LEGISLATIVE COMMITTEE MINUTES

SB459

Bill as Introduced

SB 459-FN - AS INTRODUCED

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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

22-3129
12/10

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.

(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
Revised 2/11/22

SB 459-FN- FISCAL NOTE
AS INTRODUCED

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

FISCAL IMPACT:

Due to time constraints, the Office of Legislative Budget Assistant is unable to provide a fiscal note for this bill, **as introduced**, at this time. When completed, the fiscal note will be forwarded to the Clerk's Office.

AGENCIES CONTACTED:

Department of Health and Human Services

SB 459-FN - AS AMENDED BY THE SENATE

03/17/2022 1051s

2022 SESSION

22-3129
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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

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Workplace Violence Prevention Program

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(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:

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151-J:1 Commission Established; Membership.

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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.

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(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,

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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.

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CHAPTER 151-G

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(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
Revised 2/11/22

SB 459-FN- FISCAL NOTE
AS INTRODUCED

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

FISCAL IMPACT:

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AGENCIES CONTACTED:

Department of Health and Human Services

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

SB 459-FN - AS AMENDED BY THE HOUSE

03/17/2022 1051s
21Apr2022... 1678h

2022 SESSION

22-3129
12/10

SENATE BILL ***459-FN***

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COMMITTEE: Health and Human Services

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(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

151-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 Effective Date. 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

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

SB 459-FN - AS AMENDED BY THE HOUSE

03/17/2022 1051s
21Apr2022... 1678h
4May2022... 1871h

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

AMENDED ANALYSIS

This bill requires health care facilities to implement and maintain workplace violence prevention programs and establishes the health care workplace safety commission.

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.

SB 459-FN - AS AMENDED BY THE HOUSE

03/17/2022 1051s
21Apr2022... 1678h
4May2022... 1871h

22-3129
12/10

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; and provided that "health facility" shall not include state-operated medical facilities, and voluntary compliance by a state-operated facility shall not subject such facility to the requirements of this section. The term "health facility" shall not include any non-hospital affiliated urgent care with less than 3 clinics in New Hampshire.

(b) "Workplace violence" means any act or threat of physical violence, harassment, intimidation, or other threatening behavior.

(c) "Hostile words" means aggressive and belligerent verbal abuse in which the recipient reasonably believes that the speaker intends to injure or create excessive stress, or in which the recipient suffers actual psychological trauma.

II. Except as provided in paragraph III, health facilities shall implement and maintain a workplace violence prevention program. Said program shall consider the size and complexity of the health facility and shall address the following topics, and others deemed appropriate by the health facility, the goal of which is to encourage participation and address prevention, recognition, response, and reporting of workplace violence:

(a) Policies and procedures to prevent and respond to workplace violence and hostile words.

(b) Appropriate training, education, and resources to employees based on their roles and responsibilities. Said training, education, and resources shall include:

(1) Education on what constitutes workplace violence and hostile words.

(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 and hostile words incidents.

(c) A process to report workplace violence and hostile words incidents internally and externally in order to analyze incidents and trends.

(d) A process for follow-up and to support victims and witnesses affected by workplace violence or hostile words, including information about available counseling.

(e) A process to conduct an annual facility-specific risk assessment, which shall:

(1) Examine all existing and potential workplace violence and hostile words risks, including environmental and patient-specific risk factors, the health facility's workplace violence and hostile words 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 and hostile words.

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. The commissioner of the department of health and human services shall follow up on participation in the workplace violence prevention program so that participation status is proactively known and that this status is properly reported in the annual report described in RSA 151-J:7.

V. 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 and hostile words 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 chair of the health and human services oversight committee, established in RSA 126-A:13, with the advice of the health care workplace safety commission, may recommend updates to New Hampshire statutes or recommend updates to the rules adopted for the implementation of this section. The commissioner of health and human services, in consultation with the health care workplace safety commission and the health and human services oversight committee, 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.

VI.(a) The annual report required under paragraph V shall include but not be limited to, for each workplace violence or hostile words incident, a description of:

(1) The incident, including environmental and patient-specific risk factors present at the time of the incident, as well as the appropriate categorization of the incident as workplace violence and/or hostile words.

(2) The date, time, and location of the incident.

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

(4) A classification, but not any identifiable personal information, of each perpetrator who committed the violence, including whether the perpetrator was:

(A) A patient;

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

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

(D) Any other appropriate classification.

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

(6) 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.

(7) The percentage of employees that have participated in the workplace violence prevention program in the reporting year immediately preceding the incident. This percentage shall be an annual point in time percentage and is not intended to be a rolling number calculated upon each incident.

(b) The report shall preserve the reporting distinction between workplace violence and hostile words incidents. There shall not be any identifiable personal information included in any report unless contained within an attached police report or other official report of a governmental entity. No person or health care facility shall retaliate in any manner against any reporting individual acting in good faith, 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 or hostile words 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 or hostile words 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. The commissioner of the department of health and human services shall be responsible for maintaining, in an easily navigable, searchable, distinct page on the department's website, a database to share information on the activities of the New Hampshire health care workplace safety commission. Topics included on the page shall include, but not be limited to:

(a) A listing of all health care facilities by name, with their business address included, which are subject to the provisions of the workplace violence prevention program.

(b) The participation status of each facility as active, inactive, or unknown.

(c) The dates of each meeting of the New Hampshire health care workplace safety commission.

(d) Annually, a press release shall be issued within 60 days of the end of the calendar year, highlighting the active participation of health care facilities and any major findings or recommendations.

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

151-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.(a) The members of the commission shall be as follows:

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

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

(3) 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.

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

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

(6) The attorney general, or designee.

(7) 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.

(b) The governor may remove any member of the commission with cause.

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 to health and human services oversight committee, established in RSA 126-A:13, and to the commissioner of the department of health and human services 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 terms of the chair and vice-chair shall be 2 years, with the initial term for the chair to be 3 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, other than police reports, 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. Nevertheless, the principles of data minimization will be respected to include deidentification of any personally identifiable information.

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 and data privacy as those that apply to the commission.

151-J:7 Reports. The commission shall annually 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 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.

151-J:9 Exemption; State Operated Medical Facilities. All medical facilities operated by the state of New Hampshire shall not be subject to the jurisdiction of the health care workplace safety commission established in this chapter.

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 Repeal. The following are repealed:

I. RSA 151:53, relative to the workplace violence prevention program.

II. RSA 151-J, relative to New Hampshire health care workplace safety commission.

5 Effective Date.

I. Section 4 of this act shall take effect March 1, 2034.

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

CHAPTER 340
SB 459-FN - FINAL VERSION

03/17/2022 1051s
21Apr2022... 1678h
4May2022... 1871h
05/26/2022 2104EBA

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

AMENDED ANALYSIS

This bill requires health care facilities to implement and maintain workplace violence prevention programs and establishes the health care workplace safety commission.

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.

CHAPTER 340
SB 459-FN - FINAL VERSION

03/17/2022 1051s
21Apr2022... 1678h
4May2022... 1871h
05/26/2022 2104EBA

22-3129
12/10

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:

340:1 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; and provided that "health facility" shall not include state-operated medical facilities, and voluntary compliance by a state-operated facility shall not subject such facility to the requirements of this section. The term "health facility" shall not include any non-hospital affiliated urgent care with less than 3 clinics in New Hampshire.

(b) "Workplace violence" means any act or threat of physical violence, harassment, intimidation, or other threatening behavior.

(c) "Hostile words" means aggressive and belligerent verbal abuse in which the recipient reasonably believes that the speaker intends to injure or create excessive stress, or in which the recipient suffers actual psychological trauma.

