GREATER CINCINNATI HEALTH COUNCIL

Promoting a Nonviolent Health Care Culture

2010-2012

GREATER CINCINNATI HEALTH COUNCIL

Creating connections. Improving care.

Regional Project Focus

Violence in the workplace is on the rise! Members of the Greater Cincinnati Health Council requested the formation of a multidisciplinary task force to initiate a proactive approach to ensure a safe health care environment. In July 2010 a task force was formed and the regional group developed a comprehensive toolkit that can be utilized by health care facilities to support a culture free from all types of violent behavior. This toolkit is a collection of best practices and it is not intended as standards or regional practices. The ultimate goal is to support a consistent regional message of nonviolence in our health care facilities and ensure that our health care organizations are committed to a safe environment for all Tristate patients, families, visitors and employees.

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About the Greater Cincinnati Health Council

The Greater Cincinnati Health Council is a widely recognized association that provides a unique forum for hospital and health care leaders to collaborate and create a stronger health care community. For more than 50 years, the Council has served as a trusted voice on hospitals and health care issues for the Tristate region.

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Executive Summary

Workplace violence in health care settings is on the rise!

The Occupational Safety and Health Administration (OSHA) reports that approximately two million American workers are victims of workplace violence each year. OSHA notes that workplace violence can strike anywhere and hospital/health care workers are at high risk.

While one may associate workplace violence with physical violence alone, the National Institute for Occupational Safety and Health defines workplace violence as any physical assault, threatening behavior or verbal abuse that occurs in the work setting. Acts such as psychological trauma due to threats, obscene phone calls and intimidating presence and harassment of any kind are included. Organizations that don't protect their employees from violence and threats of violence can face employees with low morale and productivity, increased medical expenses, lost work time and increased liability. While no federal law explicitly establishes an employer's duty to prevent or remedy workplace violence against employees, employers must comply with the general duty clause of the Occupational Safety and Health Act of 1970, which states that each employer "shall furnish…a place of employment which is free from recognized hazards that are causing or are likely to cause death or serious harm to his employees."

The Bureau of Labor Statistics (BLS) reports that 2,637 nonfatal assaults on hospital workers occurred in 1999 which is a rate of 8.3 assaults per 10,000 workers. This rate exceeds the rate of nonfatal assaults for all private-sector industries, which are 2 per 10,000 workers. According to a federal Bureau of Labor Statistics report, health care workers are four times as likely as the average American worker to encounter violence on the job and the risk is higher for those working in psychiatric or emergency units. Incidents of workplace violence are likely to be even higher due to the large numbers that are unreported. Health care employees have worked in a culture where assaults are often believed by some to be part of the job and therefore assume that there is no benefit to reporting.

Risk factors for patient violence have been identified such as unsecured facility access, unrestricted movement of the public, possession of weapons, lack of staff training, and even long wait times for services. Workplace violence is preventable and organizational interventions can support a nonviolent culture where employees know that violence is not part of their job and will not be tolerated. Management is the first key player to workplace violence prevention and their commitment can ensure a safe health care environment for all employees, patients and visitors.

Nonviolence Culture Commitment Letter

_________________________ (agency name) is committed and voluntarily agrees to participate in the regional initiative, *Promoting a Nonviolent Health Care Culture,* to provide a safe environment for all employees, visitors and patients that is free of behavior, actions or language causing or contributing to workplace violence. In addition, assault, harassment, intimidation, interference or threat by or against any employee, patient or visitor is unacceptable and will not be tolerated.

The above agency agrees to an internal employee, patient and visitor program that:

- Enforces facility policy standards regarding personal safety and welfare at the workplace,
- Offers training and instruction on general workplace and security practices to all employees,
- Ensures awareness that incidences against any employee, patient or visitor will be reported, investigated and mitigated as soon as possible following discovery with a process to follow-up with victims of violence, and
- Enables participation in an ongoing Tristate workforce group to collect regional data and set realistic goals to decrease incidences of violence in the workplace.

____________________________________ ____________________

Health Care Administrator Signature Date

Contact person for ongoing work in this regional group:

____

Email____

Phone____

National, State and Regional
Guidelines, Standards and Regulations

Ohio Laws

OHIO-HB 450 recognizes that violent acts against nurses in the workplace occur more frequently than in any other profession. (Appendix A)

Hospital worker protection bill reintroduced in Ohio House
MedCity News
Two Ohio lawmakers are hoping a bill that would increase the punishment for assaulting a hospital worker fares better the second time around.

Joint Commission

Sentinel Event Alerts #40 Behaviors that undermine a culture of Safety (Appendix B)
Sentinel Event Alert #45 Preventing violence in the health care setting (Appendix C)

Occupational Safety and Health Administration (OSHA)

Section 5(a)(1) of the OSH Act, often referred to as the General Duty Clause, requires employers to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees." Section 5(a)(2) requires employers to "comply with occupational safety and health standards promulgated under this Act."

Professional Behavior Recommendations from the Greater Cincinnati Health Council Physician Impact Project Report

The Health Council committee took a regional approach to set the standard for professional behavior in health care by developing a clear description of disruptive behavior and a staged approach to confronting disruptive behavior which is consistently and uniformly applied at all institutions throughout the community.

Nonviolent Health Care Culture Best Practices

The following includes helpful information and best practices shared by regional members of the Nonviolent Health Care Culture project. It is not intended as regional standards or guidelines but simply resources that can be voluntarily utilized by regional health care organizations.

Risk Factors for Violence in the Health Care Setting

- The prevalence of handguns and other weapons among patients, their families or friends
- The increasing use of hospitals by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals
- The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care (these patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others)
- The availability of drugs or money at hospitals, clinics and pharmacies, making them potential robbery targets
- Factors such as the unrestricted movement of the public in clinics and hospitals and long waits in emergency or clinic areas that lead to client frustration over an inability to obtain needed services promptly
- The increasing presence of gang members, drug or alcohol abusers, trauma patients or distraught family members
- Low staffing levels during times of increased activity such as mealtimes, visiting times and when staff are transporting patients
- Isolated work with clients during examinations or treatment
- Solo work, often in remote locations with no backup or means to request assistance, such as communication devices or alarm systems (this is particularly true in high-crime settings)
- Lack of staff training in recognizing and managing escalating hostile and assaultive behavior; and
- Poorly lit parking areas.

