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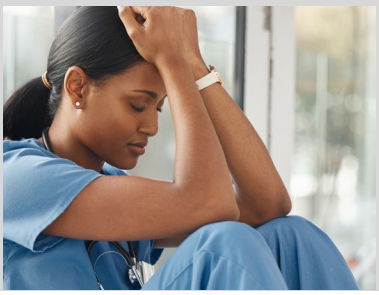
Chubb Healthcare Violence Prevention Self-Assessment Tool



Healthcare facilities are not immune to the threat of random violence. In fact, according to the Occupational Safety and Health Administration, incidents involving workplace violence are four times more common in a healthcare setting than in other workplaces. Although there are inherent risks in providing healthcare services to the greater public, a sound organizational approach to violence prevention and mitigation can reduce injury rates, save lives, and minimize liability for lack of preparation.

Chubb Insurance offers this self-assessment Violence Prevention Tool to help healthcare organizations evaluate their workplace violence prevention program and ensure they have a coordinated and rehearsed response to encounters when they occur. Routine periodic risk assessment and hazard vulnerability analysis are designed to help hospitals and other healthcare settings evaluate the effectiveness of their policies and practices.

As not all assessment parameters may be applicable to every healthcare setting, the tool should be adapted to suit specific organizational needs, based upon variations in scope of services, facility size and resource levels, geographic location, and historical exposures.

Date of Assessment: _____

Name of person conducting assessment: _____

Title and department: _____ Cell phone number: _____

Fundamentals

Organizational Composition	Response
1. Is the facility a hospital or clinic?	
2. If a clinic, what are the principal functions and scope of services?	
3. What is the square footage of the facility?	
4. Does the facility have a designated trauma level, if applicable?	
5. What is the approximate number of employees?	

Written Program	Yes	No	N/A	Comments
1. Is there a written violence protection program (VPP), inclusive of:				
• Threat management and assessment?	○	○	○	
• Searches and screening of patients, staff, and visitors for personal effects?	○	○	○	
• Emergency communication protocols?	○	○	○	
• Response protocols for terrorism and bomb threats, hostage situations, and use of lethal weaponry?	○	○	○	
• Patient abduction response and management?	○	○	○	

Written Program	Yes	No	N/A	Comments
2. Does the VPP clearly define all types of violent and abusive acts, including:				
• Physical conduct, e.g., unwanted touching, hitting, threatening gestures, throwing of physical objects?	○	○	○	
• Verbal conduct, e.g., harassment, bullying, intimidating, threatening language?	○	○	○	
• Psychological control, e.g., refusing clinical services to patients, threatening retaliation against staff members who report violence and abuse?	○	○	○	
• Interpersonal conflict, e.g., offensive jokes, bigotry, sexual harassment, demeaning behavior?	○	○	○	
• Threats of domestic violence against patients or staff?	○	○	○	
3. Does the workplace VPP support and reflect the organization's mission and values?	○	○	○	
4. Does the VPP undergo annual review?	○	○	○	
5. Does an outside law enforcement representative or security consultant review the VPP program on a periodic basis and are records of the inspection maintained?	○	○	○	
Supporting Policies and Procedures	**Yes**	**No**	**N/A**	**Comments**
1. Are associated VPP policies and procedures written in clear and concise language, understood by all levels of staff, and applicable enterprise-wide?	○	○	○	
2. Do supportive policies and procedures address the following measures, at a minimum:				
• Authorizing and managing weapons on site?	○	○	○	
• Staff reporting of safety- and security-related incidents?	○	○	○	
• Handling problematic staff terminations?	○	○	○	
• Using restraint and seclusions in clinical settings?	○	○	○	
• Managing patient elopement and wandering?	○	○	○	
• Addressing patient discharge against medical advice?	○	○	○	
• Reporting and managing domestic violence threats against patients and staff?	○	○	○	
3. Do relevant policies and procedures meet state and federal rules and regulations, as well as standards and guidelines by the following entities, among others:				
• Occupational Safety and Health Administration?	○	○	○	
• Joint Commission?	○	○	○	
• Centers for Medicare and Medicaid Services?	○	○	○	
• Society for Human Resource Management?	○	○	○	
• American Society for Health Care Risk Management?	○	○	○	
• American Society for Industrial Security?	○	○	○	
• International Association for Healthcare Security and Safety?	○	○	○	