II. Except as provided in paragraph III, health facilities shall implement and maintain a workplace violence prevention program. Said program shall consider the size and complexity of the health facility and shall address the following topics, and others deemed appropriate by the health facility, the goal of which is to encourage participation and address prevention, recognition, response, and reporting of workplace violence:

(a) Policies and procedures to prevent and respond to workplace violence and hostile words.

(b) Appropriate training, education, and resources to employees based on their roles and responsibilities. Said training, education, and resources shall include:

(1) Education on what constitutes workplace violence and hostile words.

(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 and hostile words incidents.

(c) A process to report workplace violence and hostile words incidents internally and externally in order to analyze incidents and trends.

(d) A process for follow-up and to support victims and witnesses affected by workplace violence or hostile words, including information about available counseling.

(e) A process to conduct an annual facility-specific risk assessment, which shall:

(1) Examine all existing and potential workplace violence and hostile words risks, including environmental and patient-specific risk factors, the health facility's workplace violence and hostile words 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 and hostile words.

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. The commissioner of the department of health and human services shall follow up on participation in the workplace violence prevention program so that participation status is proactively known and that this status is properly reported in the annual report described in RSA 151-J:7.

V. 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 and hostile words 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 chair of the health and human services oversight committee, established in RSA 126-A:13, with the advice of the health care workplace safety commission, may recommend updates to New Hampshire statutes or recommend updates to the rules adopted for the implementation of this section. The commissioner of health and human services, in consultation with the health care workplace safety commission and the health and human services oversight committee, 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.

VI.(a) The annual report required under paragraph V shall include but not be limited to, for each workplace violence or hostile words incident, a description of:

(1) The incident, including environmental and patient-specific risk factors present at the time of the incident, as well as the appropriate categorization of the incident as workplace violence and/or hostile words.

(2) The date, time, and location of the incident.

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

(4) A classification, but not any identifiable personal information, of each perpetrator who committed the violence, including whether the perpetrator was:

(A) A patient;

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

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

(D) Any other appropriate classification.

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

(6) 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.

(7) The percentage of employees that have participated in the workplace violence prevention program in the reporting year immediately preceding the incident. This percentage shall be an annual point in time percentage and is not intended to be a rolling number calculated upon each incident.

(b) The report shall preserve the reporting distinction between workplace violence and hostile words incidents. There shall not be any identifiable personal information included in any report unless contained within an attached police report or other official report of a governmental entity. No person or health care facility shall retaliate in any manner against any reporting individual acting in good faith, 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 or hostile words 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 or hostile words 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. The commissioner of the department of health and human services shall be responsible for maintaining, in an easily navigable, searchable, distinct page on the department's website, a database to share information on the activities of the New Hampshire health care workplace safety commission. Topics included on the page shall include, but not be limited to:

(a) A listing of all health care facilities by name, with their business address included, which are subject to the provisions of the workplace violence prevention program.

(b) The participation status of each facility as active, inactive, or unknown.

(c) The dates of each meeting of the New Hampshire health care workplace safety commission.

(d) Annually, a press release shall be issued within 60 days of the end of the calendar year, highlighting the active participation of health care facilities and any major findings or recommendations.

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.

340:2 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.(a) The members of the commission shall be as follows:

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

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

(3) 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.

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

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

(6) The attorney general, or designee.

(7) 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.

(b) The governor may remove any member of the commission with cause.

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 to the health and human services oversight committee, established in RSA 126-A:13, and to the commissioner of the department of health and human services 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 terms of the chair and vice-chair shall be 2 years, with the initial term for the chair to be 3 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, other than police reports, 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 patient 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. Nevertheless, the principles of data minimization will be respected to include deidentification of any personally identifiable information.

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 and data privacy as those that apply to the commission.

151-J:7 Reports. The commission shall annually 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 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.

151-J:9 Exemption; State Operated Medical Facilities. All medical facilities operated by the state of New Hampshire shall not be subject to the jurisdiction of the health care workplace safety commission established in this chapter.

340:3 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

340:4 Repeal. The following are repealed:

I. RSA 151:53, relative to the workplace violence prevention program.

II. RSA 151-J, relative to New Hampshire health care workplace safety commission.

340:5 Effective Date.

I. Section 4 of this act shall take effect March 1, 2034.

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

Approved: July 25, 2022
Effective Date:
I. Section 4 effective March 1, 2034

II. Remainder effective July 1, 2023

Amendments

Health and Human Services
March 9, 2022
2022-1051s
12/10

Amendment to SB 459-FN

Amend RSA 151:53, V(f) as inserted by section 1 of the bill by replacing it with the following:

(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.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Jeb Bradley, Chair
Sen James Gray, Vice Chair
Sen Kevin Avard, Member
Sen Tom Sherman, Member
Sen Rebecca Whitley, Member

Date: February 23, 2022

HEARINGS

Wednesday	03/09/2022
(Day)	(Date)

Health and Human Services	Legislative Office Building 101	9:00 a.m.
(Name of Committee)	(Place)	(Time)

9:00 a.m.	**SB 459-FN**	relative to a health care facility workplace violence prevention program.

EXECUTIVE SESSION MAY FOLLOW

Sponsors:
SB 459-FN
Sen. Gray Sen. Rosenwald Sen. Sherman Rep. Greene
Rep. McMahon

Cameron Lapine 271-2104

Jeb Bradley
Chairman

Senate Health and Human Services Committee

Cameron Lapine 271-2104

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

Hearing Date: March 9, 2022

Time Opened: 9:02 a.m. **Time Closed:** 9:38 a.m.

Members of the Committee Present: Senators Bradley, Gray, Avard, Sherman and Whitley

Members of the Committee Absent: None

Bill 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.

Sponsors:

Sen. Gray	Sen. Rosenwald	Sen. Sherman
Rep. Greene	Rep. McMahon	

Who supports the bill: Senator James Gray (Senate District 6), Senator Cindy Rosenwald (Senate District 13), Paula Minnehan (New Hampshire Hospital Association), Kris Hering (Foundation for Healthy Communities), John Patti (Catholic Medical Center), Jack Patti (Londonderry High School), Margret W. Brew (MSN-RN), Mary Behnke, Glenn Brackett (NH AFL-CIO), Mike DellaVecchia RN, Pamela DiNapoli, (NH Nurses Association), Kate Dow, Marcy Doyle, Jillian Duchesne, Katherine Engalichev, Stacie Flanagan, Stacy Gillis, Julie Gilston, Debra Goodrum, Pamela Hager, Richard Hager, Olivia Herbert, Amanda Henson, Lucas Hudon, Katherine Lajoie, Karen Leahy, Emily Millet, Mark Millet, Michael Padmore (NH Medical Society), Kathleen Paquette, Jean Proehl, Patricia Sampson, Senator Tom Sherman (Senate District 24), Katherine Smith, Julie Stephens, Stephan Thompson, Charlene Verga, Ayla Wamser, and Jade Wronowski.

Who opposes the bill: None.

Who is neutral on the bill: Holly Stevens (NAMI New Hampshire)

Summary of testimony presented in support:

Senator James Gray

Senate District 6

- Senator Gray said that SB 459-FN came as a result of months of study committee work. He said that although the language in SB 459-FN has been created in the past year, the roots go back many years. Senator Gray also described an incident at the New Hampshire Hospital (NHH) where a constituent of his was injured and out of work due to that injury.
- Senator Gray said that he would like to take and expand the NHH policy, which faces different issues than other hospitals in New Hampshire. He said that other speakers could speak to the specifics of SB 459-FN.
- Senator Gray said that some people wanted to expand the penalties for injuring people, and they are adamant on trying to deescalate a situation and then using that gained information to be able to effect an arrest of a person that can't be dealt with or is causing injury.