Source: (Department of Labor, www.osha.gov)

Workplace Violence Checklist

1. Department of Labor Facility Checklist Evaluate Risk (Appendix D)
2. *Survey Tool to Evaluate your Workplace*

Incident Report Template

Workplace Violence Incident Report (Appendix E)

Program Development Tips

At a minimum, workplace violence prevention programs should:

- Create and disseminate a clear policy of zero tolerance for workplace violence, verbal and nonverbal threats and related actions. Ensure that managers, supervisors, coworkers, clients, patients and visitors know about this policy.
- Ensure that no employee who reports or experiences workplace violence faces reprisals.
- Encourage employees to promptly report incidents and suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and measure progress.
- Outline a comprehensive plan for maintaining security in the workplace. This includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.

- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. Ensure that adequate resources are available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.
- Affirm management commitment to a worker-supportive environment that places as much importance on employee safety and health as on serving the patient or client.
- Set up a company briefing as part of the initial effort to address issues such as preserving safety, supporting affected employees and facilitating recovery.

Elements of an Effective Violence Prevention Program
The five main components of any effective safety and health program also apply to the prevention of workplace violence:

- Management commitment and employee involvement;
- Worksite analysis;
- Hazard prevention and control;
- Safety and health training; and
- Recordkeeping and program evaluation.

  Source: (Department of Labor, www.osha.gov)

Signage
Visible security signs, zero tolerance signs

Signs at each entrance to hospital
Signs at each elevator
Signs at entrance to each unit

Identification Badge Process for Visitors/ Security of Potential Weapons

All visitors must sign in at the information desk after reviewing and agreeing to the organizations zero tolerance for violence policy. It is suggested that signatures be received on a log form rather than individual forms.

- All visitors will receive an identification badge that clearly identifies them as a Visitor.
- All employees and visitors must have identification visible at all times
- All visitors will be informed that no weapons can be brought into the facility.
- For high risk facilities or departments, metal detectors may be utilized for screening.

Flagging Charts
*For *physically* violent behavior only. The following are suggested flagging guidelines:

- When a patient or visitor exhibits violence, a workplace violence report is completed. If the incident resulted in physical violence, the incident is flagged in the patients chart.
- Information is logged into a central security database used to reference for future visits.
- When a flagged person revisits, an alert is activated in the computerized system that alerts staff to what previous violent behavior occurred.
- As the EMR process develops, physically violent patient transfers can be flagged and accepting organization and staff will be alerted prior to patient arrival
- If high risk of recurrence is noted security stays alongside the person throughout their visit.

Security Procedures

- Security visible at all entrances
- Security staff hourly rounding to maintain visibility
- Use an organized alert system to prepare the organization for potential violence

- Staff should maintain open communication with security about potential violence through the alert system
- Closed-circuit television (CCTV) system may be used to visually monitor specific areas such as parking garages and outdoor sites, public areas such as the cafeteria, and high risk departments/ units
- Use appropriate lighting throughout the facility
- In the event of an armed assailant, institute your emergency plan that includes:
    - Immediate notification of security and local police
    - Protective actions that include removing anyone at risk (patients, staff, visitors, etc)
- In the event of a hostage situation/abduction
    - Notify security and local police immediately
    - Be prepared to give a physical description of all persons involved
    - Do not permit anyone to enter or leave building until cleared by local police department

Training & Education

The training of employees is recommended to be inclusive of *all* employees. This training might be achieved by employees reading written information, watching a video, online instruction or classroom face-to-face training. Online and classroom training are available if desired through the Health Council for project participants that are interested.

Online Training Program
http://www.gchc.org/wp-content/uploads/2012/01/NVC-Online-Training-Module-Final.pptx
The online program includes instruction for a nonviolent health care culture beginning with employee-to-employee disruptive behavior through potential violence from patients and visitors that could result in homicide.
This online program is free, can be tailored to include organizational specific procedures and will be updated regularly through the ongoing efforts of the Nonviolent Health Care Culture project team. Online Training can be accessed through the Health Council and member organizations' websites. Utilizing this training is not mandatory but simply available as a resource.

Classroom Training Program-Module 1 and Module 2
Classroom training, or face-to-face training, is recommended for all employees who are at high risk of violence. There are two modules available.

- **Module 1**-The first module includes general training targeted for all at-risk employees, particularly those who have direct patient care responsibilities.
- **Module 2**- Module 2 is additional training, following completion of Module 1, which includes Aggressive Behavior Management. Module 2 is targeted for employees who are *frequently* confronted with acts of violence at work.

Train-the-trainer sessions are offered at the Greater Cincinnati Health Council and dates/ times are available by calling 513-531-0200.

Module 1 Classroom Training Outline
http://www.gchc.org/wp-content/uploads/2011/06/NVC-Training-PowerPoint-Module-1.pptx

I. Introduction
  A. purpose of training
    1. Learner objectives
  B. Definitions
    1. Review definitions of violence
  C. Statistics/ Research as it relates to hospital violence
    1. Discuss current statistics of hospital violence
    2. Discuss trends in evidenced based research
II. Culture
  A. Philosophy vs. practice
  B. Labeling
  C. Shifting paradigms
III. Assessments
  A. Situation
    1. Definition
    2. Examples
    3. Role Play
  B. Patient
    1. Definition
    2. Examples
    3. Role Play
  C. Environment
    1. Definition
    2. Examples
    3. Role Play
  D. Ourselves
    1. Definition
    2. Examples
    3. Role Play
  E. Co-Workers
    1. Definition

2. Examples
3. Role Play

IV. Therapeutic Relationship/communication
A. Therapeutic relationship with patient and family
1. Definition
2. Boundaries
3. Role play

B. Therapeutic communication
1. Definition
2. Examples
3. Role Play

V. Crisis Cycle
A. Define crisis
B. Describe crisis assessment
1. Patient and family

C. Discuss stages of crisis cycle
1. Define each cycle
2. Discuss assessment and intervention
3. Role Play

VI. Hands on training
A. Protective stance
B. Blocks
C. Releases

VII. Conclusion
A. Q & A session

Module 2 Classroom Training Outline
http://www.gchc.org/wp-content/uploads/2011/06/NVC-Training-Module-2.pptx

I. Introduction
A. purpose of training
1. Learner objectives

B. Definitions
1. Review definitions of violence

II. Seclusion and Restraint
A. Definitions
B. Philosophy vs. practice
C. Shifting paradigms
D. Alternatives
E. De-escalation
F. Safety

