TheAcademy

Issue Brief

Addressing and Preventing Workplace Violence in Leading Health Systems

Healthcare has a violence problem—with one in four nurses reporting being assaulted on the job.[1] Although the COVID-19 pandemic has brought heightened attention to the issue, workplace violence (WPV) has long been on the rise. The U.S. Bureau of Labor Statistics reports a continuous increase in the incidence of healthcare WPV over the past decade, with healthcare making up 73% of all nonfatal WPV injuries requiring time off.[2] And these data likely don't account for the full scope of the issue given the well-known challenge of underreporting and variation in WPV definitions. The American Nurses Association estimates up to 80% of incidents involving nurses go unreported.[1]

The Impact of the COVID-19 Pandemic Goes Well Beyond the Number of WPV Incidents

The onset of COVID-19 contributed to an uptick in WPV within healthcare settings and as the pandemic lingers, incidents may continue to rise. Beyond the numbers, many health systems are reporting more incidents in "lower-risk" settings (e.g., medical surgical units) as well as anecdotal increases in lateral violence (e.g., bullying).

82% **Of healthcare workers experienced at least one type of WPV during the pandemic** [3]

9% **Increase in number of WPV incidents reported by nurses between March and September 2021** [3]

A variety of factors contributed to this uptick in violence, including the stress, fear, and social and economic precarity magnified by the pandemic. In addition, most health systems pressed pause on on-going education and trainings (e.g., de-escalation) to save staff time—a critically important move during the height of the pandemic. However, the unintended consequences include staff who are out-of-practice or new staff who have never been trained in WPV prevention or response.

Violence exacerbates workforce challenges, a ripple effect impacting patients and health systems.

Health system leaders universally recognize the impact of WPV on both the individuals involved and the healthcare ecosystem. Incidents can result in minor, long-term, or even fatal physical and psychological consequences for the individual. But WPV also has a ripple effect, and repeated incidents can undermine staff's sense of physical and psychological safety across an entire department or system. Care delivery may also be jeopardized as research has shown that worker burnout and injury are linked with higher risk of medication error and patient dissatisfaction.[4]

[1] American Nurses Association, End Nurse Abuse.

[2] U.S. Bureau of Labor Statistics, Workplace Violence in Healthcare, 2018. April 2020.

[3] National Nurses United, Workplace Violence and Covid-19 in Health Care. November 2021.

[4] Reith TP. "Burnout in United States Healthcare Professionals: A Narrative Review." Cureus vol. 10,12 e3681, 2018.

The Impact of WPV in Healthcare Settings

1 **Physical injury to staff, patients, and visitors.** From unwanted touching to physical injury like cuts, bruises, fractures, suffocation, or death, violence can have lasting physical effects on those involved.

2 **Psychological injury, burnout, and voluntary staff turnover.** Perhaps more common than physical injury, staff often experience psychological distress and trauma following a WPV incident. This can impact both individuals involved and those who witness or hear about the incident. The results can be devastating—ranging from short or long-term psychological impact (e.g., anxiety, depression, PTSD), not feeling safe at work, increased absenteeism, and turnover within the system or the healthcare profession all together.

3 **Impact on patient safety and quality.** In the immediate term, patients/visitors may experience same physical or psychological impacts of WPV as staff. Across the long-term, team member burnout and increased shortages due to absenteeism or staff turnover can impact care quality.

4 **Negative perception about profession, organization.** As WPV in health systems increases, so does media coverage. In many ways, raising public awareness is beneficial. However, without a clear health system response or a balance of positive healthcare news this may unintentionally cast a negative light on the profession of nursing or health systems as a whole.

Defining Workplace Violence in Healthcare Settings

Historically, WPV has been undefined or narrowly scoped to physical assaults. This makes it difficult to measure the magnitude of the problem or evaluate solutions. CNOs and other C-Suite leaders agree there needs to be a *universal definition* for WPV across health systems that encompasses a continuum of disruptions ranging from disrespectful behaviors to physical violence.

Our WPV Definition

Workplace violence is any act or threat of:

- Physical violence
- Verbal incivility (including bullying)
- Harassment, including racism, sexism, and bigotry
- Other intimidation and disrespectful or inappropriate behavior

WPV includes acts between staff and:

- Patients, families, visitors
- Other staff

Given the rise in violence and clear impact on an already worn-down workforce, health system leaders are now more committed than ever to take action. The challenge: it's hard to know where to start.

Multitude of solutions to address WPV but no one path forward.

Over the years, health system leaders, researchers, governing bodies, and professional organizations have worked diligently to address WPV through various solutions, frameworks, and evidence-based interventions. While some solutions have fostered change, there are several reasons why health systems have struggled to make meaningful progress.