Senator Cindy Rosenwald

Senate District 13

- Senator Rosenwald said that she was a member of the study committee that examined the issue of workplace violence in health care settings, and she supports SB 459-FN. Senator Rosenwald commended Senator Gray for steering the study committee to avoid criminalizing mental health.
- Senator Rosenwald said that the language in SB 459-FN threads the needle beautifully and carefully, and it represents months of collaboration between the stakeholders.
- Senator Rosenwald said that the data involved comes from a workgroup that Senator Sherman is involved with and it is critical to understanding why violence is rising in health care and how to address it.
- Senator Rosenwald said that Holly Stevens from the National Alliance on Mental Illness – New Hampshire (NAMI) is neutral to SB 459-FN and she wouldn't be present for the hearing.

Paula Minnehan and Kris Hering

Vice President of State Government Relations, New Hampshire Hospital Association and Vice President of Quality Improvement, Foundation for Healthy Communities

- Ms. Minnehan thanked Senator Gray and the cosponsors of SB 459-FN.
- Ms. Minnehan said that SB 459-FN was a result of the SB 100 (2021) study committee to look at growing incidents of violence, and a need to protect the health care workforce.
- Ms. Minnehan submitted written testimony from Lieutenant Frank Harris, the Unit Commander of New Hampshire State Police at the State Complex, who works at New Hampshire Hospital.
- Ms. Minnehan outlined the four sections of SB 459-FN:

    - Section 1 establishes a prevention program which focuses on hospitals and urgent care. She said that it also determines facilities with a higher risk of violence. She said that section 1 also says that a facility is responsible for implementing the program, and Ms. Minnehan received input from nurses on why this is important.
    - Section 2 establishes the New Hampshire Health Care Workplace Safety Commission which is modeled after the New Hampshire Health Care Quality and Safety Commission (NHHCQSC).
    - Section 3 renames the NHHCQSC, and adds "patient", as the Patient Safety Commission.
    - Section 4 changes the warrantless arrest statute to ensure that police can respond correctly.
- Ms. Herring said that she is the is the administrator of the NHHCQSC, which was established in 2005 to provide a confidential forum for health care professionals to share information on adverse patient care events and learn how to prevent them. She said that the members of the NHHCQSC look beyond their individual organizations and experiences to look at statewide data and discover trends. He said that this is a proactive approach.
- Ms. Herring said that, in 2015, hospitals saw an increase in violence against staff, and the NHHCQSC became the *de facto* forum. She said that security officers were invited to meetings on how to make hospital workplaces safer. Ms. Herring said that commission members aren't primarily responsible for safety at facilities, and the NHHCQSC urged hospitals to collect safety data, but they cannot make it mandatory. Ms. Herring said that the data is incomplete and lacking standardization.
- Ms. Herring said that attacks have increased in number and severity and that this is suboptimal to report to the NHHCQSC, which focuses primarily on patient safety. Ms. Herring said that quality professionals on NHHCQSC are not in charge of safety and cannot effect change at their facilities. Ms. Herring said that urgent care centers are not represented on the NHHCQSC.
- Ms. Herring said that the NHHCQSC was successful in patient safety, and she recommend the same structure for workplace violence prevention. Ms. Herring said that robust reporting requirements will provide the forum which is necessary for hospitals to make positive changes.
- Senator Sherman said that wanted to add something on the reporting side. He said that, in regard to Page 2, Line 36 and 37, he wanted to expand with NAMI and the Disability Rights Center to know which incidents involved disability or mental illness. Senator Sherman said that he looked at having the line expanded. Senator Sherman said that he was trying to get at if a patient was psychotic or competent. Senator Sherman said that he wanted to get at the meat of what was discussed with the American Civil Liberties Union (ACLU) and including a diagnosis code is simple. Senator Sherman asked how to incorporate it and if they are amenable to incorporate it in the report. Senator Sherman said that this does address the ACLU concerns.
    - Ms. Herring said that the concern with that the diagnosis is that the primary diagnosis will not necessarily reflect a behavioral health condition, adding that it is valuable to collect, and additional questions about behavioral health also might be important.

- Senator Sherman asked, if a diagnosis was identified, if a subsequent question on the reporting form for behavioral illness or disability would be permissible.
    - Ms. Minnehan said that it probably would be permissible if it is not too specific, and it still has to be implemented with hospitals to make sure hospitals are not being burdened. Ms. Minnehan said it must be indicated that it somehow makes sense, but it must not be too specific.
- Senator Gray said that on Page 4, the duties of commission describe several places that say "shall include but are not limited to". Senator Gray said that Senator Sherman may be correct that it should be added, but he was willing to let the commission make that decision to ask for more information on the report. Senator Gray asked if they agree.
    - Senator Sherman said that he was ok with not adding it.

John Patti

Executive Director of Support Services at Catholic Medical Center (CMC)

- Mr. Patti said that there was input from the DRC, the Attorney General, the Chiefs of Police, the ACLU, and the New Hampshire Hospital Association at the study committee.
- Mr. Patti said that the Director of Security of CMC was astonished about what clinical staff endure, and he compared the behavior to other situations such as behavior at restaurants. Mr. Patti said that just because patients are within the walls of a hospital doesn't mean that they are allowed to behave without consequence.
- Mr. Patti said that assaults and violence have increased, and health care workers are four to five times more likely than private industry employees to face workplace violence.
- Mr. Patti expressed the need for data collection and support for a commission to review and analyze data. Mr. Patti is aware of the reports of assault, and on many occasions would call the police only to be told that the police wouldn't make a warrantless arrest. Mr. Patti said that it is frightening for workers who are victims of assault to have to remain in close proximity to their attacker.
- Mr. Patti said that RSA 594-10 is a basis for not arresting, and the language requires an officer to predict future behavior of a subject to make a warrantless arrest, which places the victim in peril.
- Mr. Patti described the need to provide the police with more clarity in statute and provide health care workers with safety and assurance. Mr. Patti expressed the necessity to authorize warrantless arrests for an assault on a health care worker.

Margret Brew

MSN-RN

- Ms. Brew said that there is a dramatic impact on the ability to provide care and sustain a career when there is a fear of going to work. Ms. Brew submitted written testimony.
- Ms. Brew said that she is a health care work place violence prevention educator at two hospitals. Ms. Brew said that education entails de-escalation, self-defense, and nonphysical intervention.

- Ms. Brew said that data needs to be acquired to address the issues, and victims and witnesses must be supported.
- Ms. Brew said that students share experiences in class and work in varied roles in the health care system. Ms. Brew said that stories illuminate the issues and the toll taken on people in health care due to violence. Ms. Brew described the physical harm and scars of health care workers, and she described her dissatisfaction that reporting doesn't impact safety. She discussed how people who witnessed events of violence questioned if they want to work in health care. Ms. Brew raised the example of the shootings at Dartmouth Hitchcock Medical Center.
- Ms. Brew described one nurse's story involving an attack at an emergency care center which resulted in a head injury. She said that this health care worker was out of work for six weeks and they were not supported upon their return; the health care worker was simply told to expect that kind of injury while working in a health care setting. Ms. Brew said that physical harm is only part of the injury.
- Ms. Brew said that there is a direct impact on the health and welfare of the citizens of New Hampshire. Ms. Brew said that environments must be safe to provide care, and safety must be advocated for.
- Ms. Brew said that there must be a collaborative network to report and discuss issues, and the fiscal impact of safety in health care environment is critical to the financial wellbeing of a hospital.