III. Compare and contrast accreditation body requirements
A. Review Joint Commission standards
B. Review CMS standards
C. Comparing Joint Commission Restraint Standards and CMS Standards

IV. Conclusion
A. Q & A session

Active Shooter Course-Homeland Security
An active shooter is an individual actively engaged in killing or attempting to kill people in a confined and other populated area. In most cases, active shooters use firearms and there is no pattern or method to their selection of victims. Active shooter situations are unpredictable and evolve quickly.
All employees can help prevent and prepare for potential active shooter situations. This course provides guidance to individuals, including managers and employees, so that they can prepare to respond to an active shooter situation.
http://emilms.fema.gov/IS907/index.htm

Data Collection/Monitoring

Once regional commitment letters are received from the health care organizations, regional data collection will begin. At that time all participating regional health care facilities will complete a survey for baseline information.

Regional data collection will occur every six months and be reported to the participating organizations in the form of two reports: the first 6 months of the year and one year-end cumulative report. Participating organizations will use the following regional data collection tool:

Click here to access the tool to enter and submit organizational data.
See Appendix F for data points.

Resources

Workplace Violence Prevention Strategies and Research Needs
NIOSH Publication No. 2006-144 (September 2006)

Violence on the Job
NIOSH Publication No. 2004-100D (DVD)

Violence: Occupational Hazards in Hospitals
NIOSH Publication No. 2002-101 (April 2002)

NIOSH Current Intelligence Bulletin #57: Violence in the Workplace: Risk Factors and Prevention Strategies
NIOSH Publication No. 96-10 (July 1996)

NIOSH Report Addresses Problem of Workplace Violence, Suggests Strategies for Preventing Risks
DHHS Press Release (July 1996)
Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers
OSHA 3148-01R 2004
http://www.osha.gov/Publications/OSHA3148/osha3148.html

Health Care Facilities and Workplace Violence Prevention
Texas Department of Insurance Division of Workers Compensation Workplace Safety
http://www.tdi.state.tx.us/pubs/videoresource/stpwpvhealthc.pdf

Preventing Violence in the Health Care Setting
The Joint Commission
http://workplaceviolencenews.com/2010/06/08/preventing-violence-in-the-health-care-setting/

Workplace Violence and Corporate Policy for Health Care Settings: Zero Tolerance for Violence in the Workplace
http://www.medscape.com/viewarticle/508158_3

Emergency Nurses Association Workplace Violence Toolkit
http://www.ena.org/IENR/ViolenceToolKit/Documents/toolkitpg1.htm

ASIS International and SHRM: Workplace Violence Prevention and Intervention ANSI Standard
ASIS International and the Society for Human Resource Management (SHRM) issued a joint *ASIS/SHRM Workplace Violence Prevention and Intervention American National Standard* aimed at helping organizations implement policies and practices to more quickly identify threatening behavior and violence affecting the workplace, and to engage in effective incident management and resolution.
http://www.shrm.org/about/pressroom/PressReleases/Pages/WorkplaceViolencePreventionandInterventionstandard.aspx

APPENDICES

Appendix A

Ohio House Bill 450
As Introduced

128th General Assembly
Regular Session **H. B. No. 450**
2009-2010

Representatives Driehaus, Bolon
Cosponsors: Representatives Oelslager, Domenick, Yuko, Garland, Gardner, Patten, Chandler, Winburn, Letson

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A BILL

To amend section 2903.13 of the Revised Code to increase the penalty for assault when the victim is a registered nurse or a licensed practical nurse engaged in the performance of official duties whom the offender knows or has reasonable cause to believe is a registered nurse or a licensed practical nurse.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:
Section 1. That section 2903.13 of the Revised Code be amended to read as follows:
Sec. 2903.13. (A) No person shall knowingly cause or attempt to cause physical harm to another or to another's unborn.
(B) No person shall recklessly cause serious physical harm to another or to another's unborn.
(C)(1) Whoever violates this section is guilty of assault~~, and the court shall sentence the offender as provided in this division and divisions (C)(1), (2), (3), (4), (5), and (6) of this section~~. Except as otherwise provided in division (C)~~(1),~~ (2), (3), (4), ~~or~~ (5), (6), or (7) of this section, assault is a misdemeanor of the first degree.
~~(1)~~(2) Except as otherwise provided in this division, if the offense is committed by a caretaker against a functionally impaired person under the caretaker's care, assault is a felony of the fourth degree. If the offense is committed by a caretaker against a functionally impaired person under the caretaker's care, if the offender previously has been convicted of or pleaded guilty to a violation of this section or section 2903.11 or 2903.16 of the Revised Code, and if in relation to the previous conviction the offender was a caretaker and the victim was a functionally impaired person under the offender's care, assault is a felony of the third degree.
~~(2)~~(3) If the offense is committed in any of the following circumstances, assault is a felony of the fifth degree:
(a) The offense occurs in or on the grounds of a state correctional institution or an institution of the department of youth services, the victim of the offense is an employee of the department of rehabilitation and correction, the department of youth services, or a probation department or is on the premises of the particular institution for business purposes or as a visitor, and the offense is committed by a person incarcerated in the state correctional institution, by a person institutionalized in the department of youth services institution pursuant to a commitment to the department of youth services, by a parolee, by an offender under transitional control, under a community control sanction, or on an escorted visit, by a person under post-release control, or by an offender under any other type of supervision by a government agency.
(b) The offense occurs in or on the grounds of a local correctional facility, the victim of the offense is an employee of the local correctional facility or a probation department or is on the premises of the facility for business purposes or as a visitor, and the offense is committed by a person who is under custody in the facility subsequent to the person's arrest for any crime or delinquent act, subsequent to the person's being charged with or convicted of any crime, or subsequent to the person's being alleged to be or adjudicated a delinquent child.
(c) The offense occurs off the grounds of a state correctional institution and off the grounds of an institution of the department of youth services, the victim of the offense is an employee of the department of rehabilitation and correction, the department of youth services, or a probation department, the offense occurs during the employee's official work hours and while the employee is engaged in official work responsibilities, and the offense is committed by a person incarcerated in a state correctional institution or institutionalized in the department of youth services who temporarily is outside of the institution for any purpose, by a parolee, by an offender under transitional control, under a community control sanction, or on an escorted visit, by a person under post-release control, or by an offender under any other type of supervision by a government agency.
(d) The offense occurs off the grounds of a local correctional facility, the victim of the offense is an employee of the local correctional facility or a probation department, the offense occurs during the employee's official work hours and while the employee is engaged in official work responsibilities, and the offense is committed by a person who is under custody in the facility subsequent to the person's arrest for any crime or delinquent act, subsequent to the person being charged with or convicted of any crime, or subsequent to the person being alleged to be or adjudicated a delinquent child and who temporarily is outside of the facility for any purpose or by a parolee, by an offender under transitional control, under a

