Record: 1

Title: Workplace Violence Prevention Policies in Home Health and Hospice Care Agencies.

Authors: Gross, Nathan *nathan-gross@uiowa.edu*
Peek-Asa, Corinne[1] *corinne-peek-asa@uiowa.edu*
Nocera, Maryalice[2] *mnocera@email.unc.edu*
Casteel, Carri[3,4] *ccasteel@email.unc.edu*

Source: Online Journal of Issues in Nursing. Jan2013, Vol. 18 Issue 1, p1-1. 1p.

Document Type: Article

Subject Terms: *HOME care services
*PREVENTION of violence in the workplace
*HOSPICE care
*WORK environment
*DECISION making
*EXECUTIVES
*INTERVIEWING
*MANAGEMENT
*QUESTIONNAIRES
*OCCUPATIONAL hazards
*CROSS-sectional method
*DESCRIPTIVE statistics
*SOCIETIES

Geographic Terms: CALIFORNIA

Author-Supplied Keywords: home health
hospice care
violence prevention
Workplace violence
workplace violence prevention program

Company/Entity: UNITED States. Occupational Safety & Health Administration

NAICS/Industry Codes: 624120 Services for the Elderly and Persons with Disabilities
621610 Home Health Care Services
621390 Offices of all other health practitioners
621399 Offices of All Other Miscellaneous Health Practitioners
623110 Nursing Care Facilities (Skilled Nursing Facilities)
926150 Regulation, Licensing, and Inspection of Miscellaneous Commercial Sectors

Abstract: Workplace violence in the home health industry is a growing concern, but little is known about the content of existing workplace violence prevention programs. The authors present the methods for this study that examined workplace violence prevention programs in a sample of 40 California home health and hospice agencies. Data was collected through surveys that were completed by the branch managers of participating facilities. Programs were scored in six different areas, including general workplace violence prevention components; management commitment and employee involvement; worksite analysis; hazard prevention and control; safety and health training; and recordkeeping and program evaluation. The results and discussion sections consider these six areas and the important gaps that were found in existing programs. For example, although most agencies offered workplace violence training, not every worker performing patient care was required to receive the training. Similarly, not all programs were written or reviewed and updated regularly. Few program differences were observed between agency characteristics, but nonetheless several striking gaps were found. [ABSTRACT FROM AUTHOR]

Copyright of Online Journal of Issues in Nursing is the property of American Nurses Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use. This abstract may be abridged. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material for the full abstract. (Copyright applies to all Abstracts.)

Author Affiliations: [1]Associate dean for research for the College of Public Health, University of Iowa
[2]Project Director, University of North Carolina (UNC) Injury Prevention Research Center
[3]Research Associate Professor of Epidemiology, University of North Carolina at Chapel Hill (UNC)
[4]Associate Director, UNC Injury Prevention Research Center.

Full Text Word Count: 5207

ISSN: 1091-3734

DOI: 10.3912/OJIN.Vol18No01Man01

Accession Number: 85342801

Database: Academic Search Complete

Workplace Violence Prevention Policies in Home Health and Hospice Care Agencies

Workplace violence in the home health industry is a growing concern, but little is known about the content of existing workplace violence prevention programs. The authors present the methods for this study that examined workplace violence prevention programs in a sample of 40 California home health and hospice agencies. Data was collected through surveys that were completed by the branch managers of participating facilities. Programs were scored in six different areas, including general workplace violence prevention components; management commitment and employee involvement; worksite analysis; hazard prevention and control; safety and health training; and recordkeeping and program evaluation. The results and discussion sections consider these six areas and the important gaps that were found in existing programs. For example, although most agencies offered workplace violence training, not every worker performing patient care was required to receive the training. Similarly, not all programs were written or reviewed and updated regularly. Few program differences were observed between agency characteristics, but nonetheless several striking gaps were found.

Citation: Gross, N., Peek-Asa, C., Nocera, M., Casteel, C., (January 31, 2013) "Workplace Violence Prevention Policies in Home Health and Hospice Care Agencies" OJIN: The Online Journal of Issues in Nursing Vol. 18, No. 1, Manuscript 1.