Pam DiNapoli

New Hampshire Nurses Association

- Ms. DiNapoli thanked Senator Gray and Senator Sherman for their work on SB 459-FN.
- Ms. DiNapoli said that the New Hampshire Nurses Association had been working on this issue for years to protect health care workers, and she is happy with SB 459-FN.
- Ms. DiNapoli said that SB 459-FN was modeled on a joint commission's new recommendations, which are more robust. Ms. DiNapoli said that not all facilities in New Hampshire are accredited, and that joint commission's language must be incorporated.
- Ms. DiNapoli described testimony from a nurse working in an emergency department who suffered three incidents of violence in one weekend.
- Ms. DiNapoli said that there were three cases of violence that happened last weekend alone to one nurse in one emergency department, and cases need to be looked at across state, adding that violence is not made up.
- Ms. DiNapoli said that when she teaches classes, she asks how many have been hit and 95% say yes. She said that when they asked if they were assaulted, only 25% say yes. Ms. DiNapoli said that there is a clear disconnect between what assault is and what should be expected. Ms. DiNapoli said that violence must be defined.
- Ms. DiNapoli said that the American Nurses Association is working on the federal bill HR 1309 that protects nurses.

Summary of testimony presented in opposition: None.
Neutral Information Presented: None.

cml
Date Hearing Report completed: March 10, 2022

Speakers

Senate Health & Human Services Committee
SIGN-IN SHEET

Date: March 9, 2022 **Time:** 9:00 a.m.

SB 459-FN AN ACT relative to a health care facility workplace violence prevention program.

Name/Representing *(please print neatly)*	Support	Neutral	Oppose	Speaking?	Yes	No
Kayla Monahan, NH Hospital Association	☑	☐	☐		☑	☐
Kris Hering, Foundation for Healthy Communities	☑	☐	☐		☑	☐
John Patti Catholic Medical Center	☒	☐	☐		☒	☐
Jack Patti Londonderry High School	☒	☐	☐		☐	☒
Mayor Cindy Rosenwald (with testifier)	☒	☐	☐		☒	☐
Margaret W. Brew MSN-RN	☑	☐	☐		☒	☐
Pam Dixon	☒	☐	☐		☒	☐
Glen Gray	☑	☐	☐		☑	☐
	☐	☐	☐		☐	☐
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Senate Health & Human Services Committee
SIGN-IN SHEET

Date: March 9, 2022 **Time:** 9:00 a.m.

SB 459-FN AN ACT relative to a health care facility workplace violence prevention program.

Name/Representing ***(please print neatly)***

Name/Representing	Support	Neutral	Oppose	Speaking?	Yes	No
Holly Stevens/NAMI New Hampshire	☐	☒	☐		☐	☒
	☐	☐	☐		☐	☐
	☐	☐	☐		☐	☐
	☐	☐	☐		☐	☐
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Senate Remote Testify

Health and Human Services Committee Testify List for Bill SB459 on 2022-03-

Support: 34 Oppose: 0

Name	Title	Representing	Position
BEHNKE, MARY	A Member of the Public	Myself	Support
Gilston, Julie	A Member of the Public	Myself	Support
Lajoie, Katherine	A Member of the Public	Myself	Support
DiNapoli, Pamela	A Member of the Public	NH Nurses Association	Support
Hebert, Olivia	A Member of the Public	Myself	Support
Millet, Mark	A Member of the Public	Myself	Support
Gillis, Stacy	A Member of the Public	Myself	Support
Thompson, Stephen	A Member of the Public	Myself	Support
Duchesne, Jillian	A Member of the Public	Myself	Support
DellaVecchia RN, Mike	A Member of the Public	Myself	Support
Millet, Emily	A Member of the Public	Myself	Support
Proehl, Jean	A Member of the Public	Myself	Support
Paquette, Kathleen	A Member of the Public	Myself	Support
Verga, Charlene	A Member of the Public	Myself	Support
Doyle, Marcy	A Member of the Public	Myself	Support
Hager, Pamela	A Member of the Public	Myself	Support
Sampson, Patricia	A Member of the Public	Myself	Support
Brackett, Glenn	A Lobbyist	NH AFL-CIO	Support
Smith, Katharine	A Member of the Public	Myself	Support
leahy, karen	A Member of the Public	Myself	Support
Flanagan, Stacie	A Member of the Public	Myself	Support
Dow, Kate	A Member of the Public	Myself	Support
Henson, Amanda	A Member of the Public	Myself	Support
Engalichev, Katherine	A Member of the Public	Myself	Support
Hager, Richard	A Member of the Public	Myself	Support
WAmser, Ayla	A Member of the Public	Myself	Support
Wronowski, Jade	A Member of the Public	Myself	Support
Stephens, Julie	A Member of the Public	Myself	Support
Hudon, Lucas	A Member of the Public	Myself	Support
Stevens, Holly	A Lobbyist	NAMI New Hampshire	Neutral
Goodrum, Debra	A Member of the Public	Myself	Support
Padmore, Michael	A Lobbyist	NH Medical Society	Support
Sherman, Senator	An Elected Official	SD24	Support
Lai, Geneva	A Member of the Public	Myself	Support
Saint-Lo, Eric	A Member of the Public	Myself	Support

Testimony

SB 459 Testimony

Good Morning Chairperson and Members of the Senate.

My name is Lieutenant Frank Harris. I am the current Unit Commander for the New Hampshire State Police-State Office Complex Police Force. My Units primary responsibility is to support New Hampshire Hospital staff in managing mentally ill patients that attempt to or do commit crimes including assaults on staff. I have been working in this Unit for 22 years and am in support of SB 459. I apologize for not being present at this very important hearing however I am currently teaching Crisis Intervention Training to NH's First Responders today.

In addition to my duties as Unit Commander I also present Managing Mentally Ill subjects, Workplace Violence Prevention and Mental Health Laws to first responders and clinicians. I was a Crisis Prevention Institute (CPI) instructor for roughly 15 years and am a co-founder of the "Safer Environment through Collaborative and Unified Response to Emergencies ™ (SECURE)" program that has been presented at most of the 26 hospitals in New Hampshire. I have presented Workplace Violence discussions locally, nationally and internationally, primarily to clinicians struggling with the issue this bill addresses.

There is no substitute for quality, comprehensive and sustainable workplace violence training. I am fortunate to witness, almost daily, incredibly skilled staff at New Hampshire Hospital resolve potentially dangerous subjects in crisis. Though the ability to de-escalate a potentially dangerous situation is certainly refined over time, the fundamental base of this skill is quality and continued education is crisis resolution. Simply providing this level of training is not enough however. The reporting and monitoring of events that include violence is critical in identifying training needs in an individual facility and within New Hampshire's healthcare industry. The passage of SB 459 would address many of these much needed processes.

During these presentations at hospitals, conferences and workplace violence symposiums I often hear stories and concerns from those that have been victimized by patients within their facilities. Much of the frustrations and fears stems from the attempt to strike a balance between treating those that are injured while keeping oneself and others safe. Many of these clinicians and first responders have cited concern of abuse from dangerous patients coupled with law enforcements challenges with the inability to immediately hold those accountable after responding to a scene.

As a law enforcement officer for 33 years collectively I have personally been a victim of workplace violence and have of course witnessed it countless times only to have been frustrated with the criminal and judicial process immediately after an assault has occurred. Much of that frustration lies with not being able to meet the expected needs of the victim and holding the aggressor accountable.

Accountability for those that have assaulted caregivers while they trying their best to render care to a patient and others in the milieu all while trying to prevent further assaults or damage is an incredibly difficult task for them. Law enforcement has difficulty managing these events if not witnessed directly by the responding officer. If passed, SB 459 would allow law enforcement the discretion to take immediate action on those persons that have committed specific crimes against clinical staff and allow clinicians to continue to provide critical care in a safe environment.

In closing, I **support the passage of SB 459** and appreciate your time.