community control sanction, or on an escorted visit, by a person under post-release control, or by an offender under any other type of supervision by a government agency.
(e) The victim of the offense is a school teacher or administrator or a school bus operator, and the offense occurs in a school, on school premises, in a school building, on a school bus, or while the victim is outside of school premises or a school bus and is engaged in duties or official responsibilities associated with the victim's employment or position as a school teacher or administrator or a school bus operator, including, but not limited to, driving, accompanying, or chaperoning students at or on class or field trips, athletic events, or other school extracurricular activities or functions outside of school premises.
~~(3)~~(4) If the victim of the offense is a peace officer or an investigator of the bureau of criminal identification and investigation, a firefighter, or a person performing emergency medical service, while in the performance of their official duties, assault is a felony of the fourth degree.
~~(4)~~(5) If the victim of the offense is a peace officer or an investigator of the bureau of criminal identification and investigation and if the victim suffered serious physical harm as a result of the commission of the offense, assault is a felony of the fourth degree, and the court, pursuant to division (F) of section 2929.13 of the Revised Code, shall impose as a mandatory prison term one of the prison terms prescribed for a felony of the fourth degree that is at least twelve months in duration.
~~(5)~~(6) If the victim of the offense is an officer or employee of a public children services agency or a private child placing agency and the offense relates to the officer's or employee's performance or anticipated performance of official responsibilities or duties, assault is either a felony of the fifth degree or, if the offender previously has been convicted of or pleaded guilty to an offense of violence, the victim of that prior offense was an officer or employee of a public children services agency or private child placing agency, and that prior offense related to the officer's or employee's performance or anticipated performance of official responsibilities or duties, a felony of the fourth degree.
~~(6)~~(7) If the victim of the offense is a registered nurse or a licensed practical nurse who is licensed under Chapter 4723. of the Revised Code and who is engaged in the performance of the victim's official duties and if the offender knows or has reason to believe that the victim is a registered nurse or a licensed practical nurse, assault is a felony of the fourth degree.
(8) If an offender who is convicted of or pleads guilty to assault when it is a misdemeanor also is convicted of or pleads guilty to a specification as described in section 2941.1423 of the Revised Code that was included in the indictment, count in the indictment, or information charging the offense, the court shall sentence the offender to a mandatory jail term as provided in division (G) of section 2929.24 of the Revised Code.
If an offender who is convicted of or pleads guilty to assault when it is a felony also is convicted of or pleads guilty to a specification as described in section 2941.1423 of the Revised Code that was included in the indictment, count in the indictment, or information charging the offense, except as otherwise provided in division (C)~~(4)~~(5) of this section, the court shall sentence the offender to a mandatory prison term as provided in division (D)(8) of section 2929.14 of the Revised Code.
(D) As used in this section:
(1) "Peace officer" has the same meaning as in section 2935.01 of the Revised Code.
(2) "Firefighter" has the same meaning as in section 3937.41 of the Revised Code.
(3) "Emergency medical service" has the same meaning as in section 4765.01 of the Revised Code.
(4) "Local correctional facility" means a county, multicounty, municipal, municipal-county, or multicounty-municipal jail or workhouse, a minimum security jail established under section 341.23 or 753.21 of the Revised Code, or another county, multicounty, municipal, municipal-county, or multicounty-municipal facility used for the custody of persons arrested for any crime or delinquent act, persons charged with or convicted of any crime, or persons alleged to be or adjudicated a delinquent child.
(5) "Employee of a local correctional facility" means a person who is an employee of the political subdivision or of one or more of the affiliated political subdivisions that operates the local correctional facility and who operates or assists in the operation of the facility.
(6) "School teacher or administrator" means either of the following:
(a) A person who is employed in the public schools of the state under a contract described in section 3319.08 of the Revised Code in a position in which the person is required to have a certificate issued pursuant to sections 3319.22 to 3319.311 of the Revised Code.
(b) A person who is employed by a nonpublic school for which the state board of education prescribes minimum standards under section 3301.07 of the Revised Code and who is certificated in accordance with section 3301.071 of the Revised Code.
(7) "Community control sanction" has the same meaning as in section 2929.01 of the Revised Code.
(8) "Escorted visit" means an escorted visit granted under section 2967.27 of the Revised Code.
(9) "Post-release control" and "transitional control" have the same meanings as in section 2967.01 of the Revised Code.
(10) "Investigator of the bureau of criminal identification and investigation" has the same meaning as in section 2903.11 of the Revised Code.
Section 2. That existing section 2903.13 of the Revised Code is hereby repealed.

Appendix B **Joint Commission 2010 Sentinel Event Alert -#40**

Issue 40, July 9, 2008 **Behaviors that undermine a culture of safety**

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.
Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities.
Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions.(2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients.(7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.
Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.(2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2)
Several surveys have found that most care providers have experienced or witnessed intimidating or disruptive behaviors.(1,2,8,12,13) These behaviors are not limited to one gender and occur during interactions within and across disciplines.(1,2,7) Nor are such behaviors confined to the small number of individuals who habitually exhibit them.(2) It is likely that these individuals are not involved in the large majority of episodes of intimidating or disruptive behaviors. It is important that organizations recognize that it is the behaviors that threaten patient safety, irrespective of who engages in them.
The majority of health care professionals enter their chosen discipline for altruistic reasons and have a strong interest in caring for and helping other human beings. The preponderance of these individuals carry out their duties in a manner consistent with this idealism and maintain high levels of professionalism. The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients. Studies link patient complaints about unprofessional, disruptive behaviors and malpractice risk.(13,14,15) “Any behavior which impairs the health care team’s ability to function well creates risk,” says Gerald Hickson, M.D., associate dean for Clinical Affairs and director of the Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. “If health care organizations encourage patients and families to speak up, their observations and complaints, if recorded and fed back to organizational leadership, can serve as part of a surveillance system to identify behaviors by members of the health care team that create unnecessary risk.”