Key words: Workplace violence; home health; violence prevention; workplace violence prevention program; hospice care

Household risk factors for violence can include the presence of weapons in the home, illicit drug use, and family violence.Workplace violence is a growing concern for the home health care industry and its workers. Although precise rates of violent events specific to the home health care industry are unavailable, it has been well established that health care workers in general, and specifically those in the nursing profession, experience high rates of violence compared to most other industries (BLS, 2010; Duhart, 2001; Gacki-Smith et al., 2009). The home health care industry in particular carries unique risks and hazards compared to other health-related fields. Because home health care workers provide care in the home of the client, the environment is uncontrolled and more highly varied than that of a traditional health care facility. Household risk factors for violence can include the presence of weapons in the home, illicit drug use, and family violence. In addition, home health workers are not only at risk from the household hazards of the client, but from the surrounding community as well, which can include robbery, car theft, and vandalism.

In order to promote the safety and security of workers in the field, it is extremely important for employers to have a comprehensive workplace violence prevention program.In order to promote the safety and security of workers in the field, it is extremely important for employers to have a

comprehensive workplace violence prevention (WVP) program. In 1993, the state of California introduced guidelines designed to help ensure the security and safety of health care and community service workers (California Occupational Safety and Health Administration [Cal/OSHA], 1993). These guidelines detailed essential program elements that, when implemented, required participation throughout all levels of an organization. According to Cal/OSHA (1993), the elements of a comprehensive WVP program include environmental modifications; work practice changes; implementation of policies and practices; training; use of security and law enforcement; management commitment; risk assessments and integration with the security program; and surveillance of violent events (Cal/OSHA, 1993).

Since these recommendations were issued, several studies have emerged that support the need for comprehensive WVP programs as described in the California recommendations. While some studies have shown that WVP programs have effectively reduced the risk for violent events (McPhaul, Lipscomb, & Johnson, 2010), others have demonstrated that WVP programs can improve staff perceptions regarding their own safety (Sylvester & Reisener, 2002), and increase staff retention (Morris, Krueger, & Yaross, 2004). While several studies have examined home health care worker concerns and demonstrated the effectiveness of individual WVP program components, no studies have examined the overall WVP program contents of home and hospice care agencies using the California guidelines as a model.

This article presents a study that examined workplace violence prevention programs in a sample of 40 California home health and hospice agencies. The purpose of this study was to identify the most commonly used workplace violence program elements. Six different areas were scored, including general workplace violence prevention components; management commitment and employee involvement; worksite analysis; hazard prevention and control; safety and health training; and recordkeeping and program evaluation. The results and discussion sections consider these six areas and describe important gaps that were found in the existing programs.

Study Methods

Design

This study was a cross-sectional survey of Northern California home health and hospice agencies. The Cal/OSHA guidelines were used to guide the development of the survey. The WVP program elements as described in the Cal/OSHA guidelines included management commitment and employee involvement; worksite analysis; hazard prevention and control; safety and health training; and recordkeeping and program evaluation. The general objective of the Cal/OSHA Guidelines is for health care organizations to adapt a comprehensive workplace violence prevention program that is responsive to their individual environments.

Population and Sample

The population of agencies was identified from a list of licensed facilities maintained by the California Office of Statewide Health Planning and Development (OSHPD). The study was approved

by the University of Iowa Institutional Review Board. A stratified sample of agencies was then drawn to represent agency organization (non-profit public, non-profit private, for-profit). Seven agency administrators were contacted, of which six agreed to participate. Two of the agencies were for-profit, two were nonprofit-private, and two were nonprofit-public. There were 43 branches within the six agencies, employing approximately 1,450 workers who provided in-home patient care.

Branch managers were recruited by phone for study participation. Forty (93%) of the branch managers participated, representing 20 home health branches, 11 hospice branches, and 9 combined home health with hospice branches.

Data Collection

Information about the workplace violence policies and procedures was collected using a telephone interview conducted with the branch manager. Branch managers also completed a self-reported survey. Data from branch managers were collected between January 2007 and March 2009.

Data collected included information about current policies and procedures regarding violence prevention; type and content of workplace violence prevention training provided to employees; and management attitudes toward violence prevention practices. The phone interview took approximately 30 minutes to complete. The six scored areas are discussed below.

