HHS Public Access

Author manuscript

J Healthc Prot Manage. Author manuscript; available in PMC 2023 August 23.

Published in final edited form as:

J Healthc Prot Manage. 2017 ; 33(1): 89–105.

Workplace violence and hospital security programs: regulatory compliance, program benchmarks, innovative strategies

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Abstract

The authors describe the issue of workplace violence in hospitals, a New Jersey state law and regulations regarding workplace violence in healthcare, and some innovative strategies that are being utilized to help reduce the occurrence and risk of violence. The authors also discuss compliance with the New Jersey regulations.

INTRODUCTION

High profile and widely reported violent acts occurring in hospitals have elevated public and employee awareness about security and safety in hospitals and healthcare in general (e.g. CBS News, 2014). The Bureau of Labor Statistics (BLS) recently reported that healthcare workers had more than twice the incidence of injuries with days away from work resulting from violence compared to the overall workforce (BLS, 2015). Among healthcare and social assistance workers in the public sector the incidence of injuries requiring time away from work was more than 20 times that of the overall workforce (BLS, 2015). Nine states have passed regulations requiring workplace violence prevention measures in hospitals (GAO,

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2016). In the Spring of 2016, the Occupational Safety and Health Administration (OSHA) published a pre-rule stage request for information titled “Preventing Workplace Violence in Healthcare”. Labor organizations also petitioned the U.S. Department of Labor for a federal OSHA Workplace Violence Prevention Standard for the healthcare and social assistance industries.

In 2008, New Jersey passed the Workplace Violence Prevention (WVP) in Healthcare Facilities Act (2008) and promulgated regulations in 2011 (NJ Workplace Violence Prevention in Healthcare Facilities, 2011). These regulations include specifications for a WVP program that encompasses training, a written policy, incident reporting, violence risk assessment, and worker participation.

The training requirements specifically stated in the regulations require the following:

1. all employees should receive at least 2 hours of workplace violence prevention training, offered annually with interim training for employees who begin work between the annual training offerings
2. employees attend training on paid work time
3. the training should be offered in easily understandable terminology and if more than 10% of the staff speak a language other than English, the training should be offered in their native language
4. the training must cover ethnic and cultural diversity
5. the training must cover specified topics in the regulation such as de-escalation techniques, and
6. the training must include an overview of the most recent risk assessment survey conducted for workplace violence and details on any preventative actions taken.

The policy specifications of the regulations require:

1. the establishment of a WVP committee with a designated chairperson that oversees all aspects of the WVP program
2. the development and distribution of a written workplace violence prevention plan
3. prohibition on retaliatory action against employees who report concerns, and
4. recordkeeping requirements.

Reporting and Assessment elements of the regulations require:

1. an investigation of any incident and written documentation of specific information required by the regulations (e.g. date, time, duties at time of incident, etc.)
2. prevention measures should be stipulated
3. all victim identifiers must be confidential
4. an annual assessment of violence risk including a walkthrough survey of all areas of the hospital, and

5. a job task analysis for each healthcare worker.

Worker participation is encouraged through the regulatory requirement that at least 50% of the workplace violence prevention committee contain direct patient care staff and that the annual violence assessment walk-through surveys be conducted with at least one direct patient care staff member.

Violence and fear can significantly affect the operations of a hospital. If a hospital experiences violent incidents and does not respond effectively, the quality of care decreases, employee turnover rises, and fewer people will seek care at the facility by choosing to go to a competing hospital instead (Jackson et al. 2002, Hegney et al. 2010, Gates et al. 2011, McNamara et al. 1997, Meyer et al. 1997, Mattox et al. 2000, The Joint Commission, 2012). Despite these consequences, many hospital executives undervalue their security programs and view these programs as overhead, often citing budget limitations and a need for a customer friendly atmosphere as significant barriers to implementing a comprehensive security program (Blando et al; 2014).