Respectfully submitted,

Lt. Frank Harris

Lt. Frank N. Harris, Unit Commander
NH State Police/State Office Complex Police Unit

Presenter – New Hampshire Hospital Association Annual Conference

National Presenter- American Psychiatric Association Conference, Washington, DC

National Presenter- American Psychiatric Nursing Association Conference, Hartford, CT

National Presenter- American Psychiatric Nursing Association Conference, New Orleans, LA

International Presenter -10th International European Congress on Violence in Psychiatry in Dublin, Ireland

Selected to Present - 12th International European Congress on Violence in Psychiatry in Oslo, Norway

Presenter - Managing Mental Health Crisis to local, County, State and Federal Law enforcement agencies and Hospital Staff at requests of agencies

Past panel member - Police/Nursing Collaborative Research project, Geisel School of Medicine at Dartmouth College with Dr. Mathew Friedman M.D.

Past Committee Member- NH Suicide Prevention Council, Law Enforcement Sub-Committee

Co-authored published manuscript in the peer-reviewed Journal of Psychosocial Nursing and Mental Health Services, Nurse/Police Collaboration, September 2014

Developed "Dealing with Mental Illness: A Law Enforcement Perspective" curriculum for sworn and non-sworn public safety officials taught at NH Police Standards and Training

Co-Developed "SECURE", Safer Environments via Collaborative, Unified Response to Emergencies program- A Collaborative Model for Police/Public Safety/ED Clinicians

Recognized in OSHA's 2015 publication- Preventing Workplace Violence: A Roadmap for Health Care facilities/A Model for law enforcement and clinical collaboration based on our work at New Hampshire Hospital.

Featured in American Psychiatric Association Psychiatric News- a peer reviewed medical journal – "New Hampshire Hospital 'Stays Safe' Through Violence-Reduction Program"

Instructor - NH State Police/NAMI & Crisis Intervention Training Program

Guest on Jack Heath Radio shows discussing Mental Health and Law Enforcement

Guest on NH Public Radio discussing violence in Mental Health settings

Past Guest Lecturer at Lakes Region Community College, NH Technical Institute, Massachusetts College of Pharmacology and Health Science and Springfield College. Managing subjects with Mental Health issues.

Instruct Managing Mental Health Crisis's to Local, County, State and Federal Law enforcement agencies including Corrections and various hospital staff

Consulted for Dartmouth Hitchcock Medical Center and Maine Medical Center on patient/staff safety issues including environmental and staff safety concerns.

Currently working with NH Senate Committee to Study Workplace Safety in Health Care Settings (2021 Senate Bill 100)

NH Health Care
Quality and Safety Commission

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

Wednesday, March 9, 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.

New Hampshire Hospital Association

SENATE HEALTH AND HUMAN SERVICES COMMITTEE

Wednesday, March 9, 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 Senators Sherman and Rosenwald. 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.

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

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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).

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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

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University of New Hampshire
College of Health and Human Services

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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]

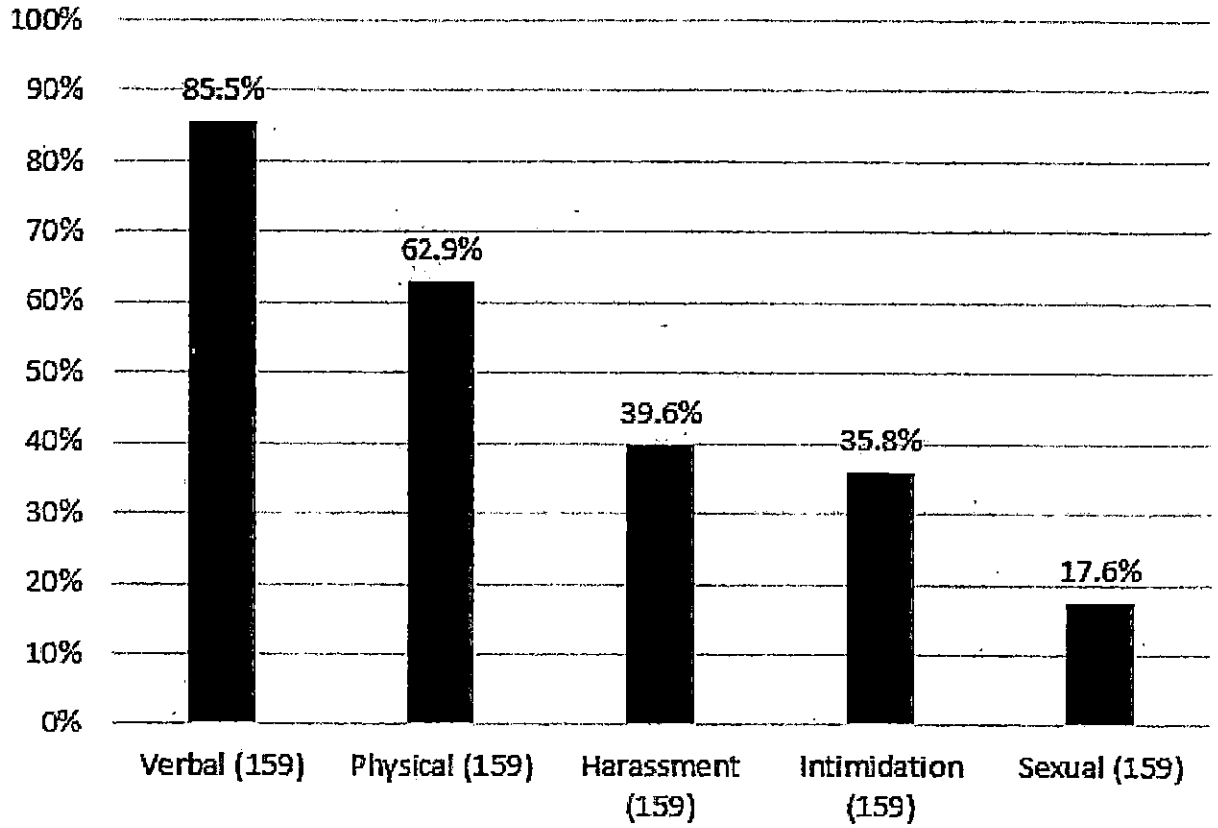
Incidence of Violence Among Healthcare Providers