The first survey questions asked about the overall WVP program. These included the presence of a program in general, whether or not the program was written, and several basic program elements such as zero tolerance policies and the encouragement of employee reporting.

Management commitment and employee involvement are mechanisms by which the organization works together to implement an effective program. Measures included participation of management in drafting and maintaining policies; formation of a safety committee including management and employees; establishment of medical and psychological counseling and debriefing for employees after violent incidents; and continual employee feedback to identify and reduce workplace violence hazards. Worksite analysis assessed how well an agency's policies informed home health workers of potential hazards. Measures included providing employees with behavioral history of new patients, and providing employees with information on criminal activity in the household or neighborhood before the first visit. Information on patient and local history may include substance abuse, mental illness, criminal activity, or previous violent behaviors.

The hazard prevention and control section examined strategies used by a facility to protect workers before, during, and after visits. Measures included WVP program reviews based on reports and trends; the presence of policies designed to protect workers on visits such as using a buddy system and/or security escort; keeping a contact person informed of employee whereabouts; and having the option to end visits early if the environment was interpreted as hazardous. The safety and health training offered by participating agencies was evaluated by assessing who received training, when training was provided, and the content of the training. The agency's record keeping and program

evaluation was scored by evaluating the system for reporting violent events and how the agency evaluated its own policies after the occurrence of a violent event.

Analysis

The comprehensiveness of the participating agencies' WVP programs was measured for the general factors and within the five categories of management commitment and employee involvement; worksite analysis; hazard prevention and control; safety and health training; recordkeeping and program evaluation. Points were awarded based on the presence of each WVP program element. Equal weight was given to each program element because no evidence was available to suggest that certain components of a program contribute more to its effectiveness. Scores were then compiled within each category to create six unit scores, and summed across all six categories for an overall composite score. Descriptive statistics were calculated for the compiled responses and Mann-Whitney U tests were used to compare the mean unit scores for each WVP program element. Mean unit scores were compared based on the entity type and entity relation of the participating agency.

Results

Workplace Violence Prevention Program

Overall, only 22 (55%) of the 40 participating agencies reported having a comprehensive WVP program. Overall, only 22 (55%) of the 40 participating agencies reported having a comprehensive WVP program (Table 1). Of the 22 agencies that did have a WVP program, 20 agencies stated that their program was written; 18 stated that their program contained descriptions of roles and responsibilities following violent events; 20 incorporated methods to involve both managers and workers; and only 14 reported that their program was regularly reviewed and updated. Interestingly, although 22 agencies reported having a program, 23 agencies stated that they had a zero tolerance policy for workplace violence and 32 stated that policies were in place to protect employees reporting violent events. No significant differences were observed when comparing the mean Workplace Violence Prevention Program unit scores between the entity types or the entity relations.

Worksite Analysis

The most commonly assessed hazard was the presence of pets in the householdThe most commonly assessed hazard was the presence of pets in the household, with 35 (87.5%) of the agencies stating that this hazard was evaluated (Table 2). Eighty percent or more agencies reported assessing patient history of mental illness and firearms in the home. Violence in the household (67.5%), illegal activity (67.5%) and criminal activity in the neighborhood (52.5%) were the least frequently assessed hazards.

Hazard Prevention and Control

All 40 participating agencies reported using the protective strategy of ending home visits early if adverse situations were to arise.All 40 participating agencies reported using the protective strategy of ending home visits early if adverse situations were to arise (Table 3). Less prevalent however, were the protective strategies of informing a contact person of whereabouts at all times (n=6, 15%); protecting workers while conducting home visits after dark (n=19, 47.5%); and using police or security escorts during home visits (n=19, 47.5%). Thirty-six (90%) of the agencies had a buddy system in place, in which a co-worker could accompany the care provider to in-home visits. While 31 (77.5%) of the agencies had policies and procedures in place to protect workers from violent or aggressive patients, only 24 (60%) had policies to protect workers from violent or aggressive household members or visitors, and 20 (50%) had policies to protect workers from violence in the community outside of the home. Only 3 (7.5%) of the agencies had policies and procedures to protect workers from intimate partner violence while on the job, and 4 (10%) agencies had policies to protect workers from violence while caring for mentally ill or psychiatric patients.