1. **Lack of universal WPV definition among health systems.** Some health systems focus exclusively on physical assaults, while others include verbal abuse and lateral violence within their organization's definition. This variation makes it difficult to measure the magnitude of the problem, which is critical to garner resources for prevention efforts. In addition, it means staff, leaders, and the industry don't have universal language for discussing the problem.
2. **Myriad of frameworks not translating into practice.** While conceptual frameworks can be valuable, it's hard for health systems to know where or how to get started, particularly with the variety of information available.
3. **Challenges disseminating and measuring impact of evidence-based practices.** The research to practice pipeline can take an average of 17 years and this lag time makes it hard for health systems to know which practices will be most effective in a timely manner. [5]

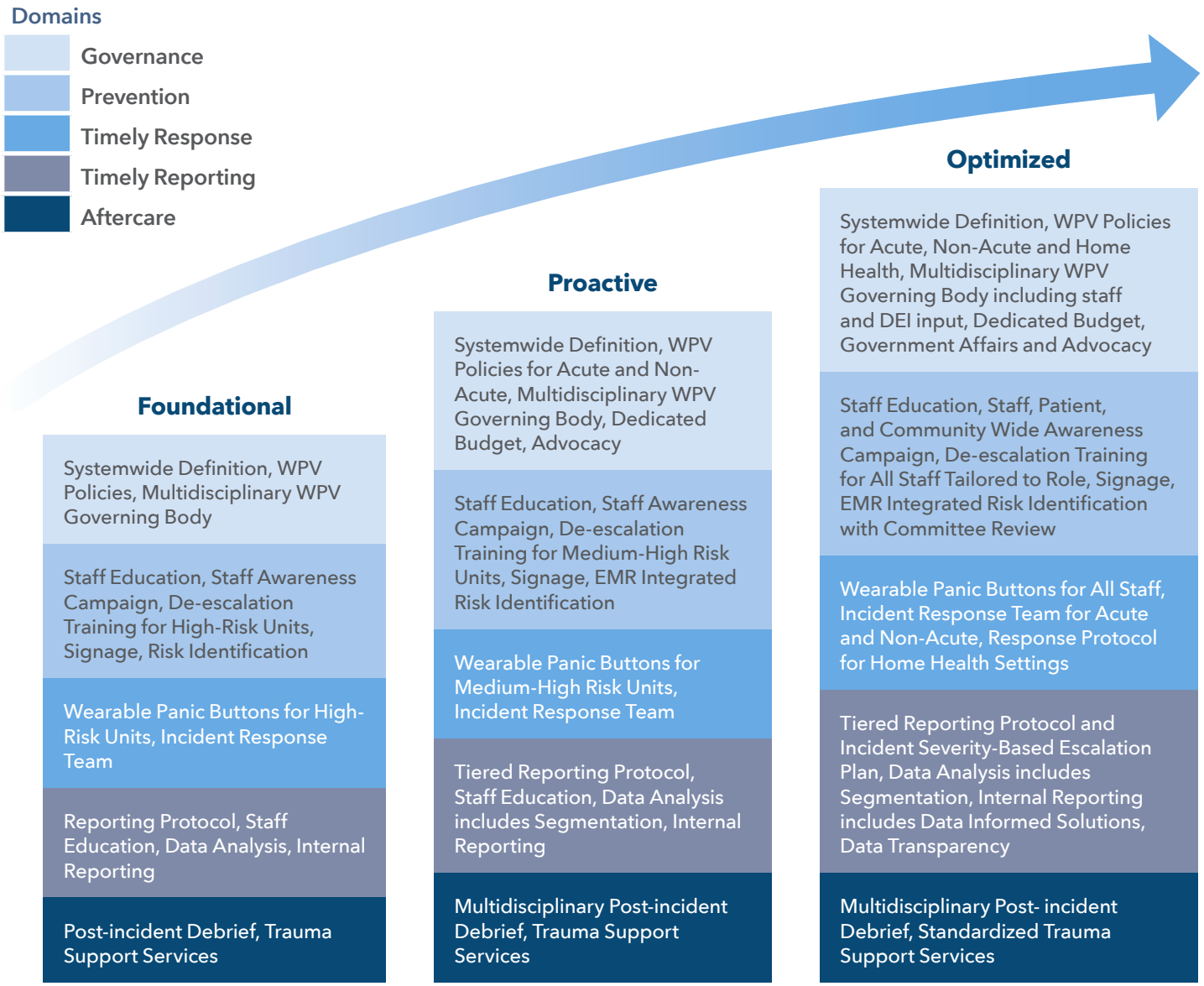
[5] Morris ZS, Wooding S, Grant J. The Answer is 17 years, What is the Question: Understanding Time Lags in Translational Research. J R Soc Med. 2011;104(12):510-520.

WPV maturity model designed to help health systems understand current state and path forward.

To help health systems determine a path forward, The Academy created a Workplace Violence Maturity Model based on the wealth of existing WPV resources (including the most up-to-date Joint Commission standards) and original qualitative research with Chief Nursing Officers, Chief Human Resource Officers, Security Leaders, and Government Affairs leaders from Leading Health Systems (LHS).[6,7] This combination of industry knowledge and on-the-ground insights from leaders provides health systems a practical and actionable resource to prevent and address WPV.