Root causes and contributing factors

There is a history of tolerance and indifference to intimidating and disruptive behaviors in health care.(10) Organizations that fail to address unprofessional behavior through formal systems are indirectly promoting it. (9,11) Intimidating and disruptive behavior stems from both individual and systemic factors.(4) The inherent stresses of dealing with high stakes, high emotion situations can contribute to occasional intimidating or disruptive behavior, particularly in the presence of factors such as fatigue. Individual care providers who exhibit characteristics such as self-centeredness, immaturity, or defensiveness can be more prone to unprofessional behavior.(8,11) They can lack interpersonal, coping or conflict management skills.
Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professionals on the health care team, (5,7,16) as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communication and for the development of trust among team members.
Disruptive behaviors often go unreported, and therefore unaddressed, for a number of reasons. Fear of retaliation and the stigma associated with “blowing the whistle” on a colleague, as well as a general reluctance to confront an intimidator all contribute to underreporting of intimidating and/or disruptive behavior.(2,9,12,16) Additionally, staff within institutions often perceive that powerful, revenue-generating physicians are “let off the hook” for inappropriate behavior due to the perceived consequences of confronting them.(8,10,12,17) The American College of Physician Executives (ACPE) conducted a physician behavior survey and found that 38.9 percent of the respondents agreed that "physicians in my organization who generate high amounts of revenue are treated more leniently when it comes to behavior problems than

those who bring in less revenue."(17)

Existing Joint Commission requirements

Effective January 1, 2009 for all accreditation programs, The Joint Commission has a new Leadership standard (LD.03.01.01)* that addresses disruptive and inappropriate behaviors in two of its elements of performance:

EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.

EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

In addition, standards in the Medical Staff chapter have been organized to follow six core competencies (see the introduction to MS.4) to be addressed in the credentialing process, including interpersonal skills and professionalism.

Other Joint Commission suggested actions

1. Educate all team members – both physicians and non-physician staff – on appropriate professional behavior defined by the organization's code of conduct. The code and education should emphasize respect. Include training in basic business etiquette (particularly phone skills) and people skills.(10, 18,19)
2. Hold all team members accountable for modeling desirable behaviors, and enforce the code consistently and equitably among all staff regardless of seniority or clinical discipline in a positive fashion through reinforcement as well as punishment.(2,4,9,10,11)
3. Develop and implement policies and procedures/processes appropriate for the organization that address:
    - "Zero tolerance" for intimidating and/or disruptive behaviors, especially the most egregious instances of disruptive behavior such as assault and other criminal acts. Incorporate the zero tolerance policy into medical staff bylaws and employment agreements as well as administrative policies.
    - Medical staff policies regarding intimidating and/or disruptive behaviors of physicians within a health care organization should be complementary and supportive of the policies that are present in the organization for non-physician staff.
    - Reducing fear of intimidation or retribution and protecting those who report or cooperate in the investigation of intimidating, disruptive and other unprofessional behavior.(10,18) Non-retaliation clauses should be included in all policy statements that address disruptive behaviors.
    - Responding to patients and/or their families who are involved in or witness intimidating and/or disruptive behaviors. The response should include hearing and empathizing with their concerns, thanking them for sharing those concerns, and apologizing.(11)
    - How and when to begin disciplinary actions (such as suspension, termination, loss of clinical privileges, reports to professional licensure bodies).
4. Develop an organizational process for addressing intimidating and disruptive behaviors (LD.3.10 EP 5) that solicits and integrates substantial input from an inter-professional team including representation of medical and nursing staff, administrators and other employees.(4,10,18)
5. Provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution.(4,7,10,11,17,20) Cultural assessment tools can also be used to measure whether or not attitudes change over time.
6. Develop and implement a system for assessing staff perceptions of the seriousness and extent of instances of unprofessional behaviors and the risk of harm to patients.(10,17,18)
7. Develop and implement a reporting/surveillance system (possibly anonymous) for detecting unprofessional behavior. Include ombuds services(20) and patient advocates,(2,11) both of which provide important feedback from patients and families who may experience intimidating or disruptive behavior from health professionals. Monitor system effectiveness through regular surveys, focus groups, peer and team member evaluations, or other methods.(10) Have multiple and specific strategies to learn whether intimidating or disruptive behaviors exist or recur, such as through direct inquiries at routine intervals with staff, supervisors, and peers.
8. Support surveillance with tiered, non-confrontational interventional strategies, starting with informal "cup of coffee" conversations directly addressing the problem and moving toward detailed action plans and progressive discipline, if patterns persist. (4,5,10,11) These interventions should initially be non-adversarial in nature, with the focus on building trust, placing accountability on and rehabilitating the offending individual, and protecting patient safety.(4,5) Make use of mediators and conflict coaches when professional dispute resolution skills are needed.(4,7,14)
9. Conduct all interventions within the context of an organizational commitment to the health and well-being of all staff, (11) with adequate resources to support individuals whose behavior is caused or influenced by physical or mental health pathologies.
10. Encourage inter-professional dialogues across a variety of forums as a proactive way of addressing ongoing conflicts, overcoming them, and moving forward through improved collaboration and communication.(1,2,4,10)
11. Document all attempts to address intimidating and disruptive behaviors.(18)

Appendix C **Joint Commission 2010 Sentinel Event Alert # 45--Preventing Violence in the Health Care Setting**

Issue 45, June 3, 2010

Once considered safe havens, health care institutions today are confronting steadily increasing rates of crime, including violent crimes such as assault, rape and homicide. As criminal activity spills over from the streets onto the campuses and through the doors, providing for the safety and security of all patients, visitors and staff within the walls of a health care institution, as well as on the grounds, requires increasing vigilant attention and action by safety and security personnel as well as all health care staff and providers.