In examining WVP program review practices, we observed that 19 (47.5%) of the agencies reviewed staff needs related to workplace violence risk, 14 (35%) examined trends and patterns of violent events, and 18 (45%) provided information about hazards and prevention practices to their workers.

Safety and Health Training

Several striking gaps were found in Safety and Health Training programs. Only 23 (57.5%) of the participating agencies reported that WVP training was offered to their employees (Table 4). Of the 24 agencies that offered WVP training, only 18 offered training to new employees and 6 required training for every employee participating in patient visits. Similarly, of the 24 agencies offering training, 14 included content on factors predicting violence and aggression; 16 provided training on characteristics of aggressive and violent patients and families; 15 included content on the characteristics of hazardous households; and 14 included content on hazardous neighborhoods. Fourteen of the 24 agencies offering WVP training included verbal methods to diffuse aggressive behavior, 12 taught physical maneuvers to diffuse or avoid aggressive behavior, and 11 trained workers on self-defense techniques in the event that preventive actions were unsuccessful.

Recordkeeping and Program Evaluation

While a large majority of facilities maintained a system for reporting violent events (n=35, 87.5%), fewer conducted evaluations of their policies and procedures following the reported incidents (Table 4). Twenty-five (62.5%) investigated factors that may have contributed to the event, 20 (50%) monitored trends in violent incidents, and 19 (47.5%) evaluated the effectiveness of existing measures to reduce or mitigate violent events.

Comparison of Program Components by Type and Relation to the Company

Out of a total of 55 possible components, entities that provide hospice care only had implemented the highest average number of 25.6 (Table 5). Home health agencies followed with an average

implementation of 24.3 components and agencies that provided both types of care had the lowest average of 19.4. These differences were not statistically significant. The only significant differences by category were observed in management commitment and employee involvement, in which home health care agencies had a significantly higher average score than agencies providing both home and hospice care.

Sole facilities and branches within larger agencies each had an average implementation over 25, while parent agencies had the lowest average of 20.47. The only significant differences were found in the training components, in which sole facilities and branches had significantly higher training scores than parent facilities.

Discussion

more agencies evaluated households for the presence of pets than for guns, substance abuse, or patient history of mental illness or violence.Despite the fact that California requires employers to have a workplace violence prevention program and provides guidelines that employers must follow, only 55% of participating agencies had formal programs in place. Of the agencies that did report having programs, several important gaps were found. The programs of two agencies were unwritten, and many of the existing programs were not regularly reviewed and updated. As for the content of the programs, more agencies evaluated households for the presence of pets than for guns, substance abuse, or patient history of mental illness or violence. While many agencies did provide policies for assessing at least some potential threats in the household, the assessment of dangers in the surrounding community was lacking.

There also seemed to be a disconnect between policies and training. For example, it was observed that 77.5% of the facilities reported having policies in place to protect workers from violent or aggressive patients, but only 15% provided training for all employees participating in patient care. Furthermore, only 35% of the agencies reported training employees on factors predicting violence and aggression, and even fewer trained workers on methods to diffuse threatening situations or protect themselves if situations were to escalate. Given these inconsistencies, the effectiveness of the existing WVP programs is likely limited.

not all agencies had a safety committee in place. Of the agencies that did not all of them included home health and/or hospice workers.Another interesting finding was that not all agencies had a safety committee in place. Of the agencies that did have a safety committee, not all of them included home health and/or hospice workers. This is an important finding, and a missed opportunity for the agencies to improve their programs. The inclusion of field employees is critical on these committees because they are the individuals who are directly exposed to the risks and hazards that the committee is charged with mitigating. For example, research has shown that the negative effects of workplace violence in the home health care industry are not a burden carried simply by the field workers themselves; they can also have a tremendous impact on the organization as a whole. History of exposure to violence has been shown to be strongly associated with low job satisfaction,

intent to change agencies, and intent to leave the home health care industry entirely (Canton et al., 2009).