Risk and Vulnerability Analysis

Organizational Awareness	Yes	No	N/A	Comments
1. Is there a multi-disciplinary process and team to oversee threat management and assessment?	○	○	○	
2. Has an analysis of safety controls been conducted throughout the organization, including a comprehensive review of:				
• Background check requirements for new hires and volunteer staff?	○	○	○	
• Employee, volunteer, and visitor identification measures?	○	○	○	
• Marked exit/escape routes?	○	○	○	
• Physical grounds for potential security breaches?	○	○	○	
• Protective glass surrounds in clinical areas?	○	○	○	
• Crisis intervention rooms with two exits?	○	○	○	
• Designated employee safe rooms?	○	○	○	
• Work spaces for furniture and equipment layout?	○	○	○	
3. Has an analysis of security provisions been conducted throughout the organization, including a comprehensive review of:				
• Uniform security guard postings and security escorts?	○	○	○	
• Lighting and illumination of external doorways, parking lots, and corridors?	○	○	○	
• Locking systems on all points of ingress?	○	○	○	
• Metal detectors and electronic access controls?	○	○	○	
• Closed circuit television monitoring systems and curved mirrors?	○	○	○	
• Emergency signaling systems, including hand-held alarms and direct dial telephone lines or cell phones?	○	○	○	
4. Has the organization's history of violent-related incidents been tracked and analyzed?	○	○	○	
5. Has a CAP Index score — i.e., measuring the types and frequency of crime rate for a local vicinity — been obtained?	○	○	○	
6. In the alternative, has an area crime analysis been provided by local law enforcement?	○	○	○	

Inherent Propensities	Ranking
1. Rank 1 thru 5 each of the following perpetrator types, according to their likelihood of violent behavior and the consequent threat posed (1 being the greatest):	
• Patients and visitors	
• Employees and contractor employees	
• Individuals motivated by extreme ideology	
• Domestic partners	
• Criminals and others suspected of criminal activity	

Inherent Propensities	Ranking
2. Rank 1 thru 15 each of the following areas/departments, if applicable, for their inherent risk exposure (1 being the greatest):	
• Administration	
• Emergency Department	
• Finance and Patient Counseling	
• Human Resources	
• HVAC Spaces	
• ICUs	
• Inpatient Behavioral Units	
• Inpatient Pharmacies	
• Maternity and Pediatrics	
• Observation/Seclusion Rooms	
• Parking Lots and Structures	
• Pharmaceutical Storage Areas in Clinical Settings	
• Reception, Registration, and Triage Areas	
• Retail Pharmacy	
• Waiting Rooms	

Incident Tracking and Record Keeping	Yes	No	N/A	Comments
1. Is there one written and consistent procedure for reporting, investigating, and documenting all acts of real or threatened violence, including verbal and written abuse, harassment, and assault?	○	○	○	
2. Is a standardized, electronic format available for incident reporting of violent and/or abusive acts?	○	○	○	
3. Are the following violence-related incidents tracked on a regular basis and analyzed relative to baseline rates:				
• Threatening behavior?	○	○	○	
• Assaults and other physical violence?	○	○	○	
• Security responses to reported incidents?	○	○	○	
• Staff response times to potentially violent and abusive patients/ visitors?	○	○	○	
4. Are aggregate data of violence, abuse, and conflict reviewed by the VPP oversight committee and reported to executive leadership and the governing board?	○	○	○	

Prevention

Program Oversight and Self-assessment	Yes	No	N/A	Comments
1. Is there a multi-disciplinary committee responsible for directing the workplace VPP?	○	○	○	

Prevention

Program Oversight and Self-assessment	Yes	No	N/A	Comments
2. Is security and safety awareness, ownership, and involvement among staff fostered by the committee?	○	○	○	
3. Does program leadership inspire all employees to be responsible members of the facility's Safety and Security Team?	○	○	○	
4. Are measures taken to foster a respectful and engaging culture?	○	○	○	
5. Are self-assessments and analyses of workplace violence conducted on at least an annual basis?	○	○	○	
6. Are security risk and vulnerability assessments conducted on at least an annual basis?	○	○	○	
7. Is an executive report prepared annually of the assessment findings, and provided to the governing board?	○	○	○	