Research has also suggested that the crime rate in the community surrounding the hospital may not be the most important predictor of injury among staff from violence, but rather the comprehensiveness of the security program may be a more important predictor of employee risk (Blando et al., 2012). In other words, data suggests that the implementation of a strong security program reduces the risk of injury to employees from violence, perhaps more than any other single factor (Blando et al., 2012). Employees at hospitals located in communities with low crime rates may still be at significant risk because of the stressful situations encountered in providing healthcare.

For example, we abstracted a case in a low crime community of an elderly security guard who had his neck fractured during an incident identified as workplace violence on the OSHA log, which was reviewed as part of the Blando et al. (2012) survey. During the review of the OSHA log for this survey, the hospital CEO provided great detail of this particular incident because he felt this was necessary and it was recorded by the survey team as an independent case report in an effort to capture all the details that were reported (Blando, 2005 unpublished case report). This altercation between brothers occurred because one brother did not notify the other that their father had a heart attack. The security guard was not trained to de-escalate these types of situations and was not able to prevent the physical violence causing his injury (Blando, 2005 unpublished case report). The hospital CEO struggled with this event and kept stating during our discussion of the OSHA log data that “they just didn’t think they really needed security because it is so beautiful and peaceful in our town”.

This paper is a summary of information collected from interviews conducted with 35 individuals representing the safety and security departments of 52 New Jersey hospitals. Details are provided in Blando et al. (2017). In summary, participants were recruited from a sample of 93 New Jersey hospitals including general acute care, trauma and psychiatric hospitals. A semi-structured face-to-face interview was used that focused on the security director’s opinion, beliefs, background, and their implementation of the WPV program. The semi-structured interview was pilot tested and validated and interviews were conducted by

trained staff. SPSS (IBM Corporation, Armonk, New York) was used to compute descriptive statistics such as frequencies, percentages, and standard deviations after the data was coded by the project investigators.

This project was approved by the Institutional Review Boards (IRB) of Old Dominion University, University of North Carolina-Chapel Hill, and the National Institute for Occupational Safety and Health (NIOSH) and verbal informed consent was obtained prior to the conduct of all interviews. The overall goal of the project was to describe hospital experiences with the New Jersey Violence Prevention in Health Care Facilities Act and to learn of effective and innovative ideas that have been implemented in hospitals. This report is subjective in nature and subject to personal bias due to the opinions and beliefs of survey participants and is not intended to serve as definitive evidence. Readers are encouraged to critically evaluate the information presented in this summary.

SECURITY DIRECTOR CHARACTERISTICS

This project collected data on the opinions, expertise, and experiences of those implementing programs in the “real world”. As such, the Chairperson of the workplace violence prevention (WVP) committee (or their designee, often the Security Director) completed a face-to-face interview with a member of the research team. Interviews were conducted between August 2012 and July 2014, which is after the NJ regulations were officially in effect and compliance was legally required. The person interviewed, either the WVP committee chair or their designee, was the person with the functional knowledge of the WVP program. This means that the interviewee was the person responsible for overseeing the WVP program and also managing the functions of the program. The average time in their current position among the survey participants was eight years, ranging from one to 28 years. They had served as WVP Committee chairperson on average for four years. In many cases, the WVP committee existed before the regulations became officially effective because some hospitals created their committees in anticipation of their compliance requirements. Twelve individuals were responsible for more than one hospital in their healthcare system.

Table one demonstrates that almost half (49%) of those interviewed reported that they had been previously employed in law enforcement, either as command staff or officers. Other employment history background included positions in Hospital Administration/Management (31%), Security (20%) and/or Patient Care/Healthcare (14%). Three individuals (9%) held an advanced degree including an MBA and/or PhD. Having a background in law enforcement was also the most frequent response when asked to describe their background in security and developing security programs, while 17% reported relying on “on the job training” or having no background in security or developing security programs.

SECURITY SERVICES

The most commonly reported organization of the security services in participating hospitals was an in-house team managed by the Security Department (75%) (Table 2). Few hospitals (10%) in this survey reported contracting their security services to a private agency. The

number of security officers varied by hospital size and location with a range of 4-200 officers. More than half (56%) of the hospitals in this survey had 50 or more security officers, and often included both part-time and full-time officers.

