REGULAR CALENDAR

April 12, 2022

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Majority of the Committee on Health, Human Services and Elderly Affairs to which was referred SB 459-FN,

AN ACT relative to a health care facility workplace violence prevention program. Having considered the same, report the same with the recommendation that the bill OUGHT TO PASS.

Rep. Lucy Weber

FOR THE MAJORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MAJORITY
COMMITTEE REPORT

Committee:	**Health, Human Services and Elderly Affairs**
Bill Number:	**SB 459-FN**
Title:	**relative to a health care facility workplace violence prevention program.**
Date:	**April 12, 2022**
Consent Calendar:	**REGULAR**
Recommendation:	**OUGHT TO PASS**

STATEMENT OF INTENT

This bill addresses the increasing problem of violence in health care workplaces. It is the product of the Committee to Study Workplace Safety in Healthcare Settings, and is the result of significant collaboration by legislators and stakeholders. The bill has four sections. The first section establishes the Workplace Violence Prevention Program, focused on hospitals and urgent care centers--the facilities at highest risk. Each facility is required to develop and implement a workplace violence prevention program, including training in de-escalation, reporting requirements, victim support, and risk assessment. The second section creates the NH Health Care Workplace Safety Commission. Although this commission is larger than usual, as it is composed of representatives of all the hospitals and many urgent care centers, the new commission is modeled on the NH Health Care Quality and Safety Commission, which addresses patient care issues, and serves as a forum where the various institutions can share best practices and learn from each other's experiences to ensure the best patient care. This new commission serves a similar function with respect to workplace safety, and the size reflects the wishes of the stakeholders. The third section changes the name of the NH Health Care Quality and Safety Commission to the NH Health Care and Patient Safety Commission to clarify the different missions of the two commissions. Finally, the last section allows law enforcement to make warrantless misdemeanor arrests at health care facilities when, through actual or threatened violence, there is interference with the provision of medically necessary health care services. The majority believes this provision is necessary in medical settings because the victim of an assault may be ethically required to continue to treat the patient who assaulted them, and an arrest will allow law enforcement to provide needed protection to the victim while treatment continues.

Vote 12-9.

Rep. Lucy Weber
FOR THE MAJORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Health, Human Services and Elderly Affairs

SB 459-FN, relative to a health care facility workplace violence prevention program. **MAJORITY: OUGHT TO PASS. MINORITY: INEXPEDIENT TO LEGISLATE.**

Rep. Lucy Weber for the **Majority** of Health, Human Services and Elderly Affairs. This bill addresses the increasing problem of violence in health care workplaces. It is the product of the Committee to Study Workplace Safety in Healthcare Settings, and is the result of significant collaboration by legislators and stakeholders. The bill has four sections. The first section establishes the Workplace Violence Prevention Program, focused on hospitals and urgent care centers--the facilities at highest risk. Each facility is required to develop and implement a workplace violence prevention program, including training in de-escalation, reporting requirements, victim support, and risk assessment. The second section creates the NH Health Care Workplace Safety Commission. Although this commission is larger than usual, as it is composed of representatives of all the hospitals and many urgent care centers, the new commission is modeled on the NH Health Care Quality and Safety Commission, which addresses patient care issues, and serves as a forum where the various institutions can share best practices and learn from each other's experiences to ensure the best patient care. This new commission serves a similar function with respect to workplace safety, and the size reflects the wishes of the stakeholders. The third section changes the name of the NH Health Care Quality and Safety Commission to the NH Health Care and Patient Safety Commission to clarify the different missions of the two commissions. Finally, the last section allows law enforcement to make warrantless misdemeanor arrests at health care facilities when, through actual or threatened violence, there is interference with the provision of medically necessary health care services. The majority believes this provision is necessary in medical settings because the victim of an assault may be ethically required to continue to treat the patient who assaulted them, and an arrest will allow law enforcement to provide needed protection to the victim while treatment continues.

Vote 12-9.

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

April 12, 2022

HOUSE OF REPRESENTATIVES

REPORT OF COMMITTEE

The Minority of the Committee on Health, Human Services and Elderly Affairs to which was referred SB 459-FN,

AN ACT relative to a health care facility workplace violence prevention program. Having considered the same, and being unable to agree with the Majority, report with the following resolution: RESOLVED, that it is INEXPEDIENT TO LEGISLATE.

Rep. Erica Layon

FOR THE MINORITY OF THE COMMITTEE

Original: House Clerk
Cc: Committee Bill File

MINORITY
COMMITTEE REPORT

Committee:	**Health, Human Services and Elderly Affairs**
Bill Number:	**SB 459-FN**
Title:	**relative to a health care facility workplace violence prevention program.**
Date:	**April 12, 2022**
Consent Calendar:	**REGULAR**
Recommendation:	**INEXPEDIENT TO LEGISLATE**

STATEMENT OF INTENT

The minority of the committee is concerned about several aspects of this bill. Most concerning is the expansion of warrantless arrests in health care settings, especially given the lack of definition of "medically necessary health care services" or how to deal with a patient fighting back against a service the provider – but not patient– deems medically necessary. There is also the concern that hospitals and ambulatory surgery centers identified the problem, but this legislation is directed at hospitals and urgent care centers. With hospital-affiliated urgent care centers covered by hospital efforts, the minority is concerned that the burden on small urgent care facilities may be anti-competitive. Lastly, the minority is concerned that including harassment and intimidation in the same definition as physical violence with injury could draw attention away from the more severe cases of workplace violence.

Rep. Erica Layon
FOR THE MINORITY

Original: House Clerk
Cc: Committee Bill File

REGULAR CALENDAR

Health, Human Services and Elderly Affairs

SB 459-FN, relative to a health care facility workplace violence prevention program. **INEXPEDIENT TO LEGISLATE.**

Rep. Erica Layon for the **Minority** of Health, Human Services and Elderly Affairs. The minority of the committee is concerned about several aspects of this bill. Most concerning is the expansion of warrantless arrests in health care settings, especially given the lack of definition of "medically necessary health care services" or how to deal with a patient fighting back against a service the provider – but not patient– deems medically necessary. There is also the concern that hospitals and ambulatory surgery centers identified the problem, but this legislation is directed at hospitals and urgent care centers. With hospital-affiliated urgent care centers covered by hospital efforts, the minority is concerned that the burden on small urgent care facilities may be anti-competitive. Lastly, the minority is concerned that including harassment and intimidation in the same definition as physical violence with injury could draw attention away from the more severe cases of workplace violence.

Original: House Clerk
Cc: Committee Bill File

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

EXECUTIVE SESSION on Bill # SB459

TITLE: AN ACT relative to a Health Care Facility Workplace Violence Prevention Program

DATE: **4/12/2022**

LOB ROOM: 205-7

MOTION:

Adoption of Amendment 2022-1387h

Moved by Rep.	Layon	Seconded by Rep.Delemus	Vote: 8-13

MOTION:

OTP

Moved by Rep.	Weber	Seconded by Rep. Pearson	Vote: 12-9

CONSENT CALENDAR: _____ YES __X___ NO

Minority Report? __X__ Yes ___ No If yes, author, Rep:___Layon_____ Motion ___ITL___

baf

Respectfully submitted: _____

Rep. Beth Folsom, Clerk

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

9/28/2021 11:15:01 AM
Roll Call Committee Registers Report

2022 SESSION

Health, Human Services and Elderly Affairs

Bill #: SB459 **Motion:** _____ **AM #:** 2022-1387 **Exec Session Date:** 4/12/2022

Members	YEAS	Nays	NV
Pearson, Mark A. Chairman		N	
Layon, Erica J. Vice Chairman	X		
McMahon, Charles E.		N	
Acton, Dennis F.	X		
Gay, Betty I.	X		
~~Cushman, Leah~~ P. Rep. Mooney	X		
Folsom, Beth A. Clerk	X		
~~Kelsey, Niki~~ Rep. Boehm	X		
King, Bill C.		N	
Kofalt, Jim	X		
DeLemus, Susan	X		
Weber, Lucy M.		N	
MacKay, James R.		N	
Snow, Kendall A.		N	
Knirk, Jerry L.		N	
Salloway, Jeffrey C.		N	
Cannon, Gerri D.		N	
Nutter-Upham, Frances E.		N	
Schapiro, Joe		N	
Woods, Gary L.		N	
~~Merchant, Gary~~ Rep. Query		N	
TOTAL VOTE:	8	13	

STATE OF NEW HAMPSHIRE
OFFICE OF THE HOUSE CLERK

9/28/2021 11:15:01 AM
Roll Call Committee Registers Report

2022 SESSION

Health, Human Services and Elderly Affairs

Bill #: SB459 **Motion:** OTP **AM #:** **Exec Session Date:** 4/12/2022

Members	YEAS	Nays	NV
Pearson, Mark A. Chairman	X		
Layon, Erica J. Vice Chairman		N	
McMahon, Charles E.	X		
Acton, Dennis F.		N	
Gay, Betty I.		N	
Cushman, Leah P.		N	
Folsom, Beth A. Clerk		N	
Kelsey, Niki		N	
King, Bill C.		N	
Kofalt, Jim		N	
DeLemus, Susan		N	
Weber, Lucy M.	X		
MacKay, James R.	X		
Snow, Kendall A.	X		
Knirk, Jerry L.	X		
Salloway, Jeffrey C.	X		
Cannon, Gerri D.	X		
Nutter-Upham, Frances E.	X		
Schapiro, Joe	X		
Woods, Gary L.	X		
Merchant, Gary	X		
TOTAL VOTE:	12	9	

HOUSE COMMITTEE ON HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS

PUBLIC HEARING on Bill # SB459

BILL TITLE: AN ACT Relative to a Health Care Facility Workplace Prevention Program

DATE: 4/12/2022

ROOM: LOB 205-7 **Time Public Hearing Called to Order: 9:44am**

Time Adjourned: 10:50am

Committee Members: Reps. M. Pearson, Layon, Folsom, Acton, McMahon, Cushman, Kelsey, Gay, B. King, Kofalt, MacKay, DeLemus, Weber, Knirk, Nutter-Upham, Salloway, Snow, Cannon, Schapiro, Woods and Merchant,

TESTIMONY

Sen James Gray –

- Implement and maintain workplace Violence Prevention Programs in healthcare facilities.
- De-escalation techniques.

Sen. Rosenwald, - strongly supports

- Mental health of workers, worked with NAMI, Why violence is rising in healthcare facilities

Dan McQuire, self – opposes

- Acts in advance of facts
- Bill proposes solutions before knowing what the problem is
- We need the full scope of the workplace violence occurrences

***Paula Minnehan, NH Hospital Association - Supports**

- Hand out provided

***Kris Hering, Foundation for Healthy Communities – Supports**

- handout provided

John Patti, Catholic Medical Center, Security - Supports

- RSA 594 – not to arrest
- Bill adds more clarity for police
- 671 Assaults in 18 months of data

Pam DiNapoli, NH Nurses Association

- Supports – identifies using risk assessment

Rep Jess Edwards – Opposes

- Long Term solution to a short-term problem – covid related
- Adds 2 Bodies, voluntary not mandated
- Recommends and end date
- Does not feel this is data driven.

Geoffrey Ward, ATTy Generals Office - Supports

Respectfully submitted,

Rep. Beth Folsom, Clerk

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill #: SB459 Date: 4/12/22

Committee: HHS

**** Please Print All Information ****

Name	Address	Phone	Representing	Pro	Con
John Williams	129 Pleasant St. Concord, NH 03301	(603) 271-9395	DHHS	✓	
Kathy Corey Cox	Manchester	617 212-7791	St. Joseph K. Hospital	✓	
Pam DiNardi	Manchester	603 566 7407	NHNA	✓	
Dick					

House Remote Testify

Health, Human Services and Elderly Affairs Committee Testify List for Bill SB459 on 2022-04-12

Support: 12 Oppose: 3 Neutral: 0 Total to Testify: 0

Export to Excel

Name	City, State Email Address	Title	Representing	Position	Testifying	Non-Germane	Signed Up
Gray, James	Rochester, NH James.Gray@leg.state.nh.us	An Elected Official	Sen. James Gray SD 6	Support	No	No	4/4/2022 3:09 PM
Rosenwald, Cindy	Nashua, NH cindy.rosenwald@leg.state.nh.us	An Elected Official	SD 13	Support	No	No	4/8/2022 1:21 PM
Smith, Carla	Fremont, NH tsmith1992@yahoo.com	A Member of the Public	Myself	Support	No	No	4/9/2022 10:46 AM
Gilston, Julie	Portsmouth, NH elvis95@comcast.net	A Member of the Public	Myself	Support	No	No	4/10/2022 1:00 PM
Pauer, Diane	Brookline, NH diane.pauer@leg.state.nh.us	An Elected Official	Myself	Support	No	No	4/10/2022 7:32 PM
Smith, Julie	Nashua, NH cantdog@comcast.net	A Member of the Public	Myself	Oppose	No	No	4/11/2022 5:25 AM
DiNapoli, Pamela	Concord, NH nhna.ned@gmail.com	A Member of the Public	NH Nurses Association	Support	No	No	4/11/2022 9:03 AM
Lajoie, Katie	Charlestown, NH jlje23@hotmail.com	A Member of the Public	New Hampshire Nurses Association	Support	No	No	4/11/2022 9:07 AM
Howland, Curtis	Manchester, NH howland@priss.com	A Member of the Public	Myself	Oppose	No	No	4/11/2022 1:06 PM
Smith, Susan	Gilford, NH ses67105@gmail.com	A Member of the Public	Myself	Support	No	No	4/11/2022 9:15 PM
Campion, Polly	Etna, NH pollykcampion@gmail.com	A Member of the Public	Myself	Support	No	No	4/12/2022 7:43 AM
Doyle, Marcy	Bedford, NH marcydoyle@hotmail.com	A Member of the Public	Myself	Support	No	No	4/12/2022 7:48 AM
Padmore, Michael	Manchester, NH michael.padmore@nhms.org	A Lobbyist	NH Medical Society	Support	No	No	4/12/2022 8:53 AM

Sherman, Senator	SD 24, NH jennifer.horgan@leg.state.nh.us	An Elected Official	SD24	Support	No	No	4/12/2022 11:03 AM
Freedman, Aubrey	Bridgewater, NH aubreyyfreedman@gmail.com	A Member of the Public	Myself	Oppose	No	No	4/12/2022 11:21 AM

ANA
AMERICAN NURSES ASSOCIATION

A NURSE'S Call To ACTION!

I WILL **PROTECT MY OWN** Life So I Can **PROTECT MY PATIENTS**

1 in 4 Nurses are ASSAULTED

PROTECT nurses & pledge to:

SHARE this pledge and ask my friends and family to sign

SUPPORT zero tolerance policies for violence against nurses

REPORT abuse against nurses whenever I safely can

WPV Response

- ✓ **Initiate** safety protocols
- ✓ **Call for help** when you suspect potential for WPV
- ✓ **Be alert**
- ✓ **Recognize** warning signs
- ✓ **De-escalate** when possible
- ✓ **Use barriers** for protection
- ✓ **Self-defense** when appropriate
- ✓ **Report WPV** immediately

STOP WPV!

I WILL NOT TOLERATE

WORKPLACE VIOLENCE

S = SITUATION: Describe what happened
T = TYPE: Verbal threat/abuse, physical assault, weapons used, etc
O = OBSERVERS: List witnesses
P = PEOPLE: List all involved

W = WHERE & WHEN did the event happen
P = PRECEDING FACTORS: Describe prior events
V = VERIFY injuries sustained: emotional, physical, threat of injury

Follow Up

- Participate in incident investigation
- Support others affected by WPV
- Access emotional support
- Employee health
- Worker's compensation

GET INVOLVED NOW!

#endnurseabuse

1. **Take the pledge!**
   Nursingworld.org/Pledge
   OR Text PLEDGE to 52886

2. **Send an email to your legislator with one click!**
   Nursingworld.org/TakeAction

Archived: Friday, April 22, 2022 9:19:06 AM
From: Pam DiNapoli
Sent: Monday, April 11, 2022 9:14:13 AM
To: ~House Health Human Services and Elderly Affairs
Subject: SB 459
Importance: Normal
Attachments:
SB 459-FN Letter of support (2).docx 98331 END Nurse Abuse One Pager.pdf olence_in_health_care_oct_2021_final (1).pdf

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Good morning Chairman Pearson and members of the House Health, Human Services and Elderly Affairs Committee
Attached please find a letter indicating the strong support by the NH Nurses Association for SB 459 being heard 4/12 at 930A. I am also attaching a study that was conducted by NHNA and UNH giving you data about perceptions about how real the problem really is in our community.
Thank you in advance for your support
Pam D

Pamela P DiNapoli, PhD, RN, CNL
Executive Director
25 Hall Street Suite 1E
Concord, NH 03301
(603)225-3783
(603) 566-7407 Cell
nhna.ned@gmail.com

Dear Chairman Pearson and members of the House Health, Human Services and Elderly Affairs Committee;.

My name is Pamela DiNapoli, Nurse Executive Director New Hampshire Nurses Association (NHNA), representing over 1300 member nurses. I am writing to encourage the committee to support SB 459-FN. We thank Senator Gray and his committee for working to submit this important bipartisan bill.

Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. According to OSHA, healthcare workers are four times more likely than workers in private industry to experience violence in the workplace. In a recent pilot study of nurses in Merrimack County the following was reported:

Type of Incident	% Reported (nurses reporting)
Physical Aggression	24% (n=16)
Sexual Aggression	3% (n=2)
Verbal Aggression	35% (n=24)
Harassment	9% (n=6)
Intimidation	15% (n=10)

However, underreporting is believed to be significant so the true picture of workplace violence for healthcare workers is unclear. A survey of Minnesota nurses indicated that 69% of physical assaults and 71% of non-physical assaults were **not reported** to a manager. Healthcare has unique challenges in dealing with violence in the workplace. The commitment to "do no harm" and recognition that the patient is impaired or experiencing ill effects of their illness contribute to underreporting and acceptance of violent acts. Workplace violence has a high cost- lost workdays as well as worker burnout, fatigue and stress lead to poorer outcomes for patients including medication errors and patient infections. This bill creates an opportunity for organizations to examine the issues surrounding workplace violence in health care as well as exploration and development of policies and structures that will protect healthcare workers.

The incidences of violence against health care workers in NH hospitals and other health care facilities continues and, while individual facilities and providers have implemented various policies and strategies to address this growing concern, we believe a more comprehensive, multi-

disciplinary approach is warranted. It should not be the expectation that a nurse, aide, physician or other caregiver will be verbally or physically harmed while doing their job caring for others. Currently, there is no specific federal statute that requires workplace violence protections, but several states have enacted legislation or regulations protecting health care workers from its effects. We support these moves by individual states and implore this senate committee to support SB 459-FN which establishes regulations assuring protections for the healthcare workers of New Hampshire.

Thank you for the opportunity to provide our comments.

Pamela P DiNapoli, PhD, RN, CNL
Executive Director
25 Hall Street Suite 1E
Concord, NH 03301
(603)225-3783
nhna.ned@gmail.com

Margaret W. Brew, MSN, RNC, CCRN-K, CPAN TCRN
P.O. Box 222
Hancock, New Hampshire 03449
April 12, 2022

New Hampshire Senate
107 North Main Street
Concord, NH 03301-4951

RE: SENATE BILL 459-FN AN ACT relative to a healthcare facility workplace violence prevention program.

Dear Senators, Representatives, and the Health and Human Services Committee,

My name is Margaret W. Brew MSN, RN. I am employed as a Workplace Violence Prevention Educator, in 2 New Hampshire hospitals. I support SB 459 FN.

SB 459-FN will empower healthcare organizations to assess and address issues related to providing a safe work environment. It will afford healthcare workers the ability to attain skills to promote their personal safety. It promotes reporting of events of workplace violence, and it supports those harmed. This in turn has an overall positive effect on patient outcomes. I endorse SB459-FN in relation to:

1. Education in de-escalation, non-physical intervention skills and self-defense techniques. The healthcare worker will have skills to effectively manage situations that pose a risk to their safety and the decorum of the organization.

2. Required reporting. It is critically important that this bill will promote a culture of reporting. Organizations will have data to address issues. This will inform practice and policy decisions and potentially will decrease events of harm.

3. Establish a process for follow-up and support of victims and witnesses affected by workplace violence. Providing support to those affected by healthcare workplace violence has a direct impact on patient care and clinical outcomes.

I have taught Workplace Violence Prevention for the past 9 years. Students that attend work in varied roles within the healthcare system. These roles include providers, nursing, security, and support services. In each class, there is at least one student who shares a story related to workplace violence. These stories illuminate the personal costs of violence and its

impact on the ability for individuals to perform their roles in healthcare. Their experiences of verbal threats by patient families, stalking by a patient, and physical assaults affect the overall safety and performance within the work environment.

One student, a Registered Nurse, shared a story of a physical attack by a patient. The patient began violently punching the nurses' head. The nurse required emergency care. Diagnosed with a closed head injury, and per physician direction, the nurse was out of work for 6 weeks. On return to work, coworkers and the manager were unsupportive. They did not understand why the nurse had been out of work so long after the injury, stating "You should expect this to happen when you take care of patients."

Students identify that when violence occurs, reporting is an additional burden. The process to file a report takes time. Students identify there is poor communication regarding the event. They perceive that overall safety does not improve after violence occurs. They express how the effects of violence has harmed organizational morale and makes it difficult to foster teamwork and trust. This directly affects healthcare delivery.

As well, students have discussed how events they were directly involved in or witnessed affected them. It has made them question if they want to continue to work in healthcare. This sentiment is currently related to the Covid-19 pandemic. It was expressed after the shootings at Wentworth Douglass Hospital in 2014, and at Dartmouth Hitchcock Medical Center in 2017.

The negative effects of verbal aggression and physical violence are related to negative patient outcomes. Negative outcomes affect third part insurance reimbursement of care. Supporting the safety of workers in the delivery of healthcare is integral to the fiscal stability of the healthcare industry in New Hampshire. Passing Senate Bill 459-FN will positively affect the health and welfare of the citizens of New Hampshire.

Respectfully submitted,

Margaret W. Brew, MSN, RN

Margaret W. Brew, MSN, RNC, CCRN-K, CPAN, TCRN

Violence & Aggression in Health Care

Assessing Health Care Worker Exposure to Acts of Violence and Aggression in the Workplace: A Pilot Study

October 2021

Provided by: The NH Healthcare Violence Prevention Workgroup

NH Healthcare Violence Prevention Workgroup

Peter Antal, PhD, Antal Consulting, LLC
Karla R. Armenti, MS, Sc.D., Institute on Disability/UCED, UNH, NH Occupational Health Surveillance Program
Pamela P. DiNapoli, PhD, RN, CNL, NHNA and UNH Department of Nursing
Lisa A. Mistler, MD, MS, Geisel School of Medicine and New Hampshire Hospital
Raelene Shippee-Rice, PhD, RN, Dept of Nursing, UNH
Rosemary Taylor, PhD, RN, CNL, UMass Chan Medical School, Tan Chingfen Graduate School of Nursing

Acknowledgments

Many thanks to Jessica Corbo, Philip Falkof, Ellen Fox, Samantha Hebeisen, and Sydney Mitchell—participants of the UNH 704P Public Health Nursing Project NURS on Workplace Violence in the Health Care Setting who helped to develop and pilot test the initial survey.

Requests for copies should be directed to Karla Armenti, Sc.D. (Karla.Armenti@unh.edu).

This project was supported by grant number 5U60OH010910 from CDC, NIOSH as well as staff from the organizations listed below. The contents are solely the responsibility of the authors and do not necessarily represent the official views of the organizations listed.

Institute on Disability/UCED
University of New Hampshire

Antal Consulting, LLC
Bringing clartiy to an often unclear world

New Hampshire Hospital

NHNA

NH Occupational Health Surveillance Program

Dartmouth Geisel School of Medicine

University of New Hampshire College of Health and Human Services

Dartmouth-Hitchcock

Table of Contents

Executive Summary

Introduction

Healthcare workplace violence is a significant, yet elusive, public health problem. According to a 2016 review article in the New England Journal of Medicine, "Healthcare workplace violence is an underreported, ubiquitous, and persistent problem that has been tolerated and largely ignored." The statistics are startling: 75% of the 24,000 workplace assaults occurring annually between 2011 and 2013 were in healthcare settings (Phillips, 2016) and healthcare workers are 20% more likely to become victims of violence than workers in any other industry (The Joint Commission, 2018; Harrell, 2011; Groenewold, Sarmiento, Vanoli, et al., 2018).

These numbers do not capture the true incidence of violence, largely due to underreporting by as much as 70% (Phillips, 2016). Data related to incidence of verbal aggression, such as threats, verbal abuse, hostility, and harassment towards staff by patients has not been collected at a national level (Phillips, 2016). Experienced by many healthcare workers on a daily basis, verbal aggression is the most common form of violence in healthcare (Renwick, Steward, Richardson, et al.; 2016; Renwick, Lavelle, Brennan, et al., 2016), yet it is the least likely to be reported or addressed in the workplace because it is seen as "part of the job" (Campbell, Messing, Kub, et al., 2011). Healthcare workplace violence has major consequences, as it contributes to staff burnout, PTSD, leaving the job, anxiety, and depression (Camerino, Estryn-Behar, Conway, et al., 2008; Foster, Bowers, Nijman, 2007; Mobaraki, Aladah, Alahmadi, et al., 2020), and adversely affects the quality and safety of patient care (Arnetz, J. E., Neufcourt, Sudan, Arnetz, B. B., Maiti, T Viens, F. 2020).

In an effort to address this serious public health issue, the Joint Commission recommended that healthcare organizations "clearly define workplace violence and put systems into place across the organization that enable staff to report workplace violence instances, including verbal abuse," as well as to "capture, track and trend all reports of workplace violence – including verbal abuse and attempted assaults when no harm occurred" (The Joint Commission, 2018).

In 2016, the New Hampshire Senate voted against a bill to require all state-licensed healthcare facilities to perform an annual workplace violence risk assessment and develop written violence prevention plans with specific actions to reduce risk. In following up, Senator James P. Gray asked for an assessment of the current situation in New Hampshire regarding workplace safety/violence. In response, we developed a survey intended for a cross-section of one county in the state with the goal of beginning to quantify the pertinent issues from the perspectives of all healthcare providers and administrators, from home healthcare workers to hospital CEOs.

Methodology

Between 1/15/2020 and 3/30/2020, an anonymous survey implemented via RedCap by Dr. Lisa Mistler was distributed to New Hampshire health providers. As

contact lists of healthcare providers were not readily available, a snowball sampling design was used, and agency contacts were asked to share the survey link with interested staff. Project staff contacted multiple organizations, of which three agreed to send out information to their members. No incentives were offered for survey completion. By the close of the survey process, 244 healthcare staff from a variety of disciplines had participated in the survey.

Critical Findings

Startingly, 73% of responding healthcare providers experienced some form of violent incident during the previous six months, including verbal, physical, harassment, intimidation, or sexual aggression.

Aggression was experienced "at least a few times per week" by half of the respondents subjected to verbal (55%), intimidation (48%), or harassment (46%). This also occurred among 37% of those experiencing physical aggression, and 7% of those experiencing sexual aggression. However, only two-thirds of those impacted by aggression (68%) reported the incident, with those working in emergency department settings the least likely to report at 58%.

As a result of these events, not only are the lives of staff put at risk, but those of patients as well. Over half of the violent events occurred during patient care (53%), while over one in four (30%) occurred during medication administration.

Unsurprisingly, when respondents were asked whether they felt protected from the threat of violence at work, 62% said no. However, of the 38% who did feel protected, many identified and contributed to a list of protective factors. Highest among these were the presence of an onsite security team, clear support from supervisors, presence of other staff, and specific security protocols.

Limitations of the Study

As the study relies on a convenience sample from a specific geographic area in New Hampshire, as well as feedback from mostly female nurses working full time, these findings are not generalizable to the broader population of healthcare providers. Analysis presented herein was limited to areas where the denominator was at least 15. Additionally, a number of research questions would need to be asked to help fill in some of the gaps in knowledge and address potential assumptions when interpreting the data. Recommended adjustments for future work have been included in the "Recommendations" section.

With those limitations in mind, there is ample evidence that, based solely on the information provided by those responding to the survey, violence in the healthcare workplace presents a serious and credible risk to healthcare providers and patients.

Recommendations

Based on the responses provided by over 200 New Hampshire health care workers, as well as what is already known from the national literature, both additional study and immediate action steps are called for to reduce risk and keep staff and patients safe in the short and long term. These include organizational action to take immediate steps for improved worker safety; new research to identify prevalence of and contributing factors to workplace violence; a multi-agency quality improvement effort to adopt and learn from best practices in the field; as well as statewide policy improvements to ensure consistency in approaches to workplace safety.

Survey Findings

Demographics

244 healthcare providers responded to the survey invitation, with 87% completing the survey. Most respondents were female (89% of 244), 9% were males, others identified as non-binary (1%), and less than 1% did not respond to the question about gender. Age of respondents ranged from 18-28 (14%), 29-45 (31%), 46-65 (48%), and those 65 and over (6%). Less than 1% of respondents did not provide an age.

Most had worked at least 10 years in healthcare (65% of 243), with about one in five working five to 10 years (21%) and about one in seven (14%) working less than five years. Two-thirds of participants were registered nurses (68% of 244), while about one in four (26%) were licensed nursing or medical assistants. Other groups with less than 5% representation included physicians (3%), contractors (1%), administrative (1%), medical technicians (1%), and dining services (<1%).

Participants generally worked full-time (64% of 252), with an even amount working evenings (18%) or nights (16%), and about 10% with a variable schedule. In terms of hours worked, a little over half (51% of 242) worked five to 10 hours a day, and about one in four worked 10 to 12 hours (26%) or over 12 hours per day (22%). Less than 1% worked one to five hours. Overall, 82% of 243 were full-time, 12% part-time, 6% per diem, and less than 1% served as volunteers or consultants.

In terms of work settings, about one in three worked in inpatient care (34% of 244), about one in five in ambulatory settings (22%), or nursing home care (18%), one in six in emergency departments (16%), and less than one in 10 in assisted living (9%) or home care (9%). 12% of respondents identified other settings.[1]

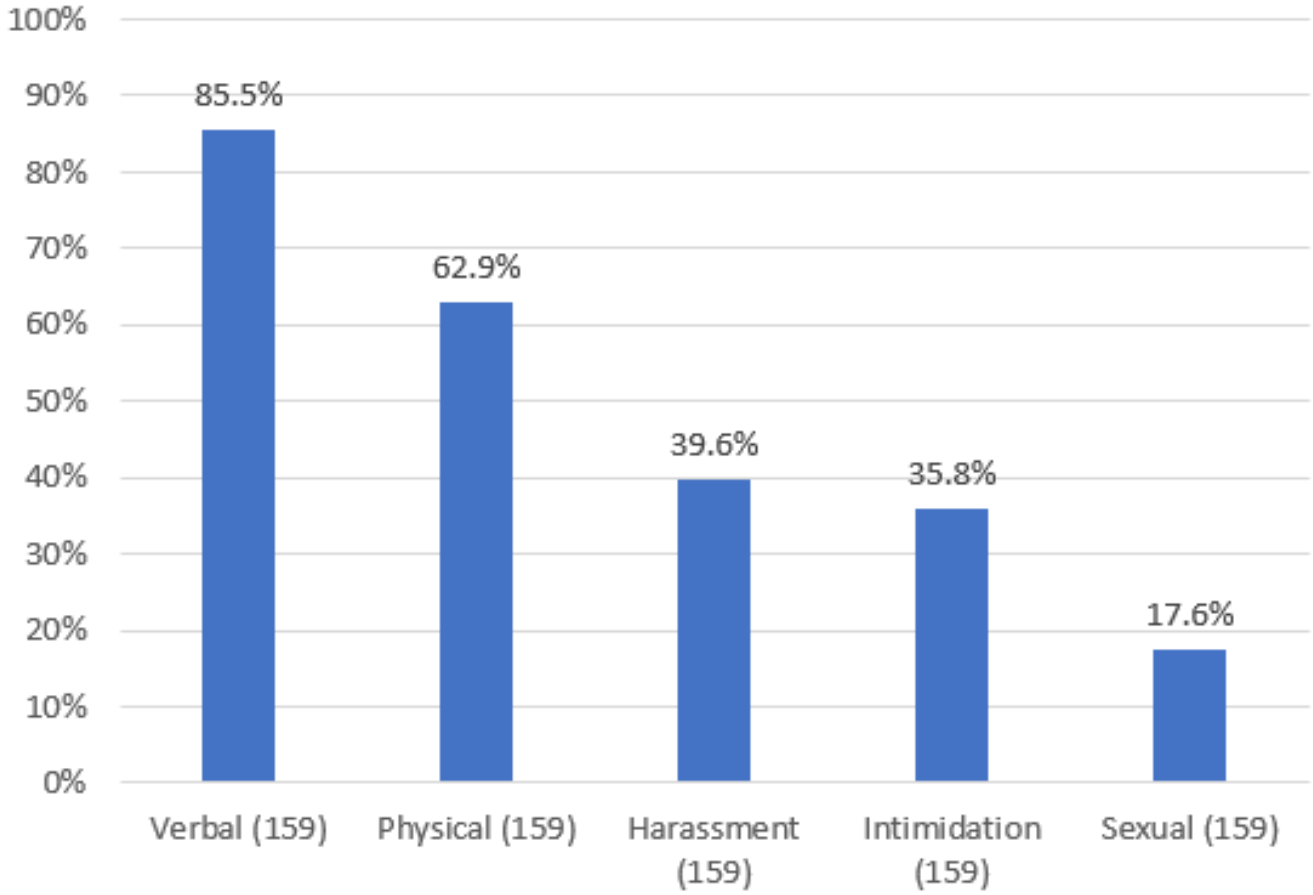
Incidence of Violence Among Healthcare Providers

73% of 219 responding healthcare providers experienced some form of violent incident over the previous six months, including verbal, physical, harassment, intimidation, or sexual aggression (see Figure 1). Aggression was experienced by men (85% of 20) and women (72% of 195), with those working less than five years (82% of 27) or 5-10 years (83% of 48) more likely to report than those with more than 10 years of experience (67% of 143). Those working evenings were the most likely to indicate a violent event (98% of 40), followed by those working nights (83% of 36), and daytime (66% of 143). In terms of hours per day, those working more than 12 hours were the most likely to relate an incident (88% of 51), followed by 74% (N=54) of those working 10-12 hours and 65% of those working under 10 hours (N=112). Of the 11 respondents who worked evenings and greater than 12-hour shifts, all 11 reported a violent event in the past six months.

Types of aggression experienced included verbal (86% of 159), physical (63%), harassment (40%), intimidation (36%), and sexual aggression (18%). Aggression was experienced several times per week by

1 20% of respondents selected two or more work settings

Figure 1: Type of Aggression Experienced (N=159)



about half of the respondents subjected to verbal violence (55% of 134), intimidation (48% of 56), or harassment (46% of 63). A similar frequency also occurred among 37% of those experiencing physical aggression (of 99), and 7% of those experiencing sexual aggression (of 28).

These events were most commonly due to patient action (81% of 159), followed by a relative of the patient (23%), or visitors (13%). **Of note, a scan of the comments shared under "other" comments indicated another employee as the source of the aggression in 15% of the cases.**

Where Aggression Occurs

In terms of where aggression occurs[2], staff working in emergency departments (93% of 29) and inpatient (85% of 53) were the most likely to have reported a violent event in the past six months. This was followed by those working in nursing homes (76% of 21) and ambulatory care settings (58% of 33) (see Figure 2).

Based on respondent feedback (N=159), Figure 3 shows two thirds of violent events occurred
in patient rooms (66%) followed by the hallway (45%) and nurse's stations (29%). Other areas identified include waiting areas (17%), patient bathrooms (13%), and patient examination rooms (12%). Less than 5% were reported for the patient/family members home[3] (3%) and medication room (3%). 20% identified locations in other areas.

2 Analysis based on respondents identifying only one type of facility as part of their work history.

3 Note that there were a limited number of respondents working in a home environment, so this number is not surprising given the demographics of respondents.

Figure 2: Experienced Violence by Type of Health Facility

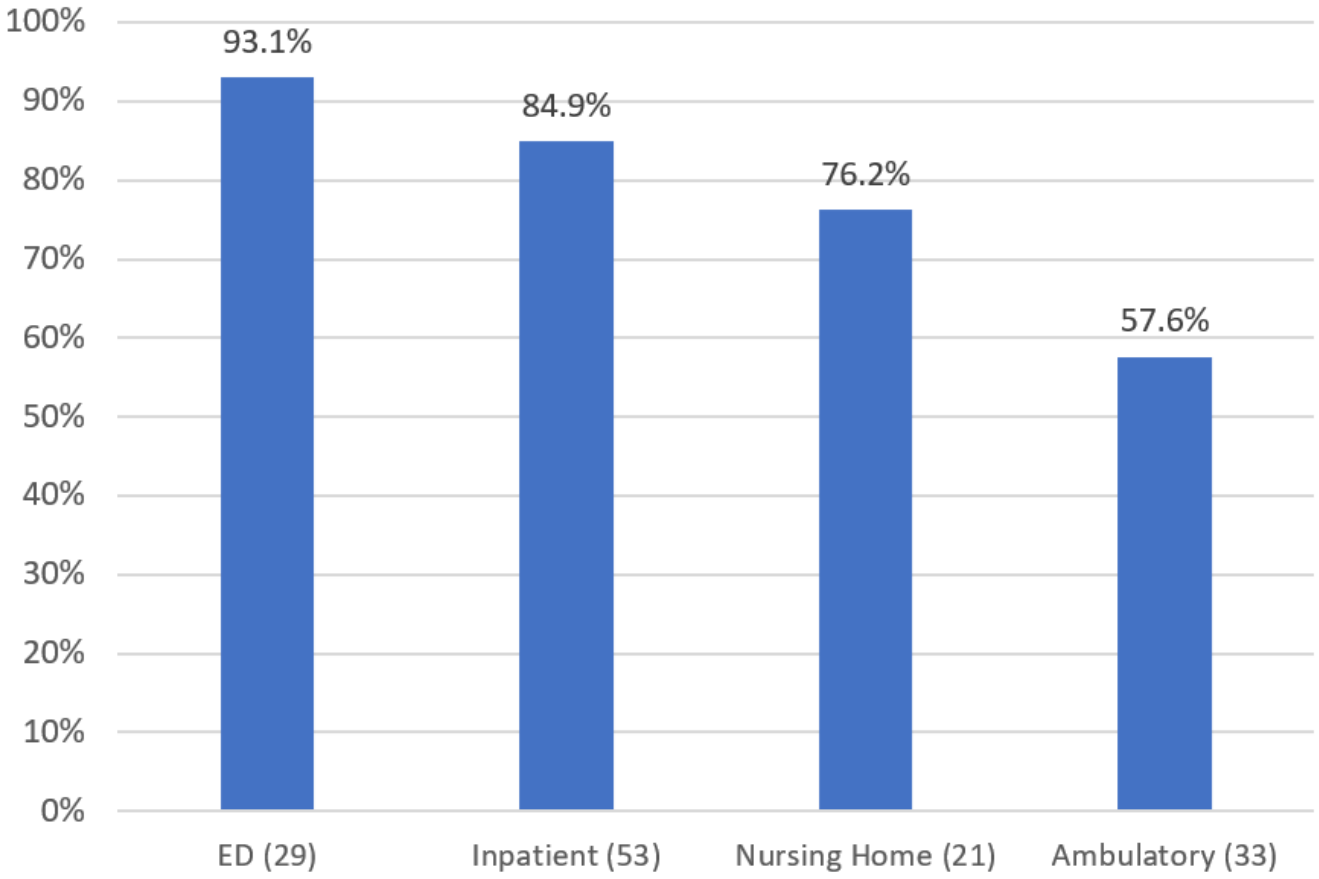


Figure 3: Where did violence occur? (N=159)

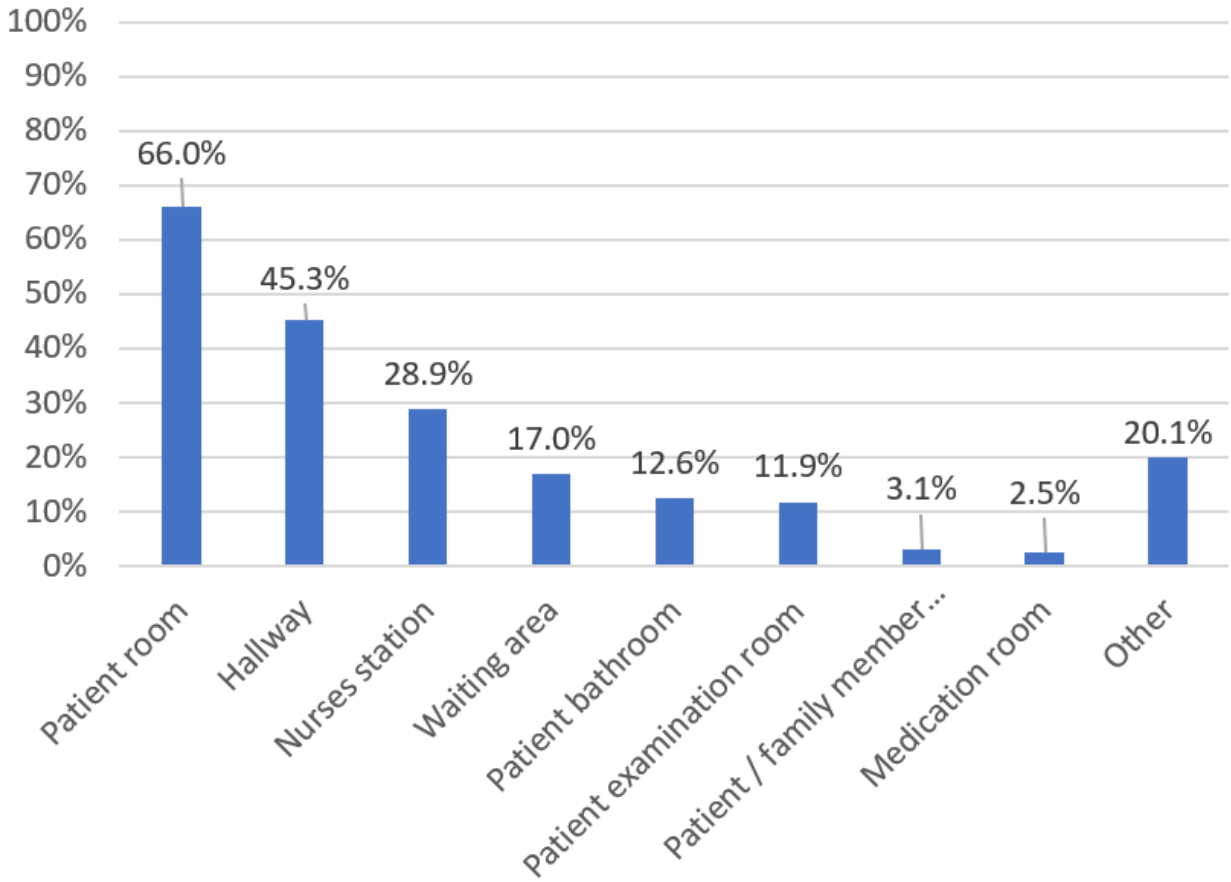
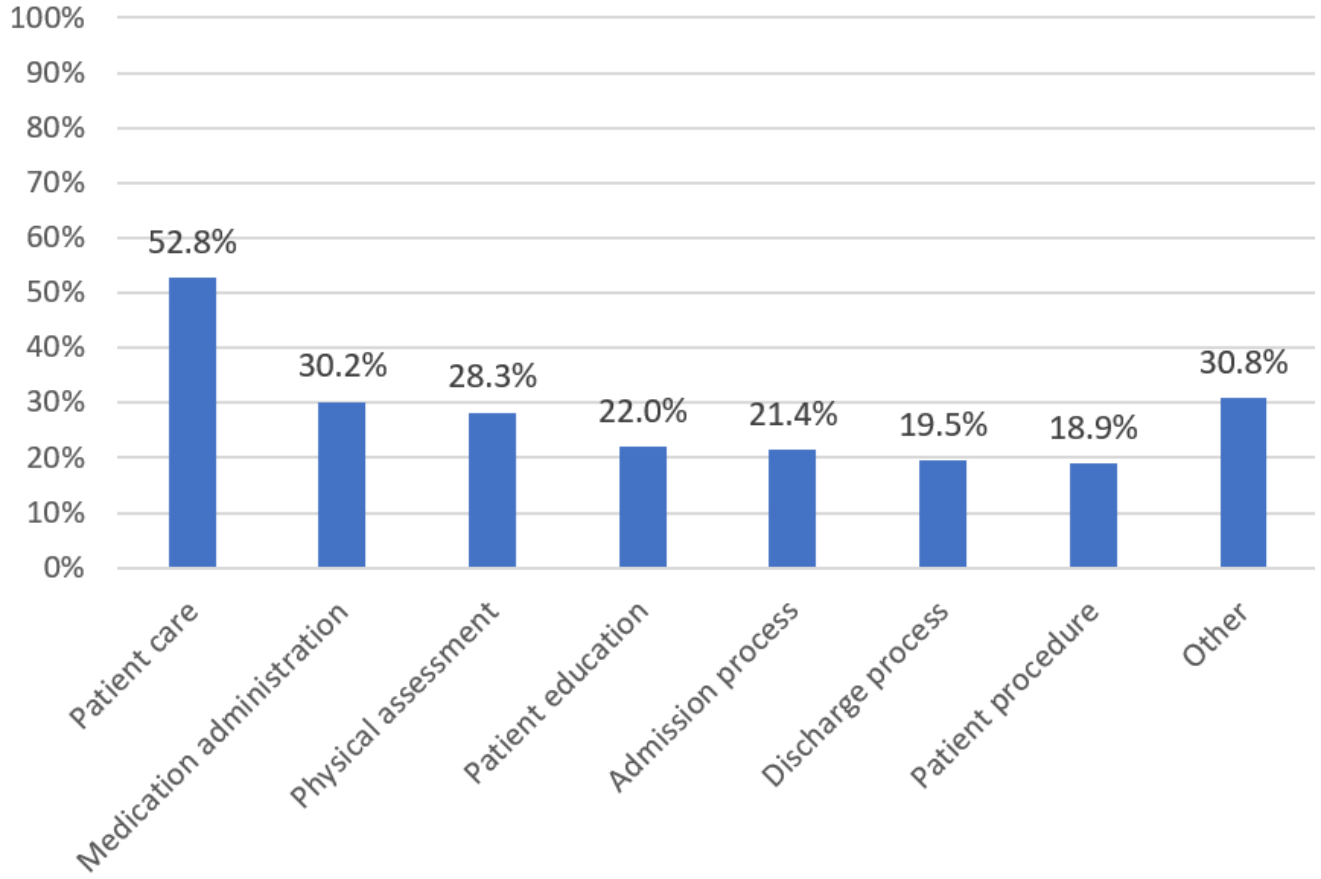


Figure 4: What activities were underway? (N=159)



Impact of Aggression

16% of those impacted reported receiving an injury as a result of the aggressive act (N=157). Of these, 22 respondents cited a range of injuries, including herniated discs and other back injuries, contusions, pulled muscles, sprains, testicular trauma, bruising, bites, slash marks, and scratches. Even though actual incidence is likely much higher, **only two individuals mentioned injury related to their mental health.**[4] One respondent reported damage to personal property.

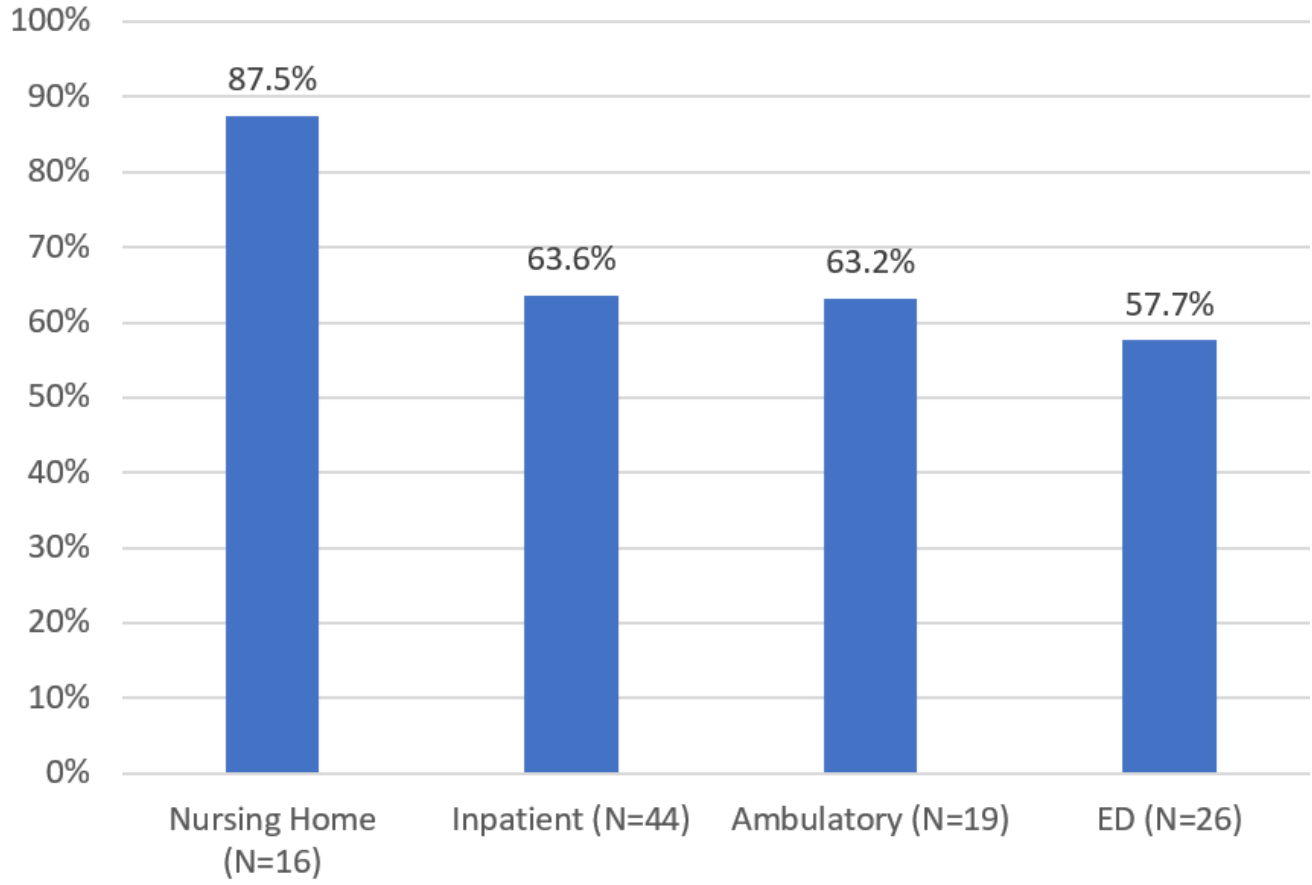
In addition to harm to the care provider, these events put patients at risk as well. When asked what healthcare activities were underway when the aggression took place, Figure 4 shows that respondents identified respondents identified a range of activity areas. Over half reported patient care (53% of 159), followed by medication administration (30%). One in four cited physical assessment (28%) and patient education (22%). About one in five identified the admission process (21%), discharge process (20%), and during a patient procedure (19%). 31% noted that the event happened during other activities.

Reporting Violent Aggression

Roughly two-thirds of respondents (68% of 157) reported the violent incident, while 22% did not. For this latter group, a follow-up survey question asked why they had

4 This likely reflects a shortcoming of the survey tool, which did not specifically ask if a mental health injury occurred. Based on the literature, incidence of mental health injury due to these types of events is likely much higher (12) and may be underreported due to stigma and misconceptions around mental health issues.

Figure 5: Percent Reporting Violent Event by Facility Type



not. Over one in three (38% of 53) indicated they did not believe the act was intentional; one in five reported they did not know if they should (21%) or were apprehensive due to repercussions (19%). 2% said they were unaware of a reporting system. Of the 11 who indicated some other reason, seven indicated that nothing would change, while two shared that verbal altercations typically go unreported.

Looking at reporting by facility type showed some variation. Figure 5 documents that those working in nursing home environments[5] were most likely to report a violent event when it happened (88% of 16). This was followed by those working in inpatient settings (64% of 44), ambulatory (63% of 19), and emergency departments (58% of 26).[6]

Protective Factors Against Violent Aggression

Although responses indicated violent aggression against healthcare providers occurred among nearly three-quarters of those responding to the survey, the presence of protective factors among respondents was far less consistent.

Only 56% of 213 respondents stated their facility promotes a standardized tool, form, or protocol. Of those who did report the presence of a tool (N=119), only 54% thought it positively impacted their environment. Of those who were not aware of a tool (N=89), a similar proportion (54%) thought it would positively impact their

5 Note small N of 16 for respondents from nursing home facilities and 19 for ambulatory. Results based on respondents with only one type of facility in their work history.

6 Analysis based on respondents identifying only one type of facility as part of their work history.

work environment if it were available.

When asked whether their supervisor encouraged reporting of violence regardless of circumstance (N=212), about two-thirds (63%) agreed. 62% of 218 respondents participated in training classes; of these (N=135), about 70% indicated the training was required. When asked whether the training was helpful (N=133), only 63% agreed.

Analysis of Protective Factors

A number of indicators related to protective factors against violence were assessed against whether a violent event was experienced (Table 1) and whether the event was reported (Table 2).

Table 1 documents that, among those responding to the survey, incidents of violence were substantially more likely (20-point difference) among those who shared that a tool or protocol for violence was NOT available (89%) or that a supervisor did NOT encourage reporting (87%). Whether or not they took violence intervention training did not appear to correspond to a higher incidence of violence.

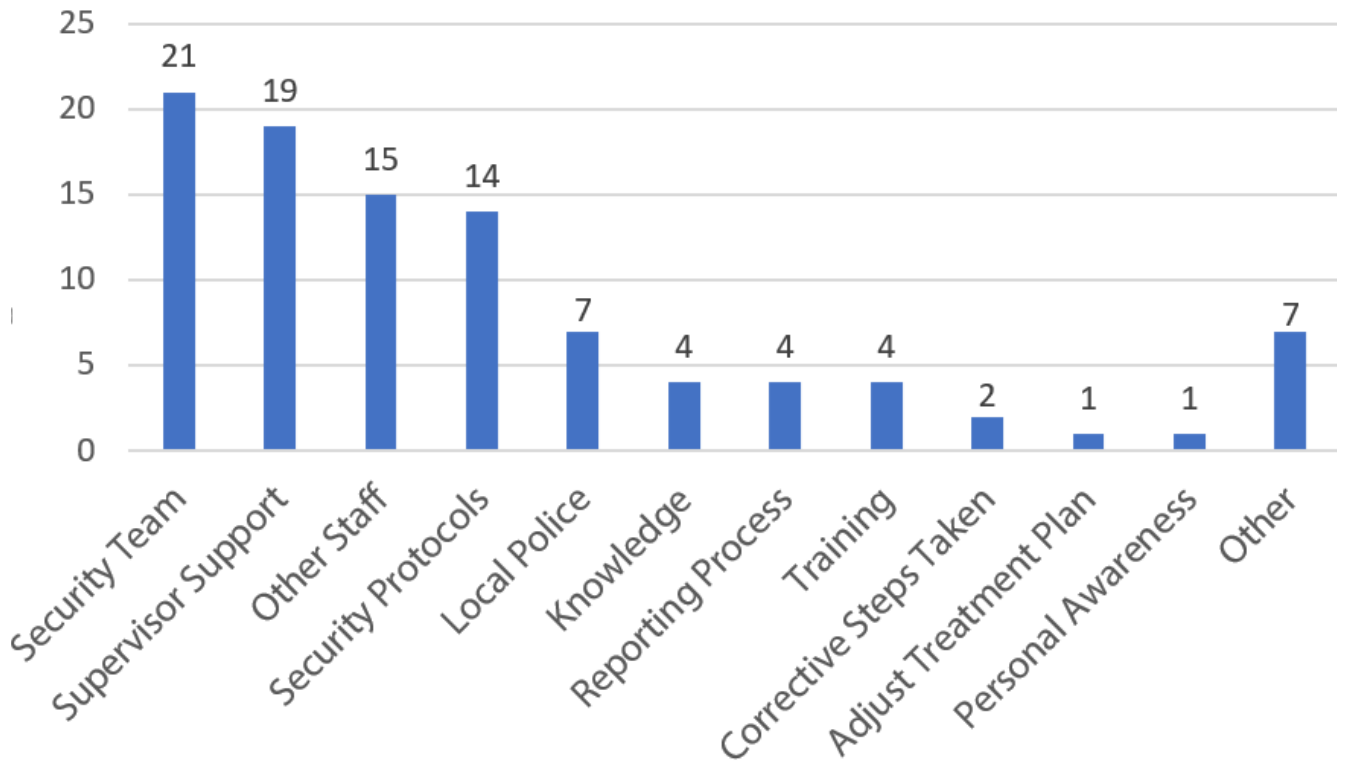
Table 1 - Experience of Violence by Presence of Protective Factors

Protective Factors	Percent Experiencing Violence
Tool or protocol available (N=120)	65%
UNSURE if tool or protocol available (N=49)	78%
Tool or protocol NOT available (N=44)	89%
Supervisor encourages reporting (N=134)	65%
Supervisor DOES NOT encourage reporting (N=78)	87%
Taken violence intervention training (N=136)	75%
DID NOT take violence intervention training (N=82)	68%

Table 2 - Reporting of Violence by Presence of Protective Factors

Protective Factors	Percent Reporting Violence
Tool or Protocol Available (78)	76%
UNSURE if Tool or Protocol Available (38)	45%
Tool or Protocol NOT Available (39)	74%
Supervisor Encourages Reporting (87)	78%
Supervisor DOES NOT Encourage Reporting (68)	54%
Taken Violence Intervention Training (101)	69%
DID NOT Take Violence Intervention Training (56)	64%

Figure 6: Why Healthcare Providers Feel Protected from Threat of Violence (N=65)



In terms of whether respondents were more or less likely to report a violent event, Table 2 shows that a similar proportion of respondents would report (about 75%) whether or not a tool or protocol was available. However, among those who were unsure, only 45% did so. The presence of violence intervention training, again, seemed to have little correspondence to likelihood of report, as each group showed similar proportions of respondents indicating that a report had been filed. **Among those with supportive supervisors, 78% said they reported the event, as opposed to only 54% among those without supportive supervisors.**

Interestingly, among those who indicated their violence intervention training was helpful, a notable difference arose. 69% of members of this group (N=84) indicated a violent incident had occurred compared to 88% of those who did not find it helpful (N=49). Percent reporting the event was the same (69%) regardless of whether they found the training helpful (N=58) or not (N=42).

Regarding whether the respondent felt protected from the threat of violence at work (n=213), 62% said no. For the 38% who did feel protected, a follow-up open comment question concerning why they felt protected yielded informative responses.

65 respondents shared comments about why they felt protected from the threat of violence at their facility. These responses were then coded based on 12 identified theme areasand presented in Figure 6. Most frequently cited reasons were the presence of an onsite security team (21) and clear support from supervisors (19), followed by the presence of other staff (15) and specific security protocols to be followed (14). Less frequent reasons for feeling protected included: access to local police (7), knowledge of how to appropriately deal with situations (4), awareness of a reporting process (4), training they received (4), organizational corrective steps were taken in the past (2), the ability to adjust treatment plans when needed (1), personal awareness (1), and other (7).

Comments shared around security protocols may be of value for additional review as respondents shared specific strategies that healthcare providers as individuals or organizations may be able to adopt. These included:

Security Teams

- Rapid response from security
- Visible and competent security
- 24/7 security coverage
- Security present when potential violent person scheduled

Duress/Panic Buttons

- Rooms with duress/panic button
- Laptops with duress/panic software
- Badges with duress/panic button

Room Security

- Badge access only rooms
- Locked doors
- Telesitter in high-risk rooms

Staffing Support

- Buddy system if feel unsafe
- Extra staff when needed

Phone System

- Unique ringtones in the call system
- Call codes for threats

Other

- Reorg assignments if staff feel unsafe

- Adjust screening process
- Access to physical restraints when needed
- Workplace violence committee

Conclusions

Despite the limitations of the study, largely due to sample size and non-random sampling, there are several findings which merit further attention. For example, among those participating in the study, violent events are experienced:

- across all age groups;
- all healthcare settings;
- occur multiple times per week for many; and
- originate from multiple sources, including patients, family members, and co-workers.

It was not surprising then to learn that 62% of healthcare workers did not feel safe at their place of employment.

Data suggest that availability of tools, protocols, and policies, as well as supervisory support, may be connected to lower incidence of violent experiences among the healthcare providers studied. For example, when tools/policies were available, 65% indicated a violent event occurred, as opposed to 89% if tools/policies were not available. Similarly, 65% experienced violence if a supervisor regularly encouraged reporting of violence at their facility vs. 87% of those with supervisors who did not.

Violence intervention training itself may or may not be helpful to reduce violence occurrence (75% experienced violence if they had taken a training vs. 68% if they had not; (See Table 1). However, in instances where respondents found the training to be helpful, they were less likely to have experienced a violent incident in the past six months (69% of respondents who reported training as helpful experienced violence vs. 88% of those who reported training as not helpful experienced violence).

Care must be taken with interpreting results too broadly from the available data. Due to limited sample sizes, there are likely additional factors at work (e.g., differences in emergency department vs. ambulatory settings, rural vs. urban hospitals, time to provide quality care, provider burnout and stress, etc.) that we do not fully understand, which could shape the frequency and impact of violent events in healthcare settings. It will be necessary to take additional steps to both address the immediate action that is needed as well as bring in new information to help guide successful long-term strategies.

Recommendations

Primary recommendations for next steps center around 1) supporting action at the organizational level to ensure implementation of agency-level policies, training, and other services to improve staff and patient safety; 2) additional research on the prevalence, drivers, and protective factors of workplace violence; 3) a multi-organization quality improvement initiative to build upon lessons learned; as well as 4) statewide policy changes to ensure healthcare providers have adequate resources, organizational and management support, and supportive environmental and cultural redesign to systematically decrease risk to provide a safe, supportive environment for healthcare providers and patients.

Organizational Action

Based on the literature review and supplemental findings from the pilot study, several immediate steps are recommended for action by regional healthcare providers and organization leaders. Particularly important to consider are recommended best practices to better ensure the safety of staff who work in potentially dangerous environments.

Towards this end, four publications are critical for further review and consideration for action by hospital staff:

- Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers by OSHA (https://www.osha.gov/sites/default/files/publications/osha3148.pdf)
- Recommended Practices for Safety and Health Programs by OSHA (https://www.osha.gov/sites/default/files/publications/OSHA3885.pdf)
- Sentinel Event Alert, Issue 59, April 2018 (https://www.jointcommission.org/-/media/documents/office-quality-and-patient-safety/sea_59_workplace_violence_4_13_18_final.pdf)
- Framework Guidelines for Addressing Workplace Violence in the Health Sector (https://apps.who.int/iris/bitstream/handle/10665/42617/9221134466.pdf?sequence=1&isAllowed=y)

Examples of recommended steps based on the above and the expertise of workgroup members include:

Crisis Prevention

- Management commitment and worker participation including training programs on workplace violence crisis response actions and policies
- Develop standard definitions and measures of violence and disseminate throughout the state
- Identify and assess risk factors for WPV in the following settings:
  - Organizational
  - Individual
- Engineering controls and workplace adaptations to reduce risk (e.g., improved lighting in parking lots; restricted access to certain areas)
- Training for administrative and treatment staff regarding therapeutic procedures that are sensitive to the

cause and stimulus of violence. For example, research has shown that Trauma Informed Care is a treatment technique that has been successfully instituted in inpatient psychiatric units as a means of reducing patient violence, as well as the need for seclusion and restraint.

- Crisis response training and simulation practice
- Development of crisis response procedures with local law enforcement and emergency responders
- Surveillance—injury record review to identify patterns of assaults or near misses

Crisis Management

- Crisis management team
- Crisis incident program in place: identification, reporting, activating emergency plan, knowing roles during incident emergencies
- Investigation of incidents (involve workers in the incident investigation)

Post-Crisis

- Reporting
  - Establishing policies that ensure the reporting, recording, and monitoring of incidents and near misses and that no reprisals are made against anyone who does so in good faith.
- Treatment
  - Employers should ensure that if an incident of workplace violence occurs, post-incident procedures and services are in place and/or immediately made available.
- Program evaluation, development of quality improvement initiatives, including changes to the physical environment, as well as work organization practices and administrative procedures
- Training of all staff

The approaches referenced in the sources above address fundamental issues which need to be addressed if we are ever to successfully improve current healthcare environments. Implementing best practice recommendations will not only decrease healthcare workplace violence but improve provider satisfaction and quality of patient care.

Research

While the pilot study helped to document the incidence of violence and aggression among a subset of healthcare providers and provided insights into the frequency and distribution of such events, it also raised more questions worthy of further study. For example, due to limited sample sizes, there is insufficient information to answer questions such as:

- Are certain types of aggression more common among those with limited experience in the field? Or among those who work part-time? Are certain types of training more or less beneficial to them?
- How does the incidence of aggression and its impacts vary by those working in emergency departments, as well as in assisted living and home care settings?
- What types of trainings, policies, and/or protocols seem most effective for different types of aggression?
- Is reporting more or less likely when a co-worker is involved in the abuse?

A broader study with a randomized stratified statewide sample with sufficient sample sizes for particular demographics would be beneficial to document the need for action, clarify multiple issues, and address some of the critical knowledge gaps in the current survey results.

In addition to gathering perspectives from staff involved in these events, it will also be critically important to gain a better understanding of patient and family perspectives surrounding each event. Insights provided by all parties involved may be instrumental in devising effective long term solutions to this complex challenge.

Quality Improvement Initiative

By combining the benefits of organizational action and ongoing research, a consortium of health organizations can work together to learn about the most effective steps which can be taken to improve staff and patient safety. In so doing, they not only add to the body of research on what works, but also are able to fine tune the application of best practice given the unique dynamics of each organization and can show systematic improvement in an area that can have far reaching implications on the ability of each organization to achieve its healthcare mission.

Policy

While steps can be taken at the organizational level as described above, additional statewide policies to supplement these activities would help to ensure that there is consistency in our efforts to protect the lives of those who may otherwise be left vulnerable to attacks born out of anger, fear, and confusion. For consideration, policy actions implemented by other states include:

- Employer-run workplace violence prevention programs
- Development and implementation of standards of conduct, as well as policies for managers and employees to reduce workplace bullying and promote healthful and safe work environments
- Amending existing statute for assaults of first responders by adding healthcare providers/nurses and/or increasing the penalty associated with such behavior
- Implementing an ID tag and badges law to relax the requirement of using full names on staff IDs
- Post warnings regarding violent behaviors in hospitals
- Update Injury & Illness Prevention Plans at least annually
- Set up committees to recommend updates and develop incident reporting procedures for patient assaults on employees to assist hospitals in better identifying the risks of such assaults.

Additional information can be found at: https://www.nursingworld.org/practice-policy/advocacy/state/workplace-violence2/.

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Appendix: Survey Tool

Please review the following definitions prior to beginning the survey, as the survey includes questions about different types of violence and aggression in the healthcare setting. For the purpose of this study, **violence** is defined as any form of physical or non-physical aggression, regardless of intent, including physical, sexual, or verbal aggression, harassment, or intimidation directed towards healthcare employees by patients, families, or visitors.

Physical aggression: behavior causing or threatening physical harm towards others. It includes hitting, kicking, biting, using weapons, or destruction of property.

Sexual aggression: any touching or grabbing that is performed without consent or makes the receiver uncomfortable in any way.

Verbal aggression: any words, phrases, or conversations that make the receiver feel threatened and/or affects them negatively. Verbal aggression includes yelling, name calling, and blaming.

Harassment: any repeated behavior that is troubling or provoking.

Intimidation: the act of coercing or frightening someone to do (or not to do) something against their will.

Part I: Demographics

1. What is your age (select one):

☐ 18-28

☐ 29-45

☐ 46-65

☐ 65+

☐ I prefer not to answer

2. How do you identify?

☐ Male

☐ Female

☐ Non-binary

☐ I prefer not to answer

☐ Other: _____

3. How long have you worked in a healthcare setting?

☐ Fewer than 5 years

☐ 5-10 years

☐ More than 10 years

4. Currently, what is your role/position in the healthcare field?

☐ Administrative or clerical (e.g., reception, accounting, customer service, and non-clinical support staff)

☐ Contractor or consultant

☐ Dining services

☐ Environmental services (e.g., housekeeping, maintenance, facilities, and security)

☐ Licensed nursing assistant or medical assistant

☐ Management

☐ Nurse practitioner or physician assistant

☐ Pharmacist

☐ Physician

☐ Registered nurse or licensed practical nurse

☐ Medical technician

☐ Volunteer

5. Are you employed:

(Please choose only one response)

☐ Part-time

☐ Full-time

☐ Per diem

☐ Volunteer/Consultant

☐ Contractor

5. Which do you normally work?

☐ Days

☐ Evenings

☐ Nights

☐ Varies

6. Approximate hours worked per workday:

☐ 1-5

☐ 5-10

☐ 10-12

☐ >12

7. Within the past six months, what type of facility have you worked in? (select all that apply)

☐ Hospital - inpatient

☐ Hospital Emergency Department

☐ Ambulatory setting, including primary care, urgent care clinic, Department of Health clinic, homeless clinic, mental health center, crisis beds

☐ Assisted living

☐ Nursing home/long-term care facility

☐ Home care or hospice agency

☐ Freestanding emergency medical facility

☐ Other: _____

Part II: Violence in the Healthcare Setting

8. Within the past six months, have you experienced a violent incident, including physical, sexual and verbal aggression, harassment, or intimidation at your place of work? If no, proceed to xxxx.

☐ Yes

☐ No, proceed to question 17

9. If you answered "Yes" to the previous question, how would you classify the incident(s)? (select all that apply)

☐ Physical aggression: behavior causing or threatening physical harm towards others. It includes hitting, kicking, biting, using weapons, or destruction of property.

☐ Sexual aggression: any touching or grabbing that is performed without consent or makes the receiver uncomfortable in any way.

☐ Verbal aggression: any words, phrases, or conversations that make the receiver feel threatened and/or affects them negatively. Verbal aggression includes yelling, name calling, and blaming.

☐ Harassment: any repeated behavior that is troubling or provoking.

☐ Intimidation: the act of coercing or frightening someone to do (or not to do) something against their will.

10. If you have experienced any of the acts of aggression and violence listed above within the past six months, how frequently have these incidents occurred?

	Everyday	A few times per week	A few times per month	Less than once a month
Physical Aggression	☐	☐	☐	☐
Sexual Aggression	☐	☐	☐	☐
Verbal Aggression	☐	☐	☐	☐
Harassment	☐	☐	☐	☐
Intimidation	☐	☐	☐	☐

11. Where were you when the violent act(s) occurred? (select all that apply)

☐ Patient room
☐ Patient bathroom
☐ Hallway
☐ Nurse's station
☐ Medication room
☐ Patient/family member's home
☐ Patient examination room
☐ Waiting area
☐ Other: _____

12. Within the last six months, during what activity(s) have you experienced workplace violence? (sexual, physical or verbal aggression, harassment, or intimidation) Select all that apply

☐ Patient care, e.g., ADLs, toileting, bathing
☐ Medication administration
☐ Physical assessment
☐ Patient education
☐ Patient procedure
☐ Admission process
☐ Discharge process
☐ Other: _____

13. Did an injury occur as a result of any of these incidents?

☐ No

☐ Yes.

If so, what was the injury? _____

14. Who committed the violence? (select all that apply)

☐ Patient/client

☐ Relative/family of patient

☐ Visitors

☐ Other: _____

15. Briefly describe the violent incident(s):

(Do not include identifying or confidential patient information in your response.)

_____

_____

_____

_____

16. When you've experienced violence while working in the healthcare setting, have you reported or documented it to a person in administrative leadership?

☐ Yes

☐ No

17. If not, what was your primary reason for not reporting?

☐ Unaware of reporting system in facility

☐ Did not believe act was intentional

☐ Apprehensive due to repercussions (victim blaming)

☐ I didn't know if I should

☐ Other:_____

18. Is there a standardized tool, form, or protocol in your facility to report violent acts committed by patients, family members, or visitors?

☐ Yes (go to question 19)

☐ No (go to next question)

☐ I am not sure (go to next question)

19. If you answered NO or UNSURE to question 17, would having a reporting tool, form, or protocol positively impact your work environment?

☐ Yes

☐ No

☐ I am not sure

If yes, in what way? _____

20. Does your unit coordinator, floor manager, or supervisor encourage you to report incidents of violence when they occur, regardless of circumstance?

☐ Yes

☐ No

21. Do you feel protected from the threat of violence at work?

☐ Yes

☐ No

If yes, how do you feel protected? _____

22. Have you as an employee taken any violence intervention and/or prevention training classes through your place of work? These can include CPI (Crisis Prevention Intervention) or MOAB (Management of Aggressive Behavior) training.

☐ Yes

☐ No

23. If you answered YES above, was this training required or optional?

☐ Required

☐ Optional

☐ Other: _____

24. Did you find the training helpful (or useful) when patients, family, or visitors begin to act aggressively?

☐ Yes

☐ No

☐ If yes, how was the training helpful? _____

25. Are there any additional comments/concerns you have as a healthcare worker that are important for us to consider? (Do not include identifying or confidential patient information in your response.)

_____

_____

_____

_____

New Hampshire Hospital Association

HOUSE HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS COMMITTEE

Tuesday, April 12, 2022

SB 459-FN – Relative to a Health Care Facility Workplace Violence Prevention Program

Testimony

Good morning, Mr. Chairman, and members of the committee. My name is Paula Minnehan, Senior Vice President, State Government Relations with the New Hampshire Hospital Association (NHHA), representing all 26 of the state's community hospitals as well as all specialty hospitals. I am here today with Kris Hering, Vice President of Quality Improvement with the Foundation for Healthy Communities, which is an affiliate of the hospital association.

The NHHA is in strong support of SB 459-FN, and we appreciate Senator Gray sponsoring the bill as well as all the cosponsors, including Representatives McMahon and Greene.SB 459-FN is the result of SB 100, that passed last year, which established a Committee to Study Workplace Safety in Health Care Settings. This legislation is extremely important due to the growing incidences of violence in health care settings and the need to protect our health care workforce. The study committee was chaired by Senator Gray and Senator Rosenwald also was on the committee, along with Representatives McMahon, Greene and Litchfield. Senator Sherman was very engaged in the study committee, attending most of the meetings and was extremely helpful in the development of the legislation before you today. In addition to the numerous study committee meetings that were held we had several work sessions on both the development of the workplace violence prevention program as well as the changes to the arrests without a warrant statute.

There are four sections of the bill that I will outline briefly and then ask Kris to explain in more detail the importance of the legislation. In addition, there are individuals here today that can address the section of the bill that changes RSA 594:10, I, Arrests Without a Warrant.

Section 1 of the bill establishes the Workplace Violence Prevention Program. The program is initially focused on Hospitals and Urgent Care Centers, because, through the study committee and subgroup work sessions, it was determined that those are the facilities where there is a higher risk of violence against health care workers. Each facility will be responsible for implementing and maintaining a workplace violence prevention program. The program requirements are outlined in detail in the legislation. We received significant input from the NH Nurses Association representatives, who are here today and can provide further input on the importance of establishing the program, which includes data collection and annual reporting to the department of health and human services.

Section 2 of the bill establishes the New Hampshire Health Care Workplace Safety Commission. The commission is modeled after the NH Health Care Quality and Safety Commission, which has been in place for over a decade. Kris Hering can explain in more detail the difference between the two commissions.

Section 3 renames the NH Health Care Quality and Safety Commission to add "Patient" to the title, before "Safety" to ensure that the two commissions are not confused. One is focused on Workplace Safety, and one is focused on Patient Safety.

Section 4 changes the Warrantless Arrest statute to ensure that law enforcement can properly respond to violent incidences in a health care setting.

Thank you for the opportunity to provide our comments in support of SB 459-FN.

NH Health Care
Quality and Safety Commission

HOUSE HEALTH, HUMAN SERVICES AND ELDERLY AFFAIRS COMMITTEE

Tuesday, April 12, 2022

SB 459-FN – Relative to a Health Care Facility Workplace Violence Prevention Program

Testimony

Good morning, Mr. Chairman, and members of the committee. My name is Kris Hering, VP Quality Improvement at the Foundation for Healthy Communities and Administrator for the NH Health Care Quality and Safety Commission.

I am here to provide background on the role and structure of the NH Health Care Quality and Safety Commission (NHHQSC) and to explain why establishing a similar entity to examine health care workplace violence is imperative. The NH Health Care Quality and Safety Commission was originally established in 2005 by the NH General Court to provide a confidential forum for quality professionals from all NH hospitals and ambulatory surgery centers (ASCs) to share information on adverse patient care events and to learn how to prevent them. For the past 17 years, Commission members have enjoyed the opportunity to look beyond their own organization's experiences and data, into statewide data, to identify patient safety trends and to share frankly with their colleagues. This ability has resulted in substantial learning for all participants and a much more proactive approach by each organization to reduce preventable patient harm.

In 2015, hospitals started seeing an increase of violent acts against healthcare workers, and the NHHQSC became the de facto entity to discuss these as no other forum existed. Hospital safety officers have been invited into Commission meetings to present on workplace safety events and to share their recommendations and policies to make hospital workplaces safer. Commission members, who often do not have primary responsibility for their hospitals' safety programs, have in turn shared these recommendations and resources with their safety officers, emergency management coordinators and senior executives. The Commission has urged hospitals to collect workplace safety data, but unlike the mandatory reporting requirement of Adverse Events by the NH Department of Health and Human Services, there is no mandatory reporting requirement for workplace violence events. Currently, workplace violence data is incomplete and lacking standardization.

Unfortunately, violent acts against healthcare workers in hospitals continue to increase in number and severity. Continuing to have these events reported via the NHHQSC is sub-optimal for the reasons that the Commission's focus is on patient safety, and not workplace safety; quality professionals are not typically in charge of hospital safety programs and the ones who can affect change in these programs; ambulatory surgery centers are not experiencing similar violence so much of this discussion is not germane to them; and other healthcare entities who are experiencing increased workplace violence (i.e., urgent care centers) are not represented.

Because the structure of the NHHQSC has been so successful in allowing hospitals and ASCs to improve patient care and patient safety, it makes sense to replicate this same structure to create a commission specifically focused on healthcare workplace violence prevention. This new commission, coupled with a robust reporting requirement for workplace violence events, will provide the forum necessary for hospitals and other healthcare entities experiencing workplace violence to make positive change.

Thank you for the opportunity to provide my comments.

Dear Chairman Pearson and members of the House Health, Human Services and Elderly Affairs Committee;.

My name is Pamela DiNapoli, Nurse Executive Director New Hampshire Nurses Association (NHNA), representing over 1300 member nurses. I am writing to encourage the committee to support SB 459-FN. We thank Senator Gray and his committee for working to submit this important bipartisan bill.

Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. According to OSHA, healthcare workers are four times more likely than workers in private industry to experience violence in the workplace. In a recent pilot study of nurses in Merrimack County the following was reported:

Type of Incident	% Reported (nurses reporting)
Physical Aggression	24% (n=16)
Sexual Aggression	3% (n=2)
Verbal Aggression	35% (n=24)
Harassment	9% (n=6)
Intimidation	15% (n=10)

However, underreporting is believed to be significant so the true picture of workplace violence for healthcare workers is unclear. A survey of Minnesota nurses indicated that 69% of physical assaults and 71% of non-physical assaults were **not reported** to a manager. Healthcare has unique challenges in dealing with violence in the workplace. The commitment to "do no harm" and recognition that the patient is impaired or experiencing ill effects of their illness contribute to underreporting and acceptance of violent acts. Workplace violence has a high cost- lost workdays as well as worker burnout, fatigue and stress lead to poorer outcomes for patients including medication errors and patient infections. This bill creates an opportunity for organizations to examine the issues surrounding workplace violence in health care as well as exploration and development of policies and structures that will protect healthcare workers.

The incidences of violence against health care workers in NH hospitals and other health care facilities continues and, while individual facilities and providers have implemented various policies and strategies to address this growing concern, we believe a more comprehensive, multi-

disciplinary approach is warranted. It should not be the expectation that a nurse, aide, physician or other caregiver will be verbally or physically harmed while doing their job caring for others. Currently, there is no specific federal statute that requires workplace violence protections, but several states have enacted legislation or regulations protecting health care workers from its effects. We support these moves by individual states and implore this senate committee to support SB 459-FN which establishes regulations assuring protections for the healthcare workers of New Hampshire.

Thank you for the opportunity to provide our comments.

Pamela P DiNapoli, PhD, RN, CNL
Executive Director
25 Hall Street Suite 1E
Concord, NH 03301
(603)225-3783
nhna.ned@gmail.com

SB 459-FN - AS AMENDED BY THE SENATE

03/17/2022 1051s

2022 SESSION

22-3129
12/10

SENATE BILL ***459-FN***

AN ACT relative to a health care facility workplace violence prevention program.

SPONSORS: Sen. Gray, Dist 6; Sen. Rosenwald, Dist 13; Sen. Sherman, Dist 24; Rep. Greene, Hills. 37; Rep. McMahon, Rock. 7

COMMITTEE: Health and Human Services

ANALYSIS

This bill requires health care facilities to implement and maintain workplace violence prevention programs and establishes the health care workplace safety commission. This bill also permits law enforcement to arrest an individual without a warrant in certain circumstances related to health care workplaces.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Two

AN ACT relative to a health care facility workplace violence prevention program.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Subdivision; Workplace Violence Prevention Program. Amend RSA 151 by inserting after section 52 the following new subdivision:

Workplace Violence Prevention Program

151:53 Workplace Violence Prevention Program.

I. In this section:

(a) "Health facility" means an acute care, rehabilitation, psychiatric, or substance abuse treatment hospital, or an urgent care center licensed under RSA 151; provided that a facility with more than one physical location shall be considered a single health facility.

(b) "Workplace violence" means any act or threat of physical violence, harassment, intimidation, or other threatening behavior that occurs at a health facility, including verbal abuse, without regard to whether the victim sustains an injury, psychological trauma, or stress.

II. Except as provided in paragraph III, every health facility shall implement and maintain a workplace violence prevention program developed by a multidisciplinary team of direct care employees and other employees, in consultation with stakeholders or experts who specialize in workplace violence prevention, emergency response, or another related areas of expertise. Said program shall consider the size and complexity of the health facility and shall:

(a) Include policies and procedures to prevent and respond to workplace violence.

(b) Provide appropriate training, education, and resources to all employees based on their roles and responsibilities at the time of hire, annually and whenever changes occur regarding the workplace violence prevention program, which encourage participation and address prevention, recognition, response, and reporting of workplace violence. Said training, education, and resources shall include:

(1) Education on what constitutes workplace violence.

(2) Education on the roles and responsibilities of leadership, clinical staff, security personnel, if applicable, and external law enforcement.

(3) Training in de-escalation, nonphysical intervention skills, response to emergency incidents, and at the discretion of the health facility, physical intervention techniques.

(4) The reporting process for workplace violence incidents.

(c) Establish a process to report workplace violence incidents internally and externally in order to analyze incidents and trends.

(d) Establish a process for follow up and support to victims and witnesses affected by workplace violence, including information about available counseling.

(e) Establish a process to conduct an annual facility-specific risk assessment to:

(1) Examine all existing and potential workplace violence risks, including environmental and patient-specific risk factors, the health facility's workplace violence incidents, and how the program's policies and procedures, training, education, and environmental design reflect best practices and conform to applicable laws and regulations; and

(2) Be used to develop recommendations to reduce the risk of workplace violence.

III. A health facility accredited by the Joint Commission on the accreditation of healthcare organizations may give proof of compliance with Joint Commission standards on workplace violence prevention to the health care workplace safety commission established in RSA 151-J, in lieu of paragraph II.

IV. Each health facility shall prepare and submit to the health care workplace safety commission established in RSA 151-J an annual report containing all workplace violence incidents reported to the health facility directed at an employee by a patient, coworker, supervisor, manager, or other individuals who have a personal relationship with a patient. The commissioner of health and human services, with the advice and consent of a majority of members of the commission, shall adopt rules pursuant to RSA 541-A deemed necessary for the implementation of this section in coordination with the department of health and human services, including a common reporting form.

V. The annual report required under paragraph IV shall include for each workplace violence incident a description of:

(a) The incident, including environmental and patient-specific risk factors present at the time of the incident.

(b) The date, time, and location of the incident, and the names and job titles of employees involved in the incident.

(c) The nature and extent of injuries to employees.

(d) A classification of each perpetrator who committed the violence, including whether the perpetrator was:

(1) A patient;

(2) An individual who has or is known to have had a personal relationship with a patient;

(3) A coworker, supervisor; or manager; or

(4) Any other appropriate classification.

(e) How the incident was abated, including any incident response and post-incident investigation.

(f) If the incident involves a patient, the patient's name or other similar identifier shall not be included in the report, provided that the report may include the patient's diagnosis code and whether or not behavioral health or disability were a factor.

(g) The percentage of employees that have participated in the workplace violence prevention program in the year preceding the incident.

VI. No person or health care facility shall retaliate in any manner against, or otherwise discriminate against, a person, employee, or subordinate who exercises any rights under this section or rules adopted pursuant to this section, or by any policy or procedure promulgated under this section or RSA 151-J, including but not limited to reporting of a workplace violence incident or otherwise providing notice to the health facility regarding the occupational health and safety of the employee or their fellow employees exposed to workplace violence risk factors. Nothing in this section shall be construed to authorize an employee to refuse to discharge his or her ordinary and customary duties in the workplace.

VII. Any health facility which violates any provision of this section, or rules adopted under this section, shall receive a written warning from the department of health and human services, for the first offense. For each subsequent offense, the commissioner of health and human services, after notice and hearing, pursuant to rules adopted under RSA 541-A, may impose an administrative fine not to exceed $2,000. Rehearings and appeals from a decision of the commissioner shall be in accordance with RSA 541. The sums obtained from the levying of administrative fines under this chapter shall be forwarded to for deposit into the general fund.

VIII. Notwithstanding the requirements of this section, a health facility that is an urgent care center shall not be required to comply with this section before July 1, 2024.

2 New Chapter; New Hampshire Health Care Workplace Safety Commission. Amend RSA by inserting after chapter 151-I the following new chapter:

CHAPTER 151-J

NEW HAMPSHIRE HEALTH CARE WORKPLACE SAFETY COMMISSION

15I-J:1 Commission Established; Membership.

I. There is hereby established a commission to review and analyze health care workplace violence safety issues including, but not limited to, reports of workplace violence incidents and trends. The commission shall also support the development and implementation of health care workplace violence prevention programs, including training, and propose changes to improve the safety in health care workplace settings.

II. The members of the commission shall be as follows:

(a) One representative of each hospital in New Hampshire, licensed under RSA 151, appointed by the hospital.

(b) The chief executive officer of the New Hampshire hospital, or designee

(c) One representative of each non-hospital affiliated urgent care network of 3 or more clinics in New Hampshire, licensed under RSA 151, appointed by the urgent care network.

(d) The commissioner of the department of health and human services, or designee.

(e) The commissioner of the department of labor, or designee.

(f) The attorney general, or designee.

(g) Three members-at-large, one of whom shall be appointed by the speaker of the house of representatives, one of whom shall be appointed by the president of the senate, and one of whom shall be appointed by the governor.

151-J:2 Duties.

I. The commission shall:

(a) Review and analyze health care workplace violence safety issues including, but not limited to, reports of workplace violence incidents and trends,

(b) Support the development and implementation of health care workplace violence prevention programs, including training.

(c) Propose changes that will improve the safety of the health care workplace.

II. Sources of data for the duties described in paragraph I may include, but are not limited to, reviews and reports currently required by or submitted to state or national regulatory and accrediting organizations.

151-J:3 Chair; Vice-Chair. The members of the commission shall elect a chair and vice-chair from among the members at the first meeting. The term of the chair and vice-chair shall be 2 years and until successors are elected. The chair shall be responsible for the orderly proceedings of the commission meetings and for compliance with mandates of this chapter. The vice-chair shall serve in the absence of the chair.

151-J:4 Education. Each member of the commission shall be responsible for the dissemination of commission discussions to his or her institutions. All such information shall be disseminated through each participant's safety and security program in order to protect the confidentiality of all participants and patients involved in any incident or topic discussed.

151-J:5 Confidentiality.

I. All information submitted to or collected by the commission, including, but not limited to, written, oral, and electronic information; records and proceedings of the commission, including, but not limited to, oral testimony and discussions, notes, minutes, summaries, analyses, and reports; and information disseminated by the commission or its members to hospitals and urgent care centers shall be confidential and privileged and shall be protected from direct or indirect means of discovery, subpoena, or admission into evidence in any judicial, administrative, or other type of proceeding. The provision of information to the commission and the dissemination of information by the commission shall not be deemed to void, waive, or impair in any manner the confidentiality protection of this section or which the information may have under any other law or regulation.

II. Information, documents, or records otherwise available from original sources shall not be construed as immune from discovery or use in any civil or administrative action merely because they were presented to the commission. Any person who supplies information to or testifies before the commission shall not be immune from discovery in any civil or administrative action because the information or testimony was presented to the commission, but such witness shall not be asked about and shall not provide information about his or her testimony before this commission or opinions formed by him or her as a result of commission participation.

III. Notwithstanding paragraph I, if a workplace violence incident involves a patient, the health care workplace safety commission and the health care quality and safety commission established in RSA 151-G may share information about the incident for the purpose of reviewing and analyzing incidents involving both a patient and an employee.

151-J:6 Administration. The commission may delegate to the department of health and human services the functions of collecting, analyzing, and disseminating workplace violence information, organizing and convening meetings of the commission, and other substantive and administrative tasks as may be incident to these activities or directed by the commission. The activities of the department of health and human services and its employees or agents shall be subject to the same confidentiality provisions as those that apply to the commission.

151-J:7 Reports. On or before June 30 of each year, the commission shall report its findings and any recommendations which may include proposed legislation to the speaker of the house of representatives, the senate president, the governor, and the health and human services oversight committee established in RSA 126-A:13. Such report shall describe the activities of the commission, indicate the extent of each institution's participation, state the aggregate relative frequency of workplace violence incidents, the nature and extent of injuries, how incidents were responded to, and, to the extent possible, identify strategies for reducing workplace violence incidents. Any information about processes or outcomes provided pursuant to this section shall be aggregate data only and shall not reference individual incidents, patients, health care providers, or institutions.

151-J:8 Rulemaking. The commissioner of the department of health and human services, with the advice and consent of a majority of members of the commission, shall adopt rules pursuant to RSA 541-A, to assure de-identification of all individuals and facilities involved in the incidents received.

3 New Hampshire Health Care Quality and Safety Commission. Amend the title of RSA 151-G to read as follows:

CHAPTER 151-G

NEW HAMPSHIRE HEALTH CARE QUALITY AND ***PATIENT*** SAFETY COMMISSION

4 Arrests Without a Warrant. Amend RSA 594:10, I(c) to read as follows:

(c) He ***or she*** has probable cause to believe that the person to be arrested has committed a misdemeanor or violation, and, if not immediately arrested, such person will not be apprehended,

will destroy or conceal evidence of the offense, [~~or~~] will cause further personal injury or damage to property, ***or while in the care of a medical professional on the premises of a residential care or health care facility, as defined in RSA 151:2, through actual or threatened violence, interfere in the provision of medically necessary health care services.***

5 Effective Date.

I. Section 4 of this act shall take effect January 1, 2023.

II. The remainder of this act shall take effect July 1, 2023.

LBA
22-3129
Amended 3/22/22

SB 459-FN- FISCAL NOTE

AS AMENDED BY THE SENATE (AMENDMENT #2022-1051s)

AN ACT relative to a health care facility workplace violence prevention program.

FISCAL IMPACT: [X] State [ ] County [ ] Local [ ] None

	Estimated Increase / (Decrease)			
STATE:	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**
Appropriation	$0	$0	$0	$0
Revenue	$0	$0	$0	$0
Expenditures	$0	$272,000	$272,000	$272,000
Funding Source:	[X] General	[ ] Education	[ ] Highway	[ ] Other

METHODOLOGY:

This bill requires health care facilities to implement and maintain workplace violence prevention programs and establishes a health care workforce safety commission. The Department of Health and Human Services states the bill will necessitate two new training and development manager positions at labor grade 24, one each at NH Hospital and Glencliff Home. Salaries and benefits for each position will total $96,000 per year. The Department further expects $40,000 in annual training costs at each of the two facilities. Total combined costs for the two facilities will therefor be $272,000 per year. With respect to the regulation and enforcement of new requirements established by the bill, the Department does not anticipate the need for any additional staff in the Bureau of Licensing and Certification.

AGENCIES CONTACTED:

Department of Health and Human Services