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

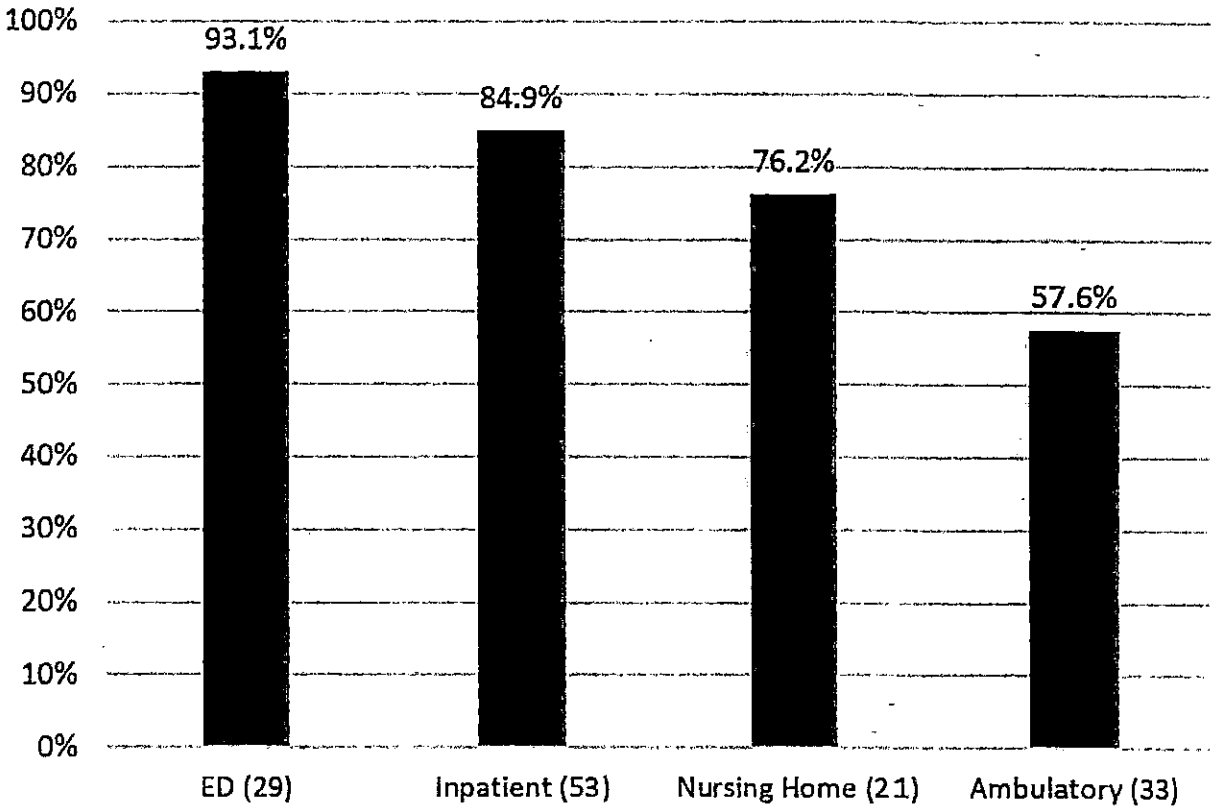


Figure 3: Where did violence occur? (N=159)

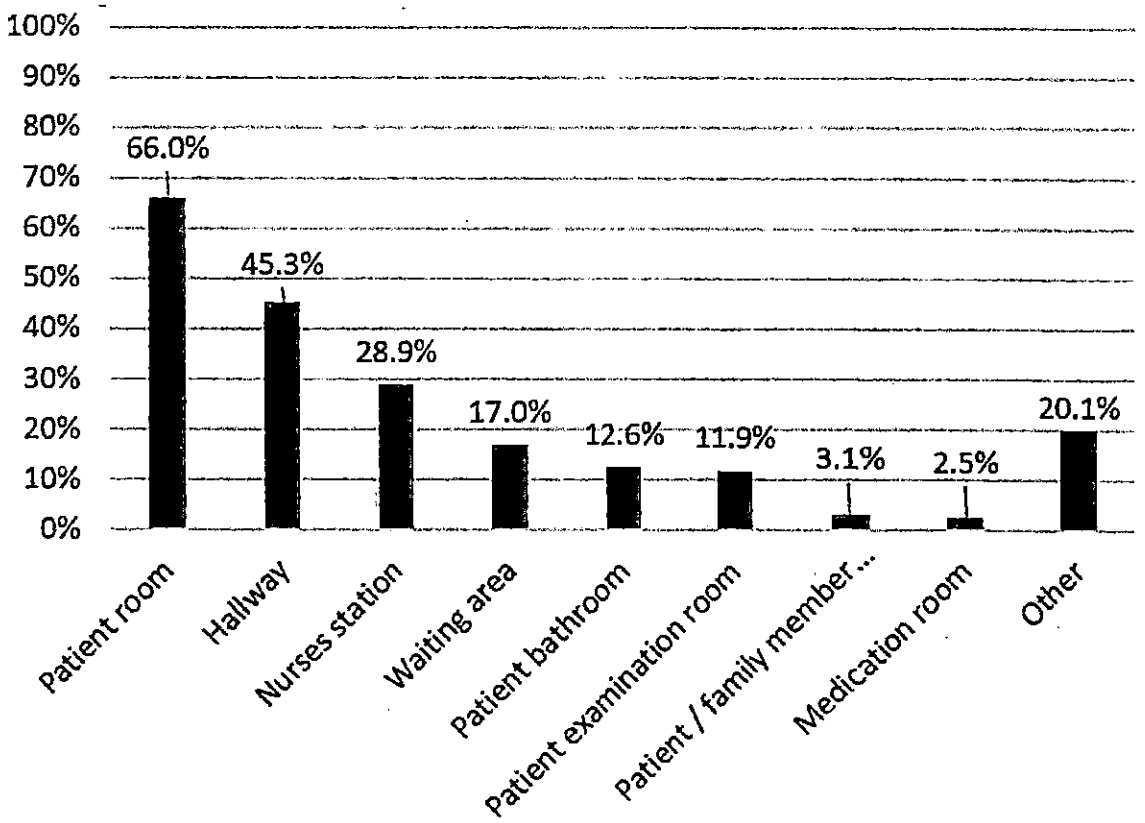
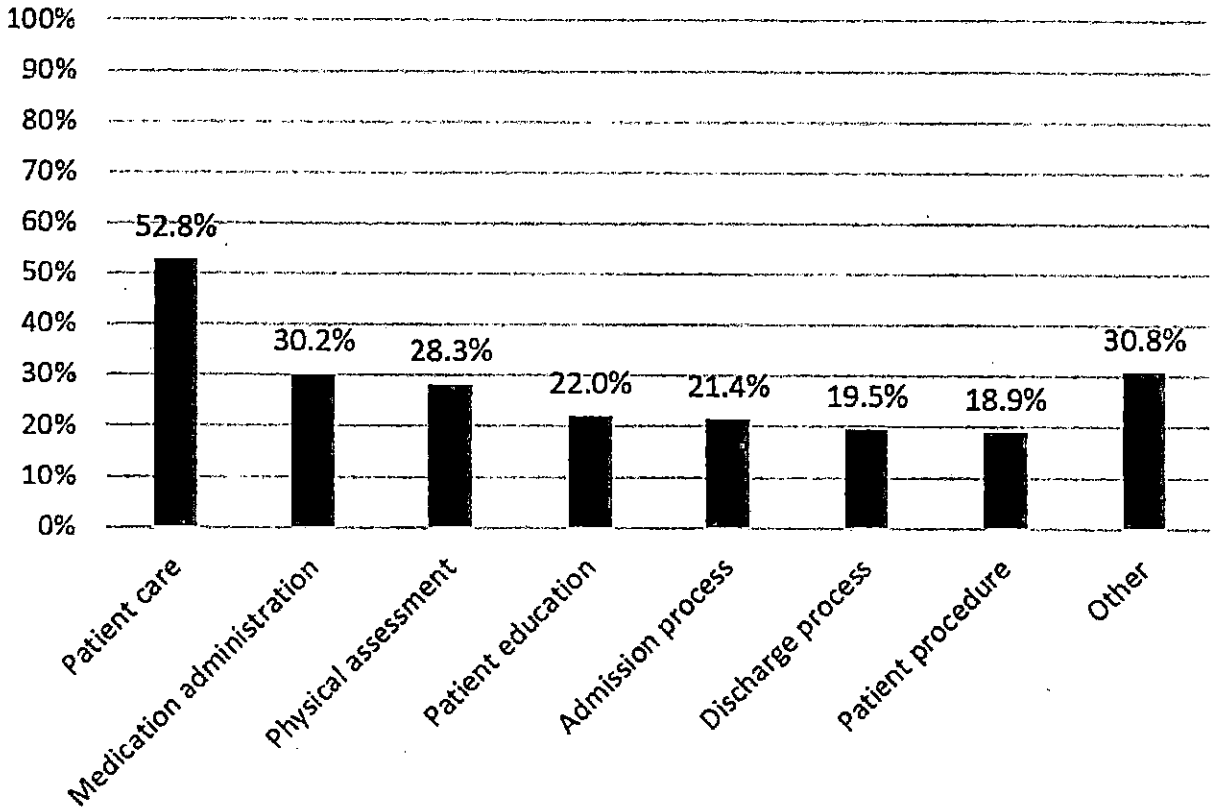


Figure 4: What activities were underway? (N=159)



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.