The model (see Figure 1) has three maturity levels—foundational, proactive, optimized—and five domains—governance, prevention, timely response, timely reporting, and aftercare. Health systems can use this model to assess their organizations' current state of WPV prevention and response and decide what concrete steps are needed to make progress in WPV maturity. A detailed version of the model can be found in the appendix.

Figure 1. Maturity Model Overview



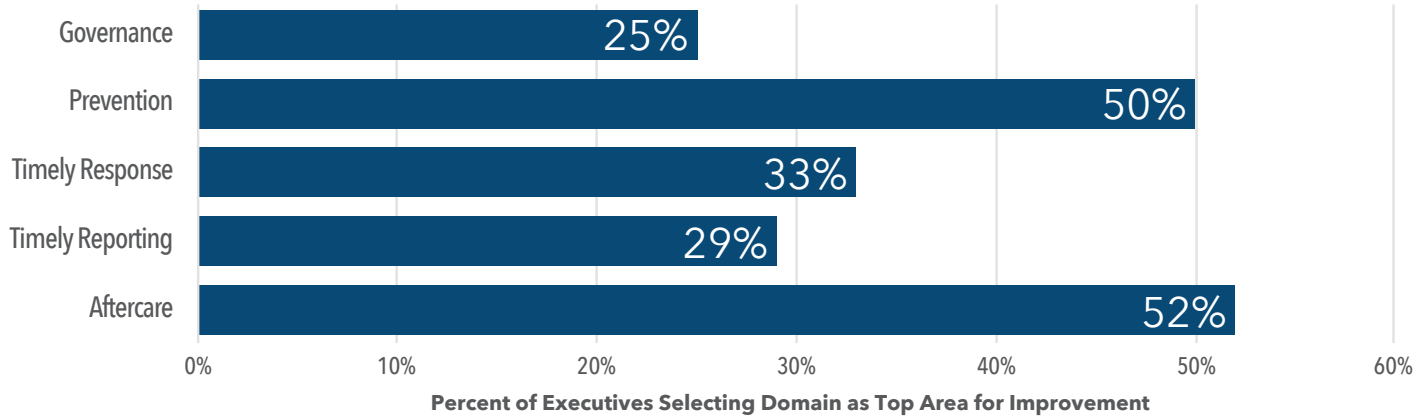
[6] Qualitative research included 10 in-depth interviews with Chief Nursing Officers, Chief Human Resource Officers, Security Leaders, and Government Affairs leaders from Leading Health Systems, 3 in-depth interviews with industry subject matter experts, and a one-hour, facilitated in-person discussion with 48 nursing leaders.

[7] Leading Health Systems (LHS): The approximately 150 innovative integrated delivery systems with over $2B in total operating revenue.

More than half of health systems (52%) reported their WPV maturity as foundational, followed by 42% as proactive and only 6% optimized.[8] In addition, performance across the domains was not equal, with prevention and aftercare representing the domains with the most opportunity for improvement.

Figure 2. Health System Opportunity for Improvement by Maturity Domains

Health System Response: Based on the maturity model, which domain(s) does your organization need to make the most progress on? [9]



The remainder of this brief examines the five maturity model domains in greater depth, including insights on the components of each domain and how participating health systems assessed their current performance.

Domain 1. Governance.

Governance is the infrastructure that holds leaders accountable through standards, policies, procedures, and operations. It is also the mechanism for continuous improvement and adaptation of changing conditions in the environment. These processes ensure a health system has a standardized and funded approach to WPV prevention, intervention, and aftercare. A governance structure includes the following components:

- **Systemwide definition.** One basic, but necessary component of governance is a systemwide WPV definition which includes physical, verbal, and lateral violence. Most health system leaders agree that it is critical to include lateral violence, or bullying, as part of a comprehensive definition because WPV is a continuum, ranging from disrespectful behaviors to physical violence. As one CNO shared: "We must have a zero-tolerance policy internally in order to set the stage externally."
- **Systemwide policies.** Most organizations already have some WPV policies in place. However, these policies generally focus on acute care settings. Governing bodies should strongly consider closing this gap by extending WPV policies and protocols to non-acute settings.
- **Multidisciplinary governing body and leadership buy-in.** A WPV governing body oversees an organization's prevention, intervention, and aftercare response. The Joint Commission requires a WPV governing body and most organizations have one in some capacity—but with varying authority levels and budgetary discretion. An impactful WPV governing body needs broad leadership support demonstrated through a dedicated budget, accountability, and decision authority. For organizations looking to build the case for a dedicated budget, The 2020 Oregon Workplace Safety Initiative, Toolkit for Prevention and Management includes helpful guidance. Optimized governing bodies should include both leadership and staff from multiple disciplines, and collaborate with the diversity, equity, and inclusion (DEI) committee or team to mitigate bias in protocols.
- **Government affairs, advocacy.** Organizations that have moved beyond the foundational level seek to influence local, state, and federal laws and urge greater lobbying support from professional organizations. Some health systems are leading policy change by deepening relationships through their government affairs team and working to secure federal funding and grant opportunities for prevention efforts. Other C-suite leaders are taking on advocacy directly.