While there are many different types of crimes and instances of violence that take place in the health care setting, this *Sentinel Event Alert* specifically addresses assault, rape or homicide of patients and visitors perpetrated by staff, visitors, other patients, and intruders to the institution. The Joint Commission's Sentinel Event Database includes a category of assault, rape and homicide (combined) with 256 reports since 1995 – numbers that are believed to be significantly below the actual number of incidents due to the belief that there is significant under-reporting of violent crimes in health care institutions. While not an accurate measure of incidence, it is noteworthy that the assault, rape and homicide category of sentinel events is consistently among the top 10 types of sentinel events reported to The Joint Commission. Since 2004, the Sentinel Event Database indicates significant increases in reports of assault, rape and homicide, with the greatest number of reports in the last three years: 36 incidents in 2007, 41 in 2008 and 33 in 2009.

Of the information in the Sentinel Event Database regarding criminal events, the following contributing causal factors were identified most frequently over the last five years:

- Leadership, noted in 62 percent of the events, most notably problems in the areas of policy and procedure development and implementation.
- Human resources-related factors, noted in 60 percent of the events, such as the increased need for staff education and competency assessment processes.
- Assessment, noted in 58 percent of the events, particularly in the areas of flawed patient observation protocols, inadequate assessment tools, and lack of psychiatric assessment.
- Communication failures, noted in 53 percent of the events, both among staff and with patients and family.
- Physical environment, noted in 36 percent of the events, in terms of deficiencies in general safety of the environment and security procedures and practices.
- Problems in care planning, information management and patient education were other causal factors identified less frequently.

Identifying high risk areas

Because hospitals are open to the public around the clock every day of the year, securing the building and grounds presents specific challenges since it would be difficult to thoroughly screen every person entering the facility. For many reasons – in particular, high-traffic areas coupled with high-stress levels – the Emergency Department is typically the hardest area to secure, followed by general medical/surgical patient rooms. "A key to providing protection to patients is controlling access," explains Russell L. Colling, M.S., CHPA, a health care security consultant based in Salida, Colo., and the founding president of the International Association for Healthcare Security and Safety. "Facilities must institute layered levels of control which includes securing the perimeter of the property through lighting, barriers, fencing; controlling access through entrances, exits, and stairwells; and positioning nurses stations, to name a few of the steps that organizations need to take."

Perpetrators of violence to patients

While controlling access to the facility is imperative and ongoing surveillance of the grounds is a necessity, administrators must be alert to the potential for violence to patients by health care staff members. The stressful environment together with failure to recognize and respond to warning signs such as behavioral changes, mental health issues, personal crises, drug or alcohol use, and disciplinary action or termination, can elevate the risk of a staff member becoming violent towards a patient. Though it is a less common scenario, health care workers who deliberately harm patients by either assaulting them or administering unprescribed medications or treatments, present a considerable threat to institutions, even when the patient is unable to identify the responsible person. These situations point directly to the critical role human resources departments have in developing and following through on hiring, firing and disciplinary practices (which should be supported by management), and in performing thorough criminal background checks on all new hires. Since criminal background checks are costly, at a minimum, organizations may want to conduct criminal background checks on job candidates who are to be placed in high risk areas, such as the ED, obstetrics, pediatrics, nursery, home care and senior care settings.

Prevention strategies

There are many steps that organizations can take to reduce the risk of violence and prevent situations from escalating. "Each hospital or institution must determine for itself how to protect the environment, and that is accomplished by doing a risk assessment and identifying all the things that can go wrong and how to address them with the least inconvenience and

resources," Russell Colling says. "The most important factor in protecting patients from harm is the caregiver – security is a people action and requires staff taking responsibility, asking questions, and reporting any and all threats or suspicious events." Colling recommends that organizations adopt a zero tolerance policy and establish strong policies mandating staff to report any real or perceived threats. "The roots of violence need to be investigated and evaluated beginning at the unit level. Nurses and other health care staff should question the presence of all visitors in patient rooms and not assume that someone is a family member or friend," says Colling.

ECRI Institute, an independent nonprofit organization that researches best practices to improve patient care, publishes a journal for health care risk managers called *Healthcare Risk Control (HRC)* (1). The September 2005 issue has a focus on "Violence in Healthcare Facilities" that discusses strategies for: preventing violent incidents; managing situations to prevent escalation; and enhancing the physical security of institutions through traditional measures (e.g., fences, locks, key inventory, strengthened windows and doors) and electronic measures (e.g., metal detectors, handheld security wands, video surveillance, alarms, access controls systems that require codes or cards). The publication also outlines:

- Techniques for identifying potentially violent individuals
- Violence de-escalation tools that health care workers can employ
- Violence management training
- Conducting a violence audit
- Conducting a violence assessment walk-through
- Responding in the wake of a violent event

In addition, the Occupational Safety and Health Administration offers advisory guidelines for preventing patient-to-staff workplace violence in the health care setting. (2) In January 2007, the International Association for Healthcare Security and Safety issued its first set of *Healthcare Security: Basic Industry Guidelines*, a resource for health care institutions in developing and managing a security management plan, addressing security training, conducting investigations, identifying areas of high risk, and more. (3)

Existing Joint Commission requirements

The Joint Commission's Environment of Care standards require health care facilities to address and maintain a written plan describing how an institution provides for the security of patients, staff and visitors. Institutions are also required to conduct risk assessments to determine the potential for violence, provide strategies for preventing instances of violence, and establish a response plan that is enacted when an incident occurs. The Rights and Responsibilities of the Individual standard RI.01.06.03 provides for the patient's right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

Joint Commission suggested actions

The following are suggested actions that health care organizations can take to prevent assault, rape and homicide in the health care setting. Some of these recommendations are detailed in the *HRC* issue on "Violence in Healthcare Facilities."

1. Work with the security department to audit your facility's risk of violence. Evaluate environmental and administrative controls throughout the campus, review records and statistics of crime rates in the area surrounding the health care facility, and survey employees on their perceptions of risk.
2. Identify strengths and weaknesses and make improvements to the facility's violence-prevention program. (The *HRC* issue on "Violence in Healthcare Facilities" includes a self-assessment questionnaire that can help with this.)
3. Take extra security precautions in the Emergency Department, especially if the facility is in an area with a high crime rate or gang activity. These precautions can include posting uniformed security officers, and limiting or screening visitors (for example, wanding for weapons or conducting bag checks).
4. Work with the HR department to make sure it thoroughly prescreens job applicants, and establishes and follows procedures for conducting background checks of prospective employees and staff. For clinical staff, the HR department also verifies the clinician's record with appropriate boards of registration. If an organization has access to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank, check the clinician's information, which includes professional competence and conduct.
5. Confirm that the HR department ensures that procedures for disciplining and firing employees minimize the chance of provoking a violent reaction.
6. Require appropriate staff members to undergo training in responding to patients' family members who are agitated and potentially violent. Include education on procedures for notifying supervisors and security staff. (4)
7. Ensure that procedures for responding to incidents of workplace violence (e.g., notifying department managers or security, activating codes) are in place and that employees receive instruction on these procedures.
8. Encourage employees and other staff to report incidents of violent activity and any perceived threats of violence.
9. Educate supervisors that all reports of suspicious behavior or threats by another employee must be treated seriously and thoroughly investigated. Train supervisors to recognize when an employee or patient may be experiencing behaviors related to domestic violence issues.