Staff Training	Yes	No	N/A	Comments
1. Are safety, security, and emergency response protocols addressed in new employee/volunteer orientation?	○	○	○	
2. Are there records of employee training on the following issues, at a minimum:				
• Indicators of impending violence and how to defuse, restrain, and/or seclude out-of-control patients?	○	○	○	
• How and when to report threats and violent occurrences to supervisors and security officers?	○	○	○	
• Conflict resolution techniques, including de-escalation of progressive behaviors?	○	○	○	
• Safe and timely response to emergencies according to a standard action plan?	○	○	○	
3. Do employees who work in higher risk settings, such as the emergency department, behavioral health units, or the security department, receive a higher level of conflict management training?	○	○	○	

Security Provisions	Yes	No	N/A	Comments
1. Is the facility's security plan kept up-to-date?	○	○	○	
2. Are there signage and other communication measures to address aggressive, threatening, and other disruptive behavior?	○	○	○	
3. Is there adequate lighting covering exterior spaces, including walkways, parking lots, and structures?	○	○	○	
4. Is there a process for planning, training, and response for the safety and security of home health and other field staff?	○	○	○	
5. Is there a process for identifying and monitoring employees who are working alone, especially after hours and weekends?	○	○	○	
6. How many security officers are assigned to each shift?	○	○	○	
7. Do security officers regularly conduct interior and exterior patrols?	○	○	○	
8. Do security officers wear identification badges that display their first name only?	○	○	○	
Security Officer Training	**Yes**	**No**	**N/A**	**Comments**
1. Are assigned security officers:				
• Proprietary/in-house?	○	○	○	
• Contracted?	○	○	○	
• Hybrid (mixture of both)?	○	○	○	
• Maintenance facility staff?	○	○	○	
2. Are security officers trained in the following areas and measures, at a minimum:				
• Conflict management and restraint use?	○	○	○	
• Concepts of healthcare security?	○	○	○	
• CPR and first aid?	○	○	○	
• Emergency communications?	○	○	○	
• Emergency response and incident management?	○	○	○	
• Engagement and customer service interaction?	○	○	○	
• Legal limits and authority?	○	○	○	
• Report writing?	○	○	○	
• Role and responsibilities on the Behavioral Response Team?	○	○	○	
• Use-of-force guidelines?	○	○	○	
• Directing and patrolling?	○	○	○	

Video Surveillance	Yes	No	N/A	Comments
1. Are video cameras strategically placed to facilitate observation of:				
• Individuals entering public entrances?	○	○	○	
• Access/exit points in high-risk areas?	○	○	○	
• Entries into parking lots and structures?	○	○	○	
2. Is the video system regularly assessed to confirm functionality, coverage, and clear resolution?	○	○	○	
3. Are video records retained for at least thirty days?	○	○	○	

Facility Access Controls	Yes	No	N/A	Comments
1. Is the electronic access control system administered by authorization levels, times, and access points?	○	○	○	
2. Is there a process to quickly de-activate access cards during potentially problematic terminations?	○	○	○	
3. Has screening for weapons and other contraband been considered?	○	○	○	
4. Can the access system be used to quickly lockdown the facility and other high-risk areas?	○	○	○	
5. Are electronic combination keypads only used for relatively low-risk areas?	○	○	○	
6. Are mechanical keys issued on a strict need-only basis and tracked according to recipients?	○	○	○	

Duress/Panic Communications	Yes	No	N/A	Comments
1. Are security devices used to communicate duress (e.g., panic buttons or call boxes)?	○	○	○	
2. Are devices provided in higher risk workstations for staff who interact with the public?	○	○	○	
3. Have employees been trained on the use of the devices?	○	○	○	
4. Are duress devices regularly tested?	○	○	○	

Duress/Panic Communications	Yes	No	N/A	Comments
5. Does the duress/panic response protocol allow for varying levels of interpretation in regard to duress and panic?	○	○	○	
6. Is there a duress response protocol which reasonably assures the safety of responders?	○	○	○	
Visitor Management	**Yes**	**No**	**N/A**	**Comments**
1. Are visitors screened and monitored into and out of higher risk clinical and administrative areas?	○	○	○	
2. Are visitors screened into the facility, at least after hours?	○	○	○	