Most health systems have many of the foundational governance aspects in place and agree that a strong governance structure sets the foundation for prevention, intervention, and aftercare response. However, as organizations push forward on governance, it needs to be simultaneous with work in other areas.

Example: Public Policy and Advocacy Response to Workplace Violence

Warner Thomas, President & CEO of Ochsner Health, released a strong public message following a WPV incident in January 2022. Ochsner executives have since brought local politicians into the system to hear firsthand accounts of the issue's severity.

Currently, the Louisiana state legislature is convening to pass policy that assigns harsher consequences for perpetrators of violent incidents. Through this work, Ochsner is demonstrating their commitment to WPV prevention to staff and the larger community.

[8] n=48 nursing leaders; live poll during in-person, facilitated discussion. Respondents could select more than one domain.

[9] n=48 nursing leaders; live poll during in-person, facilitated discussion. Respondents could select more than one domain.

Domain 2. Prevention.

WPV prevention includes education, training, risk identification, and security measures to mitigate risk and foster a safe work environment. Done well, prevention can reduce the number and severity of incidents which in turn reduces costs, workplace injury, and absenteeism. The primary components of this domain include:

- **Education and awareness campaigns.** The goal of education and public campaigns is to help staff understand the magnitude of WPV and their role in preventing it. At a minimum, annual education should include awareness of WPV protocols, role-specific responsibilities, aftercare services, security resources, and warning signs of lateral violence. Storytelling can be a particularly effective strategy to bolster education and campaign efficacy. One way to do this is to include real staff stories of WPV in the education modules.

"We use our staff to tell their stories. It shows it can happen to anyone, anywhere."
– Chief Nursing Officer, Leading Health System

- **Training**. Training provides staff with the skills to recognize and manage situations that could result in WPV. Typically, health systems provide de-escalation training to "high-risk" staff, such as those in the emergency department or behavioral health units. Now, organizations are expanding training for all staff and tailoring this training by role. In particular, staff in non-acute care settings should be prioritized for de-escalation training, as those sites often do not have onsite security to help manage escalating situations. For organizations that outsource de-escalation training, be sure to look for curricula that include scenario-based learning, and tailor trainings by role and site of care.
- **Risk identification.** Flagging patients/visitors who demonstrate escalating behaviors that may result in physical violence helps keep staff safe. In some cases, this can be an "FYI" to security that results in increased rounding on the unit. In other cases, it may include a physical warning sign outside of patient rooms (using neutral but recognizable language or symbols for staff). Some health systems are using electronic health record flags to denote significant verbal and physical WPV incidents to ensure staff across individual shifts or care sites are warned of potential safety threats. These warnings can be critical to keeping staff safe but should be accompanied by review committees who can assess flags for bias or other factors that may make the flag inappropriate or no longer necessary and (if appropriate) remove flags in a timely manner.

"Most people who are violent don't wake up knowing what they're going to do. Sometimes patients are getting life changing news or are reacting to a condition or medication."
– Chief Nursing Officer, Leading Health System

Proactive Method to Manage Lateral Violence

Most forms of lateral violence don't require a security response and can be resolved between coworkers with support from leaders. But staff need to be equipped with the skills to intervene on behalf of themselves or others.

Baylor, Scott & White implemented a common language for staff to help call attention to lateral violence in-the-moment. If a staff member is experiencing bullying, they are encouraged to use the phrase: "I **THINK** we need a pause."

T	H	I	N	K
is it **True?**	*is it* **Helpful?**	*is it* **Inspiring?**	*is it* **Necessary?**	*is it* **Kind?**

This phrase signals to others that the current tone or language being used is perceived as bullying. More often than not, it's enough to de-escalate the moment and mitigate lateral violence.

- **Signage.** Systemwide signage can communicate zero-tolerance policies for WPV and what behavior is expected of patients and visitors. While signage shouldn't be implemented as a singular prevention tactic, many health systems find clear value in it. As one CHRO shared: "With signage, people have understood. It has curbed some behavior because it communicates a consequence. Before there was a license to do or say whatever you want. It's well received from staff, they feel supported. For us, signs are working."

While health systems have traditionally focused on WPV prevention, leaders were quick to identify this as one of the domains they need to most improve—primarily by scaling current strategies from acute to non-acute care settings.

Domain 3. Timely Response.

When a WPV incident occurs, timely response is critical. Timely response includes standard approaches like a safety alert system (e.g., emergency codes called overhead) and a rapid security response. Beyond these response measures, organizations are considering the following:

- **Wearable panic buttons.** There is near universal agreement among health system leaders that wearable panic buttons are a vital solution given that team members are highly mobile, and stationary panic buttons are not always in reach. With a wearable option, staff can always call for help, which is critical in reducing response times when it matters most. Currently, device rollout tends to focus on arming nurses and clinical staff in high-risk units. When possible, health systems should extend wearables for all staff (including clinicians, consultants, administrative staff) across sites of care. For non-acute care settings, organizations will also need to determine who responds to the duress signal.