Sherman et al. (2008) also showed that exposure to environmental hazards such as cockroaches and cigarette smoke, as well as exposure to threats or actual verbal or physical abuse, was negatively correlated with job satisfaction and job retention. With reports continuing to project shortages in nursing (Buerhaus, Auerbach, & Staiger, 2009) and home health aides (HRSA, 2004) well into the next decade, the demand for both of these professions is expected to grow much faster than the national average (BLS, 2013a; BLS, 2013b). Home health care, therefore, is truly an industry that cannot afford to experience the depletion of its workforce. It is important to include home health and hospice workers on safety committees so that their experiences and ideas can be brought to light.

This study has several limitations. The data was collected through self-administered questionnaires, therefore the potential for reporting bias and misclassification of WVP program components exists. This risk was reduced however, because the branch manager for each participating agency completed the questionnaire. The branch manager was the individual responsible for overseeing development and implementation of the agency's policies and procedures, and in turn would have first-hand knowledge of the WVP program. The small sample size was also a limitation. It was difficult to make comparisons between entity types and entity relations due to small goup sizes, as evidenced by the few significant results presented in this paper. A larger sample size would have likely yielded more significant results. Despite this limitation , we felt that we were able to uncover many WVP program gaps that can guide future research.

It will be important for future research to examine the reasons for not just the lack of WVP programs in general, but also the gaps in existing programs. As seen in this study, many agencies do not have a WVP program at all, so it will be critical to uncover the barriers to program development and implementation. Future research should also examine WVP program components, along with incidents of actual violence and near misses, in an effort to determine which components are most effective and which components need to be improved.

Table 1. Overall components of a comprehensive Workplace Violence Prevention program reported by Home Healthcare Agencies, California, 2009

WVP Program Component Home Health (n=20) Hospice (n=9) Home Health & Hospice (n=11) Total (n=40) Overall Workplace Violence Program Agency has a WVP program 11 (55%) 6 (66.7%) 5 (45.5%) 22 (55%) Program is written 11 (55%) 5 (55.6%) 4 (36.6%) 20 (50%) Zero tolerance policy 11 (55%) 7 (77.8%) 5 (45.5%) 23 (57.5%) Description of roles and responsibilities following violence 9 (45%) 4 (44.4%) 5 (45.5%) 18 (45%) Ways to incorporate manager and worker involvement 11 (55%) 4 (44.4%) 5 (45.5%) 20 (50%) Program is reviewed and updated 7 (35%) 3 (33.3%) 4 (36.6%) 14 (35%) Statement encouraging employee reporting 11 (55%) 6 (66.7%) 5 (45.5%) 22 (55%) Policy to protect employees reporting violence 15 (75%) 8 (88.9%) 9 (81.8%) 32 (80%)

Management Commitment and Employee Involvement

Thirty-three (82.5%) of the agencies reported having a committee to address workplace violence and safety, but only 31 agencies specifically had home health and/or hospice workers serving on the committee (Table 2). Twenty-eight (70%) of the agencies stated that methods were in place to report or debrief near misses, while only 4 (10%) stated that regular meetings were held with senior administrators to discuss workplace violence policies. For each of the management commitment components, agencies providing home health were the most likely to have the component, followed by agencies providing hospice care, and agencies providing both types of care were the least likely to have each component.

Table 2. Management commitment and worksite analysis components of a comprehensive Workplace Violence Prevention program reported by Home Healthcare Agencies, California, 2009

WVP Program Component Home Health (n=20) Hospice (n=9) Home Health & Hospice (n=11) Total (n=40 Management Commitment and Employee Involvement Safety Committee that addresses WV and safety 18 (90%) 8 (88.9%) 7 (63.6%) 33 (82.5%) Field workers serve on committee 17 (85%) 7 (77.8%) 7 (63.6%) 31 (77.5%) Psychological counseling or debriefing after event 18 (90%) 8 (88.9%) 8 (72.7%) 34 (85%) Method to report or debrief near misses 16 (80%) 7 (77.8%) 5 (45.5%) 28 (70%) Regular meetings to discuss WVP with administrators 2 (10%) 2 (22.2%) 0 4 (10%) Worksite Analysis Patient history of violent behavior 15 (75%) 7 (77.8%) 8 (72.7%) 30 (75%) Patient history of mental illness 18 (90%) 7 (77.8%) 8 (72.7%) 33 (82.5%) Patient history of substance abuse 16 (80%) 7 (77.8%) 8 (72.7%) 31 (77.5%) Violence in the household 13 (65%) 6 (66.7%) 8 (72.7%) 27 (67.5%) Substance abuse in the household 13 (65%) 7 (77.8%) 8 (72.7%) 28 (70%) Guns in the household 16 (80%) 9 (100%) 7 (63.6%) 32 (80%) Pets in the household 18 (90%) 9 (100%) 8 (72.7%) 35 (87.5%) Illegal activity in the household 12 (60%) 8 (88.9%) 7 (63.6%) 27 (67.5%) Criminal activity in the neighborhood 11 (55%) 6 (66.7%) 4 (36.6%) 21 (52.5%)