Mitigation

Patient Risk Assessment	Yes	No	N/A	Comments
1. Is there a multi-disciplinary process for identifying and assigning risk levels to patients with violent tendencies?	○	○	○	
2. Do the various risk levels correlate with care and safety provisions, in order to effectively treat violent and/or abusive tendencies?	○	○	○	
3. Are staff members trained on the patient risk assessment process?	○	○	○	
4. Is there a system to identify patients with violent tendencies, both within the electronic record as well as in clinical areas (i.e., such as arm bands, door alerts)?	○	○	○	
Rapid Response Measures	**Yes**	**No**	**N/A**	**Comments**
1. Is there a policy and process for multidisciplinary team-based responses to conflict and threatening behavior?	○	○	○	
2. Has a trained emergency response team been established for situations involving weaponry and hostages?	○	○	○	
3. Is there a written protocol for the use of stun gun devices, including criteria for their use and safe deployment measures?	○	○	○	
4. Are “shelter-in-place” measures promptly instituted, e.g., patient room doors automatically lock, patients and staff are removed from windows and doors?	○	○	○	

Drills and Training	Yes	No	N/A	Comments
1. Are rapid response drills that replicate incidents of violence and conflict conducted throughout the organization to test preparedness?	○	○	○	
2. Do local law enforcement, fire, and first responder agencies participate in workplace violence planning, training, drills, and response?	○	○	○	
3. Are staff competency levels tested and documented annually?	○	○	○	
4. Are conflict coaches trained and designated for clinical areas to mediate disputes among patients, visitors, and staff, as well as between co-workers?	○	○	○	

Incident Response

Communication	Yes	No	N/A	Comments
1. Is there a method of communicating a crisis situation organization-wide in plain language (versus color codes), such as "Active shooter, main lobby, seek shelter"?	○	○	○	
2. Are calls to 911 and/or local law enforcement immediately placed?	○	○	○	
3. Are there adequate communications tools to announce emergencies, e.g., PA system, phone intercom, mass text and email messaging, and computer pop-up and social media messaging?	○	○	○	
4. Are staff members trained and empowered to make emergency announcements at all times?	○	○	○	
5. Is there a protocol for handling family and media inquiries?	○	○	○	

Incident Command	Yes	No	N/A	Comments
1. Does the Incident Command and Emergency Planning System address incidents of violence, including active shooter situations?	○	○	○	
2. Have Safe rooms and other shelters, into which people can move during an active threat been identified and marked?	○	○	○	
3. Is there the capability to quickly achieve lockdowns of the facility and high-risk areas?	○	○	○	
4. Does a written protocol require a command center be established outside of the organization, in the event of a lock-down situation?	○	○	○	

Post-event Recovery

Debriefing and Investigation	Yes	No	N/A	Comments
1. Are transparent and comprehensive post-incident evaluations conducted and documented, including staff debriefings?	○	○	○	
2. Is the area of conflict barricaded following an incident for thorough investigation?	○	○	○	
3. Is a root-cause analysis conducted of the risk factors associated with violent incidents?	○	○	○	
4. Are written action plans created in a non-punitive fashion?	○	○	○	
5. Are counseling programs available to victims of workplace violence and is their participation monitored?	○	○	○	

Reporting	Yes	No	N/A	Comments
1. Are records maintained of administrative and clinical practice changes to evaluate their effectiveness in lowering the frequency and severity of workplace violence/abuse?	○	○	○	
2. Are records of hazard analyses and corrective actions maintained, where situations indicate?	○	○	○	
3. Is the corporate executive suite and governing board notified in writing of all potential and actual violent incidents, including employee-on-employee occurrences, inclusive of the following information:				
• Date, time, and location of incident?	○	○	○	
• Type of incident and identification of parties involved?	○	○	○	
• Description of incident?	○	○	○	
• Factors contributing to the violent/abusive incident?	○	○	○	
• Follow-up review and action plan?	○	○	○	
4. Are reporting mechanisms compliant with state-mandated reporting programs for abuse victims, protective service agencies, and the Occupational Safety and Health Administration?	○	○	○	

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