"Roll out of wearable devices is going remarkably well, but you need the resources. You need a 24/7 security workforce. We thought people wouldn't respond well to "big brother" tracking them, but everyone loves them. Other departments want them." – Chief Nursing Officer, Leading Health System

- **Incident response.** Health systems need 24/7 security and behavioral health response teams trained to respond appropriately to a variety of incidents. Every incident is different and requires a nuanced approach. Response teams should be trained to tailor their response appropriately in-the-moment. This may require a multi-disciplinary approach to response teams that includes security, clinicians, and other dedicated staff.

Almost all health systems already have an incident response strategy and most feel they've made headway in this domain. Similar to prevention, health systems need to expand progress in the acute care space into non-acute settings.

Domain 4. Timely Reporting.

Timely reporting is a key function that helps leadership not only understand WPV trends, but also inform data-driven solutions to prevent future incidents. The Joint Commission requires health systems to have an incident reporting strategy. But beyond a standard approach to reporting, health systems need to change the culture around reporting. Currently, many nurses and other staff view most WPV as "part of the job." This will take time and dedicated effort to change. One strategy is to use organizational learnings from patient safety reporting, including:

- **Staff education.** Effective staff education not only teaches staff how and when to report but done well, can foster a positive WPV reporting culture. Messaging must be clear—staff should report all events regardless of severity and without fear of retaliation. In addition, organizations should be transparent about how the data are used. Similar to awareness campaigns, using storytelling to spotlight positive employee experiences can reduce fear and normalize reporting.
- **Reporting protocol.** One basic, but necessary element of reporting protocol is the staff's need to know what to report based on the systemwide WPV definition. Clearly outlining zero tolerance for all WPV reinforces the message that this isn't "part of the job." Mature health systems are using tiered reporting protocols that concretely outline how to report WPV based on incident severity. Some health systems are also leveraging existing technology as part of the reporting protocol, integrating reporting mechanisms into nurse workflows to make it as easy as possible.

"About three years ago (right before COVID), our CNO and I were doing quite a bit of work around education on how to use the system and how to report. Reports go to executives, area leaders, and security. We created a culture of reporting." – Chief Human Resources Officer, Leading Health System

- **Internal reporting and data analysis.** Data should be reported directly to the WPV governing body to help with action planning. This transparency can foster trust between health systems and staff, especially after high-profile incidents. Sharing data and action plans demonstrates a health system's commitment to protect staff and prevent future incidents.

Timely reporting is a challenging domain. While nearly all systems have a reporting structure in place, the culture of not reporting is still common. Health systems with measurable room for improvement will need to focus on consistent, executive messaging and actions that foster a safe reporting culture.

Domain 5. Aftercare.

In the aftermath of a WPV incident, staff need to feel supported by their employer. Traditionally, health systems focused on having Occupational Safety and Health Administration (OHSA) compliant worker's compensation practices but leave legal response to the involved parties. Mature organizations are starting to rethink their role in legal protections for staff. Beyond legal action, there are two areas to prioritize:

- **Post-incident debrief.** A formalized debrief process can identify how incidents occurred and address underlying factors to prevent future incidents. Modeled after adverse event analyses, health systems should consider using root cause analysis (RCA) following an incident to reinforce a culture of continuous progress and align with existing patient safety protocols.
- **Trauma support.** Short and long-term trauma care provided by health systems helps staff feel safe and supported. Health systems should strongly consider standardizing their trauma support services and allocating dedicated resources.

In general, health systems have some type of trauma support in place. However, more than half (52%) of nursing leaders prioritized this domain as the number one area for improvement. This is primarily due to inconsistent debriefing and support in both acute and non-acute care settings. For organizations looking to improve, start by talking with staff about what type of support they want. Support is only valuable if staff use it and believe it will help.

Examples of Trauma Support

- Peer support programs
- Social worker unit rounding
- Employee Assistance Program (EAP) services, including counseling and referrals
- Mental health support
- Financial support from employer

Getting started.

The Point-of-Care Violence Maturity Model provides health systems with a clear path forward to address WPV. While all domains are important, **start with Timely Response** to ensure staff are physically safe. From there, target components of the remaining four domains to align with resources, policies, or programs your health system already has in place. A health system's maturity may vary between domains and that's okay. Focus on making sure foundational components within each domain are included within your WPV program and from there, continue to expand.

And keep in mind, addressing WPV is difficult work. It will require ongoing time and resources and (importantly) requires managing a wide variety of human emotions and behaviors. Perfection isn't likely—the goal here is continued progress.