Sixteen security directors were asked their opinion about the quality of in-house and contract security guards. Most (n=14) felt that in-house security staff performed better than contract security services, while two were ambivalent. One security director suggested that budget and administrative needs should be factored into the final decision about the organization of the security program. Another noted that healthcare systems that consisted of multiple hospitals had enhanced flexibility because they had a pool of security officers from which to draw upon when unexpected needs arose. Officers could be pulled from one facility to another with short notice, which provides flexibility to ensure proper staffing of hospitals.

During the interviews, six security directors discussed their facility's policies on physical contact between guards and patients/visitors. During these discussions about "hands on" approaches only one security director reported having explicit policies that prohibited physical contact between guards and patients/visitors. Three security directors who participated in the interviews indicated that former police officers were, in their view, not necessarily the best guards because they felt these retired officers had difficulty making the distinction between law enforcement and the more customer-centered approach required in hospital security departments. However, two security directors strongly indicated that retired police officers are the best option when possible.

Many security departments are actively involved with preparations and planning for an active shooter scenario. Security directors in our study were very mixed in their attitudes and beliefs regarding the presence of guns among security officers patrolling the facility. One security director felt this was necessary, three had no opinion but were considering allowing firearms among security staff, and four felt this was dangerous. Those security directors who explicitly objected to guns being present in the hospital cited the potential for escalation to deadly force and the potential for an officer to lose control of their weapon during an altercation. One interviewee, who was a retired police officer that carried a gun, told a story where he was involved in a physical incident in their emergency department where he did not feel confident that he could retain control of his gun in the holster beneath his jacket. In the security setting the guard's goals are not simply rule enforcement but also to assist the medical team in restraining combative patients and as such this can potentially leave the guard in possession of a gun vulnerable to loss of control.

KEY OBSERVATIONS & BENCHMARKS

Regulatory Compliance

This survey was conducted in New Jersey, which has statewide regulations regarding workplace violence in healthcare settings as a result of the passage of the Violence Prevention in Healthcare Facilities Act. Information collected during our interviews demonstrated that program deficiencies were common when benchmarked to the Violence Prevention in Healthcare Facilities regulations. For example, the NJ regulations require that all employees receive two hours of workplace violence prevention training annually,

however, only 40% of the hospitals that provided data actually provided this amount of training. In addition, only 34% of hospitals had workplace violence prevention committees that functioned as the regulations intended. Although many hospitals had committees, the interviews indicated that many of these committees functioned informally and on an adhoc basis without a clearly identified mandate.

The regulations require that the committee systematically review training, security risk assessments, plans and policies, risk factors, reporting systems, and make recommendations for improvements. In addition, the committee should also review data and trends to assess the effectiveness of their program. In many cases, these comprehensive committee activities were not performed, but rather the committee would informally discuss whatever topic came to mind at the time of the meeting. The regulations also required that healthcare facilities conduct an annual comprehensive violence risk assessment. Our survey found that 83% of the hospital(s) conducted a comprehensive risk assessment, and 77% conducted these assessments annually, as required in the regulations. As such, 17% did not conduct a comprehensive assessment that incorporated the OSHA, 2004 Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers (OSHA, 2004; updated OSHA, 2015), as required by the regulations. Our survey also found that 56% of the facilities surveyed utilized data to assess trends in violent incidents and security responses, as the regulations required.

Workplace Violence Prevention Training

Training was frequently listed by those interviewed as one of the strengths of the regulations and as one of the most beneficial aspects of the hospital's workplace violence prevention program. Most hospitals (85%) offered differentiated levels of training; i.e. employees in high risk areas received more or specialized training. The standardized training programs most frequently used included Crisis Prevention Institute (CPI, Milwaukee, WI) (40%), Handle with Care (Handle With Care Behavior Management System, Inc., Gardiner, NY) (42%) and Management of Aggressive Behavior (MOAB® Training International, Inc, Kulpsville, PA) (10%) (Table 3). There was a wide variation in length of training sessions; training could take anywhere from 10 minutes to four hours. Approximately one quarter (23%) of the hospitals or 40% of those who provided training data had training that lasted at least two hours. In particular, knowledge of de-escalation techniques were specifically identified as helpful by 14% of the security directors. Many security directors felt that de-escalation techniques were particularly useful for behavioral health staff, emergency department staff, substance abuse center staff, and security officers.