Table 3. Hazard prevention and control components of a comprehensive Workplace Violence Prevention program reported by Home Healthcare Agencies, California, 2009

WVP Program Component Home Health (n=20) Hospice (n=9) Home Health & Hospice (n=11) Total (n=40) Hazard Prevention and Control WVP program review to assess staff needs and training 11 (55%) 4 (44.4%) 4 (36.6%) 19 (47.5%) Examine trends and patterns of violent events 8 (40%) 3 (33.3%) 3 (27.7%) 14 (35%) Provide information about hazards & prevention to workers 10 (50%) 4 (44.4%) 4 (36.6%) 18 (45%) Policies to protect from violent or aggressive patients 15 (75%) 7 (77.8%) 9 (81.8%) 31 (77.5%) Policies to protect from violent or aggressive household members and visitors 11 (55%) 6 (66.7%) 7 (63.6%) 24 (60%) Policies to protect from violence in the community or outside of the home 9 (45%) 5 (55.6%) 6 (54.6%) 20 (50%) Policies to protect from violence perpetrated by other workers in the agency 13 (65%) 6 (66.7%) 9 (81.8%) 28 (70%) Policies to protect from intimate partner violence while on the job 1 (5%) 0 2 (18.2%) 3 (7.5%) Policies to protect from violence when caring for mentally ill or psychiatric patients 2 (10%) 2 (22.2%) 0 4 (10%) Policies to informing contact person of whereabouts at all times 0 4 (44.4%) 2

(18.2%) 6 (15%) Strategies for conducting home visits after dark 9 (45)% 4 (44.4%) 5 (54.6%) 19 (47.5%) Strategies for ending a home visit early 20 (100%) 9 (100%) 11 (100%) 40 (100%) Policies for using a buddy system (with a co-worker) 18 (90%) 7 (77.8%) 11 (100%) 36 (90%) Policies for using police or security escorts 10 (50%) 4 (44.4%) 5 (45.5%) 19 (47.5%) Policies for using any safety equipment 18 (90%) 5 (55.6%) 11 (100%) 34 (85%)

Table 4. Training, record keeping, and program evaluation components of a comprehensive Workplace Violence Prevention program reported by Home Healthcare Agencies, California, 2009

WVP Program Component Home Health (n=20) Hospice (n=9) Home Health & Hospice (n=11) Total (n=40) Safety and Health Training Agency offers WVP training 13 (65%) 6 (66.7%) 4 (36.6%) 23 (57.5%) Agency offers training to new employees 9 (45%) 5 (55.6%) 4 (36.6%) 18 (45%) Agency offers ongoing training to employees at least annually 11 (55%) 4 (44.4%) 4 (36.6%) 19 (46.5%) Every employee that sees patients receives training 4 (20%) 0 2 (18.2%) 6 (15%) Training content includes customer service 8 (40%) 3 (33.3%) 3 (27.3%) 14 (35%) Training content includes factors predicting violence and aggression 6 (30%) 5 (55.6%) 3 (27.3%) 14 (35%) Training content includes characteristics of aggressive and violence patients and families 9 (45%) 4 (44.4%) 3 (27.3%) 16 (40%) Training content includes characteristics of hazardous households 8 (40%) 4 (44.4%) 3 (27.3%) 15 (37.5%) Training content includes characteristics of hazardous neighborhoods 8 (40%) 3 (33.3%) 3 (27.3%) 14 (35%) Verbal methods to diffuse aggressive behavior 8 (40%) 4 (44.4%) 2 (18.2%) 14 (35%) Physical maneuvers to diffuse or avoid aggressive behavior 8 (40%) 3 (33.3%) 1 (9.1%) 12 (30%) Self-defense if preventive action does not work 7 (35%) 3 (33.3%) 1 (9.1%) 11 (27.5) Policies and methods for reporting a violent event 9 (45%) 5 (55.6%) 4 (36.6%) 18 (45%) Resources available for victims of workplace violence 10 (50%) 5 (55.6%) 4 (36.6%) 19 (47.5) Record Keeping and Program Evaluation Maintain system for reporting violent events 18 (90%) 9 (100%) 8 (72.7%) 35 (87.5%) Identify factors that contributed to violent event 12 (60%) 6 (66.7%) 7 (63.6%) 25 (62.5%) Monitor trends in violent incidents 10 (50%) 6 (66.7%) 4 (36.6%) 20 (50%) Evaluate effectiveness of policies 8 (40%) 5 (55.6%) 6 (54.6%) 19 (47.5)