Health System Spotlight

Addressing and Preventing Workplace Violence

MHP | MAJOR HEALTH PARTNERS

- Rural, community healthcare provider in southeastern Indiana
- 46- bed hospital, 1 Medical Center with acute, ambulatory, ancillary services
- 1500 employees
- Serves over 24,000 patients annually

Major Health Partners Uses Vocera Smartbadge to Safeguard Nurses and Other Frontline Workers

In 2020, Major Health Partners (MHP) wanted to improve staff safety by decreasing response time to workplace violence (WPV) incidents. At the time, MHP averaged 3-5 incidents requiring security response every week at their flagship hospital. They had a centralized security call system, but responses were slower than desired. In addition, leaders worried that in-room panic buttons were inaccessible in moments of distress.

To improve incident response time, leaders developed a two-fold approach:

First, MHP partnered with Vocera, a leading provider of clinical communication and workflow solutions, and rolled out wearable **Smartbadges** to nurses in high-risk units. The Smartbadge is a small, lightweight communication device that gives nurses and other care team members the ability to communicate and collaborate hands-free. The voice-controlled device allows staff to connect with the right person at the right time simply by saying a name, role, or group. Additionally, the Smartbadge features a dedicated panic button that enables staff to discreetly open a communication channel to the security team.

MHP used the Smartbadge panic button to reduce security response time by streamlining communication channels during WPV incidents. Implementation was quick as the Smartbadge required little education during rollout. In the event of a WPV incident, MHP staff press the panic button to alert security staff of their location. Security can hear what is happening for real-time situational awareness. This dedicated communication channel ensures staff had immediate help when needed.

"The Smartbadge was an ask from staff. Using smartphones at the bedside is a disadvantage for nurses in a security situation because it's more cumbersome to call security. Partnering with Vocera met a great need. That was a big win from the bedside nursing perspective. The dedicated panic button on the Smartbadge gives team members a sense of security and peace of mind." – Director of Clinically Integrated Technology

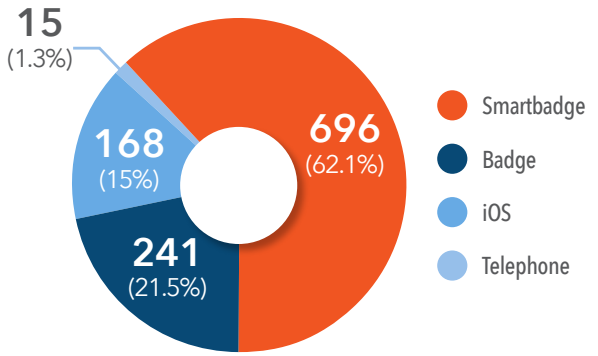
Simultaneously, MHP invested in facility safeguards, including: access control in high-traffic areas, security cameras, "safe rooms" in the emergency department outfitted with reinforced walls, and removable equipment to protect both staff and patients during an incident.

Since implementing this two-part strategy, MHP has observed:

- **Increased reporting of WPV.** Prior to rolling out the Smartbadge, MHP reported 253 total calls in the Security Department (2019). After implementation, the number of reported incidents increased by over 300% to 1,426 in 2020 and 1,120 in 2021.
- **Reduced response time.** Almost immediately, the hospital experienced faster security responses during WPV incidents due to streamlined communication, the increase in incident reporting, and ease of reporting.
- **Increased safety.** Staff comfort improved knowing that with the push of a button incidents are swiftly de-escalated.

"The most sage advice I would offer is to make sure your planning and decision-making process brings in the people closest to the situation. In our process planning, we engaged our ED nurses and security staff. It wasn't just us telling them how to use [wearable devices]. They were part of how we designed our systems and processes."
– Vice President and Chief Operating Officer/Chief Nursing Officer

Uptick in WPV Reporting Primarily Driven by Smartbadge
Calls by Device Type, 2021
Total calls=1,120



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About The Academy

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About Vocera

Vocera, now part of Stryker, provides clinical communication and workflow solutions that help protect and connect team members, increase operational efficiency, enhance quality of care and safety, and humanize the healthcare experience. Nearly 2,800 facilities worldwide, including more than 2,300 hospitals and healthcare facilities, have selected Vocera solutions to enable their workforce to communicate and collaborate, and engage with patients and families. Our platform can integrate with most clinical and operational systems used in hospitals. Mobile workers can choose the right device for their role and workflow, including smartphones or our wearable, hands-free communication devices, and use voice commands to easily reach people by name, role, or group. For more information, visit Vocera.com.

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The Academy extends its appreciation to Vocera for the financial support for this brief