A number of security directors (23%) reported their belief that while training is highly valued, the training required by the regulations was too burdensome and too in-depth because they required all staff to receive comprehensive training, which they felt was not necessary. They also mentioned that the required in-depth training was too lengthy. As such, these security directors felt that more targeted in-depth training to those staff at highest risk would be more effective than a blanket requirement for everyone. However, some basic level of simple awareness training might be justifiable for all staff. A web-based self-paced training that could be used is a free on-line course developed by NIOSH,

Workplace Violence for Nurses, which offers the opportunity to earn 2.6 free continuing nursing education units (Workplace Violence for Nurses, 2013).

WORKPLACE VIOLENCE PREVENTION COMMITTEE AND PLAN

The NJ regulations require that every applicable healthcare facility has a workplace violence prevention committee that has half the committee composed of staff with direct patient contact and meets at a minimum every quarter. Fifty (96%) of the hospitals surveyed in New Jersey had a Violence Prevention Committee. Eight of the 35 (23%) interviewees had WVP committees with less than 50% of members having clinical duties. The frequency of meetings for these committees varied. Forty percent of the hospitals had committees that met 6 times or more per year and another 34% held meetings quarterly, while 26% met less than the quarterly requirement of the regulations (Table 4).

Security directors identified a variety of sources used by the committee to develop their hospital's workplace violence prevention plan. The most frequently cited sources included the 2011 NJ Violence Prevention in Health Care Facilities Regulations (89%), Occupational Safety and Health Administration (OSHA, 2004; 2015) Guidelines for Security and Safety of Health Care Workers (54%), the Joint Commission (JCAHO, 2012) Standards (33%), New Jersey Hospital Association (NJHA) (14%), and the National Institute for Occupational Safety and Health (NIOSH) (10%) (Table 4). Respondents also used peer input (17%) and relied on professional journals (12%) and internet resources (8%).

INNOVATIVE OR UNIQUE EMPHASIS IN PROGRAMS

The security directors surveyed in this project reported several program elements that they felt were particularly effective in preventing workplace violence. As such, many of our security directors emphasized these elements in the security program at their healthcare facility. Trending and following violent event data was reported as an important aspect of an effective violence prevention program. It was clear to our participating security directors that effective reporting is a precursor to awareness and enables early detection of potential problems. In addition, several security directors indicated that report writing and documentation of investigations involving violent incidents was crucial for security guards. Discussion of violent events in post-event debriefing were also reported as extremely helpful by 17% of our security directors because this de-briefing allows for a detailed assessment of the causes and consequences of an event. This also allows for the effective development of interventions to prevent similar events from occurring in the future. Interestingly, cameras or surveillance systems were not frequently mentioned as helpful features for violence prevention but six security directors suggested that they are useful for documentation purposes.

Security directors also reported some aspects of their programs that they felt were very helpful and innovative. For instance, several facilities had developed the ability for secure remote video feeds so that supervisors can view cameras and situations in realtime when not on site. One facility utilized this remote access feature to eliminate the need for a guard in the command center at a satellite location, as the video feed went directly to the command

center at the flagship hospital. Another facility utilized secure remote access cameras to reduce costs associated with “one-on-one” patient observers. Using the cameras allowed one patient observer staff member to simultaneously view multiple patients, thereby reducing the number of staff needed for “one-on-one” observation. However, patient confidentiality was a factor they had to carefully consider. Several security directors also indicated that their practice of checking hospital registrations before giving visitor badges was very useful to allow better access control among visitors. Security officers quickly checked to determine if the person a visitor was requesting to see was actually in the hospital, where they were located, and if there were restrictions or restraining orders before giving visitor passes.

