routinely practiced and supported by hospital leadership, strengthens a hospital's position in keeping staff and patients free from harm.

DEVELOPING A WORKPLACE VIOLENCE PREVENTION PROGRAM

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IMPLEMENTING THE WORKPLACE VIOLENCE PREVENTION PROGRAM

STRATEGIES FOR IMPLEMENTATION

Once a hospital has developed its workplace violence prevention program, an implementation strategy is needed. In planning the implementation strategy, hospitals should consider the following:

- What strategies are easy to implement, inexpensive and/or would help win needed buy-in from staff or management?
- What strategies should be piloted prior to house-wide implementation to ensure there are no unintended consequences?
- What strategies need budget approval? What additional information or leadership support is needed for obtaining that approval?
- What strategies are most targeted toward our areas of highest risk and vulnerability?
- What implementation framework or process works well in our organization and which strategies can we implement through that framework?

[Section 7](#) of the Oregon Associations of Hospital and Health Systems' workplace violence toolkit outlines additional considerations for implementation.

In an article in the January 2016 issue of Online Journal of Issues in Nursing, James Blando and associates [outlined seven common barriers](#) to effective implementation of workplace violence prevention programs. They include the following:

- Lack of action resulting from reporting of events.
- Varying perceptions of what constitutes violence and should be addressed and reported.
- Bullying from colleagues or supervisors.
- The impact of money- and profit-driven management models.
- Lack of management accountability.
- Intense focus on customer service.
- Weak social service and law enforcement approaches to mentally ill patients.

While not all barriers may be present at every hospital, integrating this knowledge into the implementation strategy can improve the program's chance for success.

The workplace violence prevention committee should oversee implementation of the program by defining action items, assigning roles and responsibilities, establishing timelines and reviewing progress and effectiveness at regular intervals. Ongoing leadership support is needed, and managers and directors at all levels should be knowledgeable of the workplace violence prevention program and implementation strategy.

IMPLEMENTING THE WORKPLACE VIOLENCE PREVENTION PROGRAM

Hospitals may wish to involve their marketing department in designing a tag line or theme to the workplace violence prevention program, such as the South Carolina Hospital Association's [Hospital Safe Zones](#) and their posters with memorable taglines such as, "You Report. We Support." See the example of [Medical University of South Carolina](#).



WORKPLACE VIOLENCE PREVENTION PROGRAMS ARE COMPLEX AND MULTI-FACETED AND TAKE TIME TO FULLY IMPLEMENT. OVERSIGHT AND MONITORING BY THE WORKPLACE VIOLENCE PREVENTION COMMITTEE AND CONSISTENT SUPPORT FROM DEDICATED LEADERSHIP WILL ENSURE ITS SUCCESS.

AHRQ (Agency for Healthcare Research and Quality) [System-Focused Event Investigation and Analysis Guide](#) is written in the context of medical harm but describes a process for conducting in-depth investigations that apply to events of all types.

American Hospital Association [Hospitals Against Violence](#) contains resources on reducing violence both in the workplace and the community as does their [Workforce and Workplace Violence Prevention](#) site. Hospitals Against Violence holds [#HAVhope Friday](#) the first Friday of June, a day for spreading social media awareness on ways communities come together to combat violence and racism.

American Nurses Association - [#EndNurseAbuse](#) campaign with downloadable resources.

[ASPR TRACIE](#) (Office of the Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center and Information Exchange) offers resources on emergency preparedness that have application to workplace violence.

The Institute for Healthcare Improvement's [Centering a More Holistic View of Workforce Safety](#) provides six key principles that help organizations go beyond physical safety to address workforce safety more holistically.

The [November 2018 issue](#) of Review, a publication of the Virginia Hospital and Healthcare Association, is devoted to addressing workplace violence in healthcare.

[Stop the Bleed](#) is a national awareness campaign from the U.S. Department of Homeland Security. The campaign encourages bystanders to become trained, equipped and empowered to help in a bleeding emergency such as could occur with a mass shooting.

[Sample hospital policy](#) on searching non-behavioral health patients for contraband.

American Society for Health Care Risk Managers (ASHRM)/American Hospital Association (AHA) white paper series:

- [Behavioral Health Care in the Emergency Department Setting](#)
- [Behavioral Health in the Ambulatory/Outpatient Setting](#)

[Key Considerations to Defuse an Angry or Upset Patient](#) – A one-page reference guide drawn from a Hospital News [article](#).

INNOVATIONS IN WORKPLACE VIOLENCE PREVENTION

- [LifeSafe Platform](#) – A mobile app for quick reporting of safety concerns, communication with security, access to security resources, provision of a virtual escort and more.
- Lippencott Nursing Center article – [Behavioral challenges: A novel approach to mental health workers in medical nursing](#)
- [Knightscope Security Robots](#) – Hospitals in Texas are piloting socially intelligent security robots to aid with patrols and extend hospital security surveillance. The robots are over five feet tall, weigh 400 pounds and are equipped with 360-degree cameras, thermal imaging, license plate recognition, a siren and strobe light, and a two-way communication system. Painted with attractive designs and given cute names, the robots are popular with the public. See an example from [Texas Children’s Hospital](#).

RELEVANT JOURNALS

- [Campus Safety](#)
- [Journal of Healthcare Protection Management](#)
- [Workplace Health and Safety](#)

EXAMPLES AND RESOURCES FROM OTHER HOSPITALS

- [Grady Health System, Atlanta, GA](#) building a workplace violence program.
- Ann and Robert H. Lurie Children’s Hospital of Chicago taking a lead in reducing community violence through its [Strengthening Chicago’s Youth program \(recorded webinar\)](#).
- [Piedmont Athens Regional](#) developing a comprehensive workplace violence program.
- Jacobi Medical Center [Violence Reduction Program](#) forms and protocol.
- [Sample workplace violence policies](#) Western Connecticut Health Network.
- Via Christi Hospitals Wichita [student orientation guide](#) that includes a section on security and safety.
- Study from Michigan State University Medical Center on a [worksite walkthrough intervention](#) to prevent workplace violence on hospital units.

CONCLUSION

Hospitals can help prevent workplace violence-related harm by establishing a workplace violence prevention program. Key elements of an effective program include:

- Conducting baseline and ongoing risk assessments.
- Establishing a workplace violence prevention team that designs and maintains a written workplace violence prevention plan.
- Implementing strategies to address each area of identified risk.
- Training providers and staff in the workplace violence prevention plan and skills specific to their work area and level of risk.
- Maintaining provider and staff competency through routine drilling, refresher training and post-event debriefings.
- Monitoring event data and other metrics to ensure program effectiveness.
- Working with community organizations to recognize and treat victims of violence and help prevent community violence.

This guide provides information on best practices and resources to aid hospitals in the development or improvement of their workplace violence prevention program. It is updated regularly. For questions and information regarding this guide, contact [Rhonda Dickman](#) at THA, 615-401-7404.