	Foundational	Proactive	Optimized
Governance	❑ **Definition.** Systemwide WPV definition includes physical, verbal, and lateral violence ❑ **Prevention program.** ❑ **Policies.** Systemwide policies, response and reporting protocol, lateral violence retaliation procedures, worksite analysis and interventions for acute care settings ❑ **Multidisciplinary governing body.** Assigned lead, ad hoc convening ❑ Includes acute and non-acute care leaders ❑ **Buy-in.** C-Suite, D-Suite support for WPV initiatives	❑ **Definition.** Systemwide WPV definition includes physical, verbal, and lateral violence ❑ **Prevention program.** ❑ **Policies.** Systemwide policies, response and reporting protocol, lateral violence retaliation procedures, worksite analysis and interventions for acute and non-acute care settings ❑ **Multidisciplinary governing body.** Assigned lead, regular convening, active department level collaboration ❑ Includes acute and non-acute care leaders ❑ Includes frontline staff ❑ Include DEI committee members ❑ **Buy-in.** C-Suite, D-Suite support for WPV initiatives with dedicated budget ❑ **Government affairs, advocacy.** Communication with local or federal politicians, lobbyists, professional organizations	❑ **Definition.** Systemwide WPV definition includes physical, verbal, and lateral violence ❑ **Prevention program.** ❑ **Policies.** Systemwide policies, response and reporting protocol, lateral violence retaliation procedures, worksite analysis and interventions for acute, non-acute, home health settings ❑ **Multidisciplinary governing body.** Assigned lead, regular convening, robust department level collaboration ❑ Includes acute and non-acute care leaders ❑ Includes frontline staff ❑ Include DEI committee members ❑ Includes union representatives, community partners ❑ **Buy-in.** Strong Trustee, C-Suite, D-Suite support for WPV initiatives with dedicated budget ❑ Governing body uses budget at discretion ❑ **Government affairs, advocacy.** ❑ Regular communication with local or federal politicians, lobbyists, professional organizations ❑ Legislative collaboration ❑ Advocating for federal funding to expand prevention strategy

	Foundational	Proactive	Optimized
Prevention	❑ **Staff education.** Mandatory, annual WPV staff education includes: ❑ WPV definition, response and reporting protocol, role specific responsibilities, aftercare services ❑ Lateral violence education, warning signs ❑ **WPV awareness campaign.** Staff awareness campaign for acute, non-acute, home health settings, aligned with education curriculum ❑ **Training.** Mandatory, annual WPV staff training includes: ❑ Emergency response, all staff ❑ De-escalation, nonphysical intervention skills, physical intervention techniques, high-risk units only ❑ **Risk identification.** Proactive security rounding, high-risk units ❑ **Facility.** Annual worksite analysis and interventions ❑ **Technology.** Enhanced safety measures including video surveillance, access control, entry privileges, duress alarm; high-risk units, mass notification system ❑ **Signage.** Aligned with awareness campaign language ❑ **Security officers.** Compassionate, high-emotional control; may hold full power to arrest, search, seize ❑ Relationship with unit staff, high risk units	❑ **Staff education.** Mandatory, annual WPV staff education includes: ❑ WPV definition, response and reporting protocol, role specific responsibilities, aftercare services ❑ Lateral violence education, warning signs ❑ Bias module, systemwide ❑ **WPV awareness campaign.** ❑ Staff awareness campaign for acute, non-acute, home health settings, aligned with education curriculum ❑ Patient WPV education campaign, includes definitions, resources, bystander intervention ❑ **Training.** Mandatory, annual WPV staff training includes: ❑ Emergency response, all staff ❑ De-escalation, nonphysical intervention skills, physical intervention techniques, medium, high-risk units ❑ De-escalation skills, lateral violence ❑ Scenario-based physical intervention techniques training, high-risk units ❑ **Risk identification.** ❑ Proactive security rounding, medium, high-risk units ❑ Integrated EMR alert, high-risk patient, visitor identification ❑ **Facility.** Annual worksite analysis and interventions ❑ **Technology.** Enhanced safety measures including video surveillance, access control, entry privileges, duress alarm; medium, high-risk units, mass notification system ❑ **Signage**. Aligned with awareness campaign language ❑ **Security officers.** Compassionate, high-emotional control; may hold full power to arrest, search, seize ❑ Relationship with unit staff, medium and high-risk units	❑ **Staff education.** Mandatory, annual WPV staff education includes: ❑ WPV definition, response and reporting protocol, role specific responsibilities, aftercare services ❑ Lateral violence education, warning signs ❑ Bias module, systemwide ❑ **WPV awareness campaign.** ❑ Staff awareness campaign for acute, non-acute, home health settings, aligned with education curriculum ❑ Patient WPV education campaign, includes definitions, resources, bystander intervention ❑ Community awareness campaign, includes patient, visitor behavior expectations, prevention initiatives ❑ **Training.** Mandatory, annual WPV staff training includes: ❑ Emergency response, de-escalation, nonphysical intervention skills, physical intervention techniques, all staff tailored by role ❑ De-escalation skills, lateral violence ❑ Scenario-based nonphysical, physical intervention techniques training, medium, high-risk units ❑ **Risk identification.** ❑ Proactive security rounding, systemwide ❑ Integrated EMR alert, high-risk patient, visitor identification ❑ Dedicated committee reviewing flags ❑ **Facility.** Annual worksite analysis and interventions ❑ **Technology.** Enhanced safety measures including, video surveillance, access control, entry privileges, duress alarm; all units, mass notification system ❑ **Signage**. Aligned with awareness campaign language ❑ **Security officers.** Compassionate, high-emotional control; diverse backgrounds; may hold full power to arrest, search, seize ❑ Relationship with all units