CONCLUSION

Many hospitals and security programs that were the focus of this survey are taking important steps in the prevention of workplace violence. Despite the fact that every security director would like a larger budget and more resources, cost was not identified as a primary barrier to implementation of the workplace violence prevention program or training. While significant progress has been made, additional efforts are necessary and should result in continuous improvement that will protect healthcare employees, patients and visitors, and the healthcare organization. Several interesting approaches highlighted in this report may be of interest to workplace violence prevention committees and security directors as they work on furthering the goal of a safer and healthier workplace.

Acknowledgements

This research was supported by the National Institute for Occupational Safety and Health (Contract # 212-2012-M-51289).

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“In addition, citations to websites external to NIOSH do not constitute NIOSH endorsement of the sponsoring organizations or their programs or products. Furthermore, NIOSH is not responsible for the content of these websites. All web addresses referenced in this document were accessible as of the publication date.”

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Table 1.

Characteristics of Interviewees (n=35)

	Mean	SD
Years in Position (Range 1-28)	8.17	5.623
Years as Chairperson (Range 1-11) of the Violence Prevention Committee	3.92	2.3
Years in position	**n**	**%**
<5 years	9	26
5-10 years	15	43
>10 years	11	31
Cover more than one hospital?		
No	23	66
Yes	12	34
Background in Law Enforcement		
Yes	17	49
No	18	51
Previous Employment (multiple responses allowed)		
Law Enforcement	17	49
Hospital Admin/Management	11	31
Security	7	20
Patient Care/Healthcare	5	14
Advanced Degree	3	9
Management (Not Healthcare)	3	9
Background in security and developing security programs (multiple responses allowed)		
Law Enforcement	17	49
None	6	17
On the Job Training	6	17
Attend training	5	14
Hospital Security >10 years	4	11
Security (Non Healthcare)	3	9

	Mean	SD
Military (Not MP)	3	9

Table 2.

Security Service Characteristics (n=52 hospitals)

Average number officers per hospital	64.6	
Standard deviation average#	52.5	
Total # of Officers	**n**	**%**
<25	9	17
25-49	13	25
50-100	20	39
>100	8	15
missing	2	4
Security Department Organization	**n**	**%**
In-House (managed by Security)	39	75
Contracted to Private Agency	5	10
Both In-House and Contract	6	12
Other: Federal Police	2	4

Table 3.

Characteristics of WPV Prevention Training (n=52 hospitals)

	n	%
Training Frequency		
Annual	43	82
Initial only	4	8
Every other year	1	2
Unknown	4	8
Package programs used		
Crisis Prevention Institute	20	40
Handle With Care	22	42
Management of Aggressive Behavior	5	9
No package used	5	9
Differentiated Training Offered		
Yes	44	85
No	5	10
missing	3	5
Training length		
≤30 minutes	5	10
> 30 and ≤ 60 min	6	12
120 min	12	24
240 min	7	14
Missing	20	40

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Table 4.

Characteristics of Workplace Violence Prevention (WVP) Program (n=52 hospitals)

	N	%
WVP Committee Meeting Frequency		
Greater than or equal to 6X Year	20	40
Quarterly [4X year]	17	34
Less than 4 X year	7	14
Missing	6	12
WVP program uses data to evaluate trends		
Yes	29	56
No	6	12
Not specified	17	32
Resources used to develop WVP plan (multiple responses allowed)		
NJ Violence Prevention in Health Care Facilities Regulations[1]	46	89
OSHA Guidelines for Security and Safety of health Care Workers[2]	28	54
JCAHO[3]	17	33
Peer input	9	17
NJHA[4]	7	14
Professional Journals	6	12
National Institute for Occupational Safety and Health (NIOSH)[5]	5	10
American Society for Industrial Security (ASIS)[6]	4	8
Internet Resources	4	8
NJDHSS final report on hospital security[7]	3	6
Other	8	15

See reference list:

[1] NJ Violence Prevention in Health Care Facilities Regulations, 2011.

[2] OSHA 2004, 2015.

[3] JCAHO, 2012.

[4] New Jersey Hospital Association, www.njha.com

[5] NIOSH, www.cdc.gov/niosh

[6] ASIS, https://www.asisonline.org/Pages/default.aspx

[7] Peek-Asa et al. 2007