Table 5. Mean Scores of Workplace Violence Components, by Entity Type and Entity Relation of participating facilities, Home Healthcare Agencies, California, 2009

Mean Unit Scores General program (8 points) Management Commitment And Employee Involvement (5 points) Worksite Analysis (9 points) Hazard Prevention and Control (15 points) Training (14 points) Records and Evaluation (4 points) Average Total Points (55 points) Entity Type Home health only (n = 20) 4.35 3.551 6.60 2.50 5.90 1.40 24.30 Hospice Only (n = 9) 4.78 3.56 7.33 2.31 6.00 1.63 25.61 Home health with Hospice (n = 11) 3.82 2.451 6.00 2.20 3.73 1.24 19.44 Entity Relation to Company Sole Facility (n = 13) 4.77 3.38 7.00 2.26 6.852 1.59 25.85 Parent (n = 19) 4.00 3.26 6.32 2.30 3.262,3 1.33 20.47 Branch (n = 8) 4.25 3.00 6.63 2.75 7.753 1.29 25.67 1 Home health compared to HH & Hosp $p < 0.1$ 2 Parent compared to Sole Facility $p < 0.1$ 3 Parent compared to Branch $p < 0.1$

References

Buerhaus, P. I., Auerbach, D. I., & Staiger, D. O. (2009). The recent surge in nurse employment: Causes and implications. Health Affairs, 28(4), 657-668.

Bureau of Labor Statistics, U.S. Department of Labor (2006). Percent of establishments that have experienced an incident of workplace violence in the 12 months prior to the survey by selected type of incident, industry, and size class, 2005. Retrieved from www.bls.gov/iif/oshwc/ostb1629.pdf

Bureau of Labor Statistics. (2013a) U.S. Department of Labor, Occupational Outlook Handbook, 2012-13 Edition, Home Health and Personal Care Aides. Retrieved from www.bls.gov/ooh/healthcare/home-health-and-personal-care-aides.htm

Bureau of Labor Statistics. (2013b) U.S. Department of Labor, Occupational Outlook Handbook, 2012-13 Edition, Registered Nurses. Retrieved from www.bls.gov/ooh/healthcare/registered-nurses.htm

California Occupational Safety and Health Administration (Cal/OSHA). (1993). Guidelines for security and safety of health care and community service workers. Sacramento: California Department of Industrial Relations, Medical Unit, 1993. Available at: www.dir.ca.gov/dosh/dosh%5Fpublications/hcworker.html.

Canton, A. N., Sherman, M. F., Magda, L. A., Westra, L. J., Pearson, J. M., Raveis, V. H., &

Gershon, R. R. M. (2009). Violence, job satisfaction, and employment intentions among home healthcare registered nurses. Home Healthcare Nurse, 27(6), 364-373.

Duhart, D. T. (2001). Violence in the workplace 1993-1999. Bureau of Justice Statistics. Special Report 190076. Washington, DC: US Department of Justice.