	Foundational	Proactive	Optimized

Intervention Timely Response	❑ **Safety alert system.** Notifies security and essential staff of incident in progress
	❑ **Wearable panic buttons.** High-risk units
	❑ **Incident response.**
	  ❑ **Response team.** Security-led, rapid response team; emphasizes de-escalation, available in acute care settings 24/7
	  ❑ **Behavioral team response.** Dedicated team trained in behavioral health response; available in acute care settings 24/7
		❑ **Safety alert system.** Notifies security and essential staff of incident in progress
		❑ **Wearable panic buttons.** Medium-high risk units.
		❑ **Incident response.**
		  ❑ **Response team.** Multidisciplinary rapid response team; emphasizes de-escalation, available in acute care settings 24/7
		  ❑ **Behavioral team response.** Dedicated team trained in behavioral health response; available in acute care settings 24/7
			❑ **Safety alert system.** Notifies security and essential staff of incident in progress
			❑ **Wearable panic buttons.** All staff
			  ❑ Available for contractors, temporary employees, ad hoc unit visits
			❑ **Incident response.**
			  ❑ **Response team.** Multidisciplinary rapid response team; emphasizes de-escalation, available in acute care settings 24/7; non-acute care settings where feasible
			  ❑ **Behavioral team response.** Dedicated team trained in behavioral health response; available in acute care settings 24/7; non-acute care settings where feasible
			  ❑ **Dedicated response.** Protocol for home health settings

Intervention Timely Reporting	❑ **Protocol.** Includes reporting of verbal, physical, lateral violence
	❑ **Staff education.** Annual workforce safety, reporting, protocols training
	❑ **Reporting system.** Joint Commission compliant system
	❑ **Data analysis.** Quality, safety team reviews incident reports
	❑ **Internal reporting**. Incident reports, data analysis regularly shared with WPV governing body
	  ❑ Interventions around trends owned by WPV governing body
		❑ **Protocol.** Includes reporting of verbal, physical, lateral violence
		  ❑ Protocol outlines tiered reporting based on severity of incident
		❑ **Staff education.** Annual workforce safety, reporting, protocols training
		❑ **Reporting system.** Joint Commission compliant system
		  ❑ Reporting aligned with staff workflow (i.e., EMR)
		❑ **Data analysis.** Interdisciplinary quality, safety team reviews incident reports
		  ❑ Includes health equity and violence type segmentation
		❑ **Internal reporting.** Incident reports, data analysis regularly shared with WPV governing body and C-suite leadership
		  ❑ Interventions around trends owned by WPV governing body
		  ❑ Data transparency with staff, when appropriate
			❑ **Protocol.** Includes reporting of verbal, physical, lateral violence
			  ❑ Protocol outlines tiered reporting based on severity of incident
			  ❑ Includes a reporting escalation plan based on severity of incident
			❑ **Staff education.** Annual workforce safety, reporting, protocols training
			❑ **Reporting system.** Joint Commission compliant system
			  ❑ Reporting aligned with staff workflow (i.e., EMR)
			  ❑ All incident reporting systems are integrated (e.g., adverse events, WPV)
			❑ **Data analysis.** Interdisciplinary quality, safety team reviews incident reports
			  ❑ Includes health equity and violence type segmentation
			❑ **Internal reporting.** Incident reports, data analysis regularly shared with WPV governing body, C-suite leadership, Trustees
			  ❑ Interventions around trends owned by WPV governing body
			  ❑ Data informed solutions
			  ❑ Data transparency with staff, when appropriate

	Foundational	Proactive	Optimized
Aftercare	❑ **Post-incident debrief.** ❑ Unit level debrief with involved staff for patient and visitor-based incidents ❑ Co-worker mediation, lateral violence ❑ Report sent to WPV governing committee ❑ **Trauma support.** Individualized trauma support services for involved staff ❑ **Worker's compensation.** OSHA compliant practices ❑ **Legal response.** Responsibility of involved staff	❑ **Post-incident debrief.** ❑ Unit level debrief with involved staff for patient and visitor-based incidents ❑ Co-worker mediation, lateral violence ❑ Report sent to WPV governing committee, relevant leadership ❑ Multidisciplinary root cause analysis (RCA), including corrective action plan ❑ **Trauma support.** ❑ Individualized, long-term trauma support services for involved staff ❑ Timely trauma support for involved staff, witnesses, other staff ❑ **Worker's compensation.** OSHA compliant practices ❑ **Legal response.** Responsibility of involved staff	❑ **Post-incident debrief.** ❑ Unit level debrief with involved staff for patient and visitor-based incidents ❑ Co-worker mediation, lateral violence ❑ Report sent to WPV governing committee, relevant leadership ❑ Multidisciplinary root cause analysis (RCA), including corrective action plan ❑ **Trauma support.** ❑ Standardized trauma support strategy, individualized and long term for involved staff, witnesses, other staff ❑ All support offered within 24 hours ❑ **Worker's compensation.** OSHA compliant practices ❑ **Legal response.** Health system responsibility, decisions informed by involved staff