10. Ensure that counseling programs for employees who become victims of workplace crime or violence are in place. Should an act of violence occur at your facility – whether assault, rape, homicide or a lesser offense – follow-up with appropriate response that includes:
11. Reporting the crime to appropriate law enforcement officers.
12. Recommending counseling and other support to patients and visitors to your facility who were affected by the violent act.
13. Reviewing the event and making changes to prevent future occurrences.

Appendix D-**Workplace Violence Checklist**

This checklist helps identify present or potential workplace violence problems. Employers also may be aware of other serious hazards not listed here.

Designated competent and responsible observers can readily make periodic inspections to identify and evaluate workplace security hazards and threats of workplace violence. These inspections should be scheduled on a regular basis; when new, previously unidentified security hazards are recognized; when occupational deaths, injuries, or threats of injury occur; when a safety, health and security program is established; and whenever workplace security conditions warrant an inspection.

*This form was taken from: Guideline for Preventing Workplace Violence for Health Care and Social Service Workers. OSHA3148 1996.

TRUE notations indicate a potential risk for serious security hazards:

__T__F This industry frequently confronts violent behavior and assaults of staff.

__T__F Violence has occurred on the premises or in conducting business.

__T__F Customers, clients, or coworkers assault, threaten, yell, push, or verbally abuse employees or use racial or sexual remarks.

__T__F Employees are **NOT** required to report incidents or threats of violence, regardless of injury or severity, to employer.

__T__F Employees have **NOT** been trained by the employer to recognize and handle threatening, aggressive, or violent behavior.

__T__F Violence is accepted as "part of the job" by some managers, supervisors, and/or employees.

__T__F Access and freedom of movement within the workplace are **NOT** restricted to those persons who have a legitimate reason for being there.

__T__F The workplace security system is inadequate-i.e., door locks malfunction, windows are not secure, and there are no physical barriers or containment systems.

__T__F Employees or staff members have been assaulted, threatened, or verbally abused by clients and patients.

__T__F Medical and counseling services have **NOT** been offered to employees who have been assaulted.

__T__F Alarm systems such as panic alarm buttons, silent alarms, or personal electronic alarm systems are **NOT** being used for prompt security assistance.

__T__F There is no regular training provided on correct response to alarm sounding.

__T__F Alarm systems are **NOT** tested on a monthly basis to assure correct function.

__T__F Security guards are **NOT** employed at the workplace.

__T__F Closed circuit cameras and mirrors are **NOT** used to monitor dangerous areas.

__T__F Metal detectors are **NOT** available or **NOT** used in the facility.

__T__F Employees have **NOT** been trained to recognize and control hostile and escalating aggressive behaviors, and to manage assaultive behavior.

__T__F Employees **CANNOT** adjust work schedules to use the "Buddy system" for visits to clients in areas where they feel threatened.

__T__F Cellular phones or other communication devices are **NOT** made available to field staff to enable them to request aid.

__T__F Vehicles are **NOT** maintained on a regular basis to ensure reliability and safety.

__T__F Employees work where assistance is **NOT** quickly available.

Appendix E

WORKPLACE VIOLENCE DATA COLLECTION FORM
Template for hospitals to use internally

The National Institute for Occupational Safety and Health defines workplace violence as any physical assault, threatening behavior, or verbal abuse occurring in the workplace.

Date Report Completed__________________ Time__________

Location of the Incident (street, city, state, zip)
____

Work Location – (If different then incident location): (street, city, state, zip)
____

Immediate Supervisor's name: ____

Has Immediate Supervisor been notified: □ **Yes** □ **No**

If Supervisor is involved in the incident has the next level of authority been notified:
□ **Yes** □ **No**

Victim's Name (Last, First, Middle) ____**Victim's Gender:** □ **Male** □ **Female**

Victim's Home Address (street, city, state, zip) **Victim's Home Phone Number**____

Facility employed by: ___________________ Victim's Job Title:________________

Victim's Work Address: (street, city, state, zip) **Victim's Work Phone Number**

Victim's E-mail address: ____

Assailant(s) involved in the incident:
Name: ____
Unit: ____

Predisposing Factors:
____under influence of drugs/alcohol
____dissatisfied with wait time
____prior history of violence
____dissatisfied with care
____Grief reaction
____other ____

Individual's affiliation with the facility:
□ Doctor
□ Staff
□ Visitor
□ Personal relation
□ Other (please explain)

Any prior history of violence with any of the individuals involved:
□ **Yes** □ **No**
If so, when and where:
____
____

Was it reported: □ **Yes** □ **No**

Who else was present?
Name: ____
Department: _______________________________________
Address: (street, city, state, zip)
____
Phone Number: ____________________________________

Type of Incident (please check one)
□ **Verbal**
Detailed Description of Incident: (Who or what was threatened? What was said?)
____
____
____
____
____

□ **Physical**
Detailed Description of Incident:
____
____
____
____
____

□ **Threatening Behavior**
Detailed Description of Incident:
____
____
____
____
____

Were weapons were used, if any: □ Yes □ No Type of weapon used:
____

Describe injuries, if any. Clearly identify who received injury.
____
____
____

If physical contact or injury occurred to:
***Staff-Employee Incident Report must be completed**
***Assailant-Patient/Visitor Incident Report must be completed**

Any property damage
□ Yes □ No
If so, please
explain____
____

<u>Resolution of Incident</u>
_____Diffused
_____Police on Scene
_____Arrested
Were restraints used?
Yes____ if so, type used________________
No_____

<u>Disposition of Assailant</u>
_____Stayed on Premises
_____Left on Own Accord
_____Escorted off Premises
_____Other

Do you need any other assistance?
□ Yes □ No
Any other information you would like to
include:____
____
____
____

Completed by: ________________________________ _______________________
Name **Date**

Appendix F

Promoting a Nonviolent Health Care Culture
Data collection

Date of Incident—00/00/00

Incident Day --Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, Sunday

Time Incident Occurred

Location--ED, OB, Psych Unit, Critical Care, Inpatient Unit, Outpatient Unit, On-campus (choose the best one that fits your location)

Victim--Was the victim a patient, visitor, employee or physician?