GackiSmith, J., Juarez, A. M., Boyett, L., Homeyer, C., Robinson, L., & MacLean, S. L. (2009). Violence against nurses working in US emergency departments. Journal of Nursing Administration, 39(7/8), 340-349.

Health Resources & Service Administration, U.S. Department of Health & Human Services. (2004). Nursing aides, home health aides, and related health care occupations - National and local workforce shortages and associated data needs. Retrieved from http://bhpr.hrsa.gov/healthworkforce/reports/rnhomeaides.pdf

McPhaul, K., Lipscomb, J., & Johnson, J. (2010). Assessing risk for violence on home health visits. Home Healthcare Nurse, 28(5), 278-289.

Morris, R., Krueger, C., & Yaross, D. (2004). Better safe than sorry, one agency's successful safety and security strategies. Home Healthcare Nurse, 22(6), 417-423.

Sherman, M. F., Gershon, R. R. M., Samar, S. M., Pearson, J. M., Canton, A. N., & Damsky, M. R. (2008). Safety factors predictive of job satisfaction and job retention among home healthcare aides. Journal of Occupational and Environmental Medicine, 50(12), 1430-1441.

Sylvester, B. J. & Reisener, L. (2002). Scared to go to work: A home care performance improvement initiative. Journal of Nursing Care Quality, 12(1), 71-82.

~~~~~~~~

By Nathan Gross, MSN, RN, COHN-S/CM, nathan-gross@uiowa.edu; Corinne Peek-Asa, PhD, corinne-peek-asa@uiowa.edu; Maryalice Nocera, MS, RN, mnocera@email.unc.edu and Carri Casteel, PhD, ccasteel@email.unc.edu

Nathan Gross, MSN, RN, is a graduate student at the University of Iowa, College of Public Health, Department of Occupational and Environmental Health. He holds a BSN and an MSN degree in Occupational Health Nursing, both from the University of Iowa. He is currently pursuing a PhD degree in the Occupational Injury Prevention Research Program. Nathan has clinical experience in long-term care and occupational health nursing and is a board certified occupational health nurse specialist and case manager. As a graduate student, he was selected to participate in the OSHA graduate nurse intern program at the U.S. Department of Labor in Washington, DC. Nathan's research interests include occupational injury prevention and workplace violence prevention.

Corinne Peek-Asa, PhD is the associate dean for research for the College of Public Health, University of Iowa. She is a Professor in the Department of Occupational and Environmental Health and the Director of the Centers for Disease Control and Prevention (CDC)-funded Injury Prevention Research Center. Dr. Peek-Asa received a BS in Biochemistry from the University of New Mexico, and her Master's in Public Health and PhD from the University of California, Los Angeles. Dr. Peek-Asa's area of expertise is injury and violence prevention. She has conducted research in the areas of road traffic safety, interpersonal violence, workplace violence, residential fire injuries, poisoning, and acute care. Her work has included surveillance; risk factor identification; design, implementation, and evaluation of prevention programs; design and evaluation of safety policy; and translation and dissemination methods.

Maryalice Nocera, MSN has a Master of Science in Nursing from the University of Michigan. She is currently a Project Director at the University of North Carolina (UNC) Injury Prevention Research Center. As a project director, Ms. Nocera has managed multiple research studies that focus on the prevention of occupational violence in the retail and health care sectors, and is currently managing a large, statewide evaluation of a shaken baby prevention program disseminated to all hospitals in North Carolina. Her responsibilities have included the development of data collection instruments and field and research protocols, data collection, data management and analysis, student training and research dissemination. Ms. Nocera was the Project Director on this research project.

Carri Casteel, PhD has a Masters of Public Health and PhD in Epidemiology from the University of California, Los Angeles. She is currently a Research Associate Professor of Epidemiology at the
~~~~~~~~

University of North Carolina at Chapel Hill (UNC) and Associate Director of the UNC Injury Prevention Research Center. Dr. Casteel's primary area of research has focused on the prevention of occupational violence among high-risk populations in the retail and health care sectors. In these areas, she has conducted etiologic research; intervention and policy evaluations; and research in the dissemination and implementation of evidence-based public health programs. She was the Principal Investigator on this research project.

Copyright of Online Journal of Issues in Nursing is the property of American Nurses Association and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.