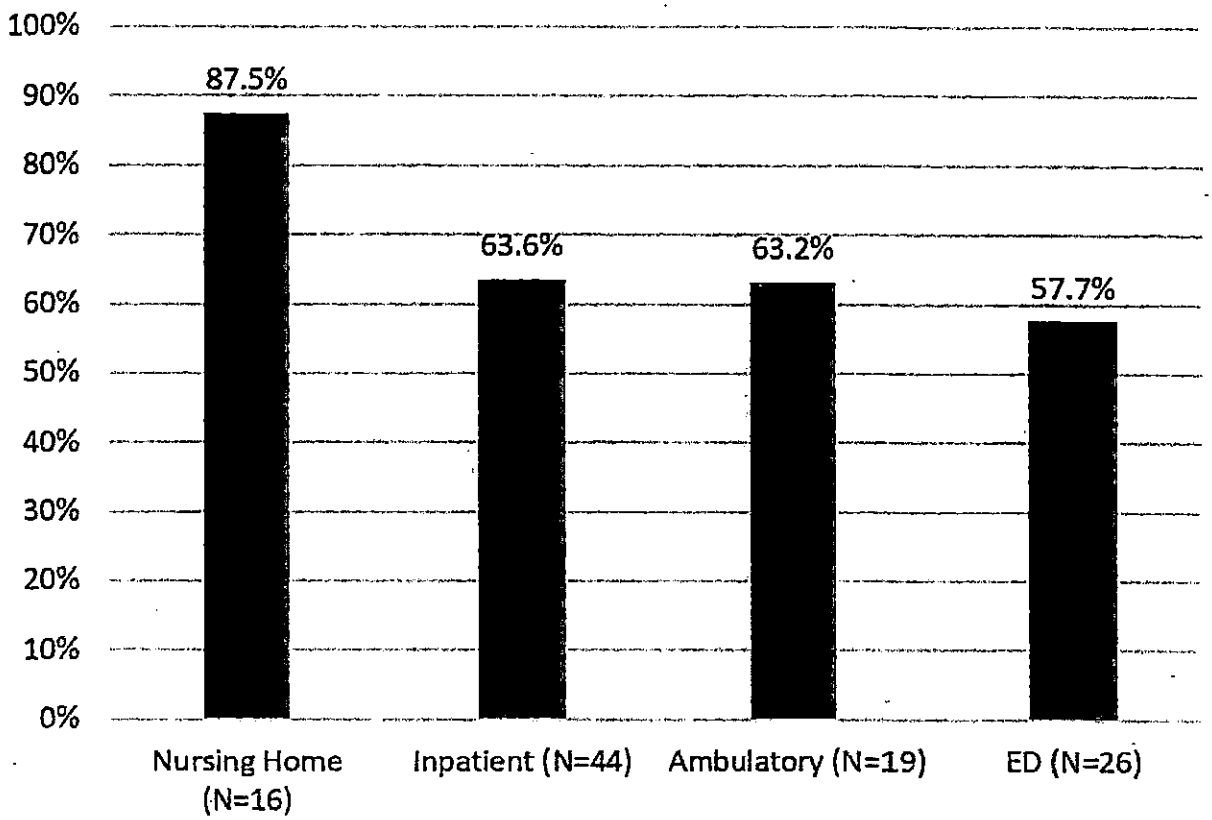
In addition to harm to the care provider, these events put patients at risk as well. When asked what healthcare activities were underway when the aggression took place, Figure 4 shows that respondents identified respondents identified a range of activity areas. Over half reported patient care (53% of 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.

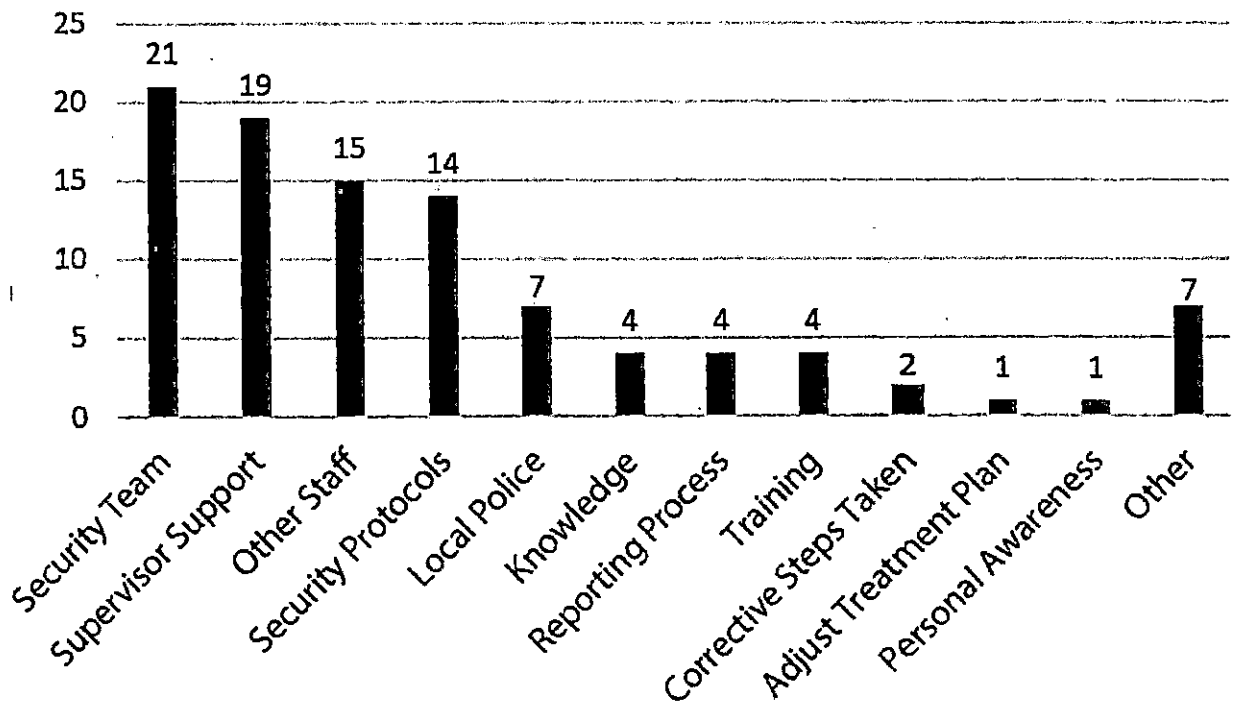
Table 1 - Experience of Violence by Presence of Protective Factors

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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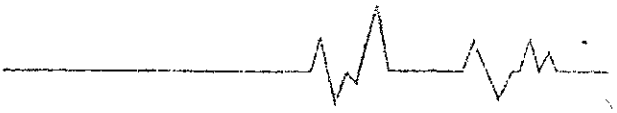


Appendix: Survey Tool

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.)

Margaret W. Brew, MSN, RN-CS, CCRN-K
P.O. Box 222
Hancock, New Hampshire 03449

March 9, 2022

Senator James Gray
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 James Gray, Cindy Rosenwald, Thomas Sherman,
Representatives Bob Greene, Charles McMahon,
The Senate HHS Committee,

My name is Margaret W. Brew, MSN, RN. I am employed as a Healthcare 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, and it supports those harmed. It will provide a collaborative network to address Healthcare Workplace Violence for all New Hampshire healthcare facilities. This in turn will have an overall positive effect on patient outcomes.

My professional endorsement of SB 459-FN is 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. This bill will promote a culture of reporting. Reporting of events provides data that organizations will utilize to address issues. This data will support policy decisions, changes in practice, 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 patient clinical outcomes. This includes the provision for Arrests Without a Warrant.

In each class that I have taught in the past 9 years, students have shared their experiences with Healthcare Workplace Violence. The students that attend work in varied roles within the healthcare system, including providers, nursing, security, and ancillary services. Their stories illuminate the personal costs of violence and its impact on the ability for individuals to perform their roles in healthcare post event. Students have shared experiences of physical harm, such as showing scars from physical altercations. They have expressed their dissatisfaction that they perceive reporting events will not have an effect in improving safety. As well, they have discussed how events that they witnessed have made them question if they want to continue to work in healthcare. Students expressed this after the shootings at Dartmouth Hitchcock Medical Center and Wentworth Douglass Hospital.

One student, a Registered Nurse, shared a story of a physical attack by a patient. Due to the severity of the attack, they required emergency care. Diagnosed with a closed head injury, and per physician order, they were out of work for 6 weeks. On their 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." The anguish on the nurse face as they recounted this event was a clear sign that the physical harm was only a part of the injury that they incurred.

The importance of addressing Healthcare Workplace Violence has a direct impact on the health and welfare of the citizens of New Hampshire. The citizens of New Hampshire need a healthcare industry where the staff is safe to provide care. Workplace Violence Prevention Education will afford staff the skills to advocate for their personal safety. It will promote a culture of reporting and build a collaborative network to address issue that affect the overall function of the healthcare industry. The fiscal impact of promoting and providing a safe healthcare environment is critical to the overall financial stability of the hospitals and The State of New Hampshire.

Thank you for your commitment to the wellbeing of healthcare workers.

Respectfully submitted,

Margaret W. Brew, MSN, RN-CS, CCRN-K

Margaret W. Brew, MSN, RN-CS, CCRN-K,

ANA
AMERICAN NURSES ASSOCIATION

A NURSE'S Call To ACTION!

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

in Nurses are **nurses & pledge to:**

- this pledge and ask my friends and family to sign
- zero tolerance policies for violence against nurses
- 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!

OR Text **PLEDGE** to **52886**

2. Send an email to your legislator with one click!

Cameron Lapine

From: Joan Widmer <jwidmer56@gmail.com>
Sent: Thursday, March 3, 2022 11:49 AM
To: Becky Whitley; Tom Sherman; Kevin Avard; Jeb Bradley; James Gray; Cameron Lapine
Subject: Upcoming Hearing on SB 459FN

Senators Whitley, Sherman, Bradley, Avard, Gray, and Lapine:

As a Registered Nurse working in home care in New Hampshire I strongly support this bill. The American Nurses Association and the American Nurses Foundation recently released the results of its second Pulse on the Nation's Nurses Survey: the COVID-19 Two-Year Impact Assessment Survey. This national survey, with over 12,600 nurses responding, found that 66% of nurses "said they have experienced increased bullying at work in the past year, while 33% said they have experienced violence at work. Alarmingly, the issue extends beyond work, with 23% of nurses reporting bullying outside of work and 12% reporting violence outside of work. In this same survey, 52% of nurses responded that they are now intending to leave the profession of nursing, or considering leaving. For younger nurses, under the age of 35, this number increases to 63%. With 89% of nurses reporting staffing shortages in their organization already, this is a very concerning issue.

Similarly, a 2019 survey of nurses in Merrimack County, 24% of nurses reported experiencing physical aggression in the past six months, while 35% experienced verbal aggression. Most of this aggression was committed by patients. Of particular concern, 46% of the nurses who responded to this survey did not feel protected from threats of violence in their workplace.

One way New Hampshire legislators can demonstrate to nurses that they care about their safety and welfare is to **vote YES on SB 459FN**. Show nurses struggling to care for patients during this global pandemic, such as myself, that you care for and support them.

Respectfully,

Joan

--

Joan C. Widmer, MS, MSBA, RN
Home Healthcare Nurse, Nurse Advocate & Volunteer
Amherst, New Hampshire

Dear Chairman Bradley and members of the Senate Health and Human Services 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.

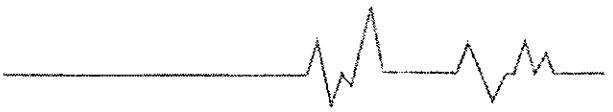
Pamela P DiNapoli, PhD, RN, CNL
Executive Director
25 Hall Street Suite 1E
Concord, NH 03301
(603)225-3783
nhna.ned@gmail.com

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

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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]

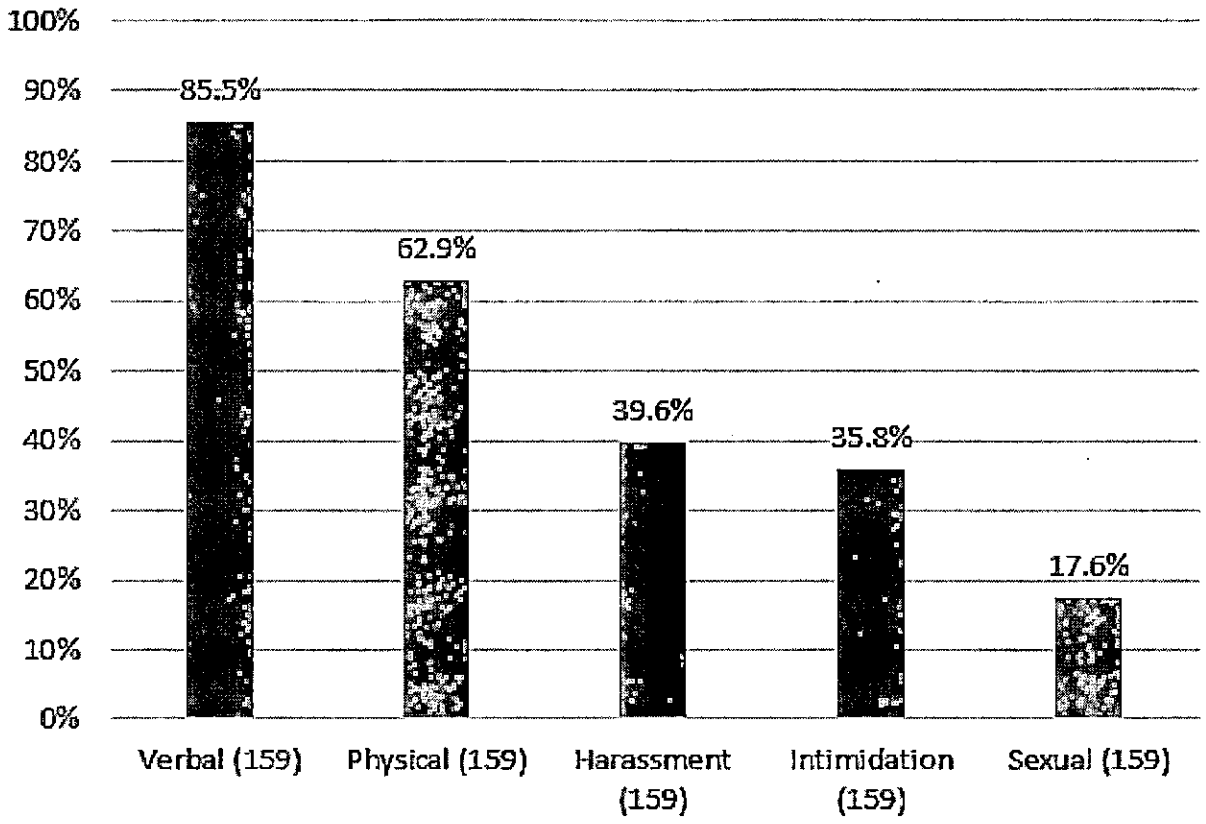
Incidence of Violence Among Healthcare Providers

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