Assailant--Was the assailant a patient, visitor, employee or physician?

Incident Type-- Was this incident threatened (expressed or implied), verbal (abusive involving expressed or written language) or physical (use of physical force)

Weapon--Was a weapon/tool used with the intention of causing harm? List weapon/tool or note NA

Outcome--Was the incident diffused, was security called, were police at the scene or was assailant arrested? Note highest level of intervention only.

Type of Injury-- Was there a *physical* injury (harm to body), *emotional* (injury causing fear, anxiety or stress) or no injury

Missed Days-- How many days did the victim miss work due to the incident (zero or number)

Follow-up Care-- Did the victim need *physical care* due to injury or *counseling*/ emotional care by a manager etc. or mental health professional)

Process Change-- Did the organization issue a process/procedure change due to this incident?

Appendix G

News and Information

1. Hospital Gunman Kills Mother, Himself After Shooting Doctor Sep 16, 2010 – 3:25 PM
http://www.aolnews.com/2010/09/16/doctor-shot-at-baltimores-hopkins-hospital/

2. Bitten, shot, spat on: Violence in hospitals common for staff
September 17, 2010
http://www.cnn.com/2010/HEALTH/09/16/hospital.violence.hopkins/index.html?hpt=C1

3. ER Nurses Suffer Violence, Often Without Employer Response
Nurse News, Nurse News Staff, 10/28/2010
Between 8 and 13 percent of Emergency Department nurses are victims of physical violence each week in the U.S., according to a study by the Emergency Nurses Association. More alarming is the 45 percent of incidents resulting in injury, no action was taken by the hospital against the perpetrator.

4. Increasingly, Nurses Face Violence on the Job
Philadelphia Inquirer, Jane M. Von Bergen, 11/10/2010
Temple University Hospital emergency room nurse Joan Meissler of Northeast Philadelphia is now working on light duty until she heals from the June 21 patient beating that wrecked her finances—leaving her in permanent pain, angry and disheartened. On Wednesday, nearly 180 nurses and other health care workers will seek guidance on this issue at a session on workplace violence for health care workers, sponsored by the Pennsylvania Association of Staff Nurses and Allied Professionals.

5. Violence in Hospitals, H&HN, January, 2011
http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/Article/data/01JAN2011/0111HHN_FEA_security&domain=HHNMAG

6. Hospitals Have a Higher Rate of Workplace Violence, February 22, 2011
http://www.ajc.com/jobs/hospitals-have-a-higher-848571.html

7. July 9, 2011 Pittsburgh Tribune-Review – (Pennsylvania) **Hospital staff 'a little shaken' by emergency room shooting.** An elderly Mt. Lebanon, Pennsylvania, man, who sought treatment in St. Clair Hospital's emergency department died of a self-inflicted gunshot wound to the head July 8. He apparently drove himself to the Mt. Lebanon hospital emergency room about 10 p.m., complaining of shortness of breath and nausea. Hospital personnel took him to an examination room when he told a nurse he had to go to the bathroom. He insisted he go by himself. The nurse followed him to the bathroom and waited outside the door. The nurse heard a noise and found the patient dead. From the time the man arrived to the time he shot himself took about 7 minutes. He did not threaten other patients or staffers. Handguns are not permitted in the hospital. The hospital does not have metal detectors.
Source: http://www.pittsburghlive.com/x/pittsburghtrib/news/pittsburgh/s_746004.html

8. OHIO HOUSE BILL 62 HEARING IN THE SENATE-CANCELLED
HB62 (GONZALES A) is a bill to increase the penalty for assault when the victim is a health care worker engaged in the performance of official duties whom the offender knows is a health care professional, health care worker, or security officer of a hospital. Video of the House session in which

HB62 was passed is available at
http://www.ohiochannel.org/MediaLibrary/Media.aspx?fileId=131239&returnTo=Collection
What's next for HB62?
Today's Senate Committee meeting (Senate Judiciary – Criminal Justice), scheduled for 10am, was cancelled at 9:45am without further comment. The Senate begins their recess at the end of this week and will return to work on Tuesday September 13th. We hope for a hearing to be scheduled during the month of September.
History on HB62:
Introduced: 1/26/2011 (1st Consideration)
Referred to: Criminal Justice
1st Hearing: 3/23/2011 (Sponsor testimony only)
2nd Hearing: 4/6/2011 (Proponent testimony only) - Ohio HB62
Proponent Testimony delivered by Nicholas Chmielewski.
Additional testimony by Dan Abbey, Ivy Cook, and Meghan Long.
Immediate Past President Nancie Bechtel present and delivered testimony on behalf of COTS (Central Ohio Trauma System).
Several other nurses also in attendance.
3rd Hearing: 5/18/2011. 3rd Hearing for HB62 – attended by Nick Chmielewski. An amendment was offered by Rep. Coley, which passed by a vote by 9-2.
The Ohio Prosecutors Association testified in opposition to the bill.
The bill was then referred back to the Rules and Reference Committee with a recommendation for passage – by a vote of 9-2.
2nd Consideration was given on the House Floor during session on 5/18/2011.
VOTE: Third Consideration and floor vote. Bill passes 83-12:
Introduced: 6/2/2011 (1st Consideration)
Referred to: Senate Judiciary Committee on Criminal Justice
1st Hearing: 7/13/2011 (CANCELLED)
Below is a synopsis of the 3 bills, HB62, SB111, and HB154 – AS OF 7/1/2011
HB62, SB111, and HB154 are now IDENTICAL BILLS

	Action	Coverage	Exclusions
HB62 SB111* HB154*	Increases assault against _______ from a first degree misdemeanor to a fourth degree felony	health care professionals, health care workers, and security officers of a hospital**	Applies to all offenders without exclusions**

* The table above is information of the bills as introduced. SB111 & HB154 were introduced as identical bills.
** For HB62, this coverage and exclusion is based on the substituted version of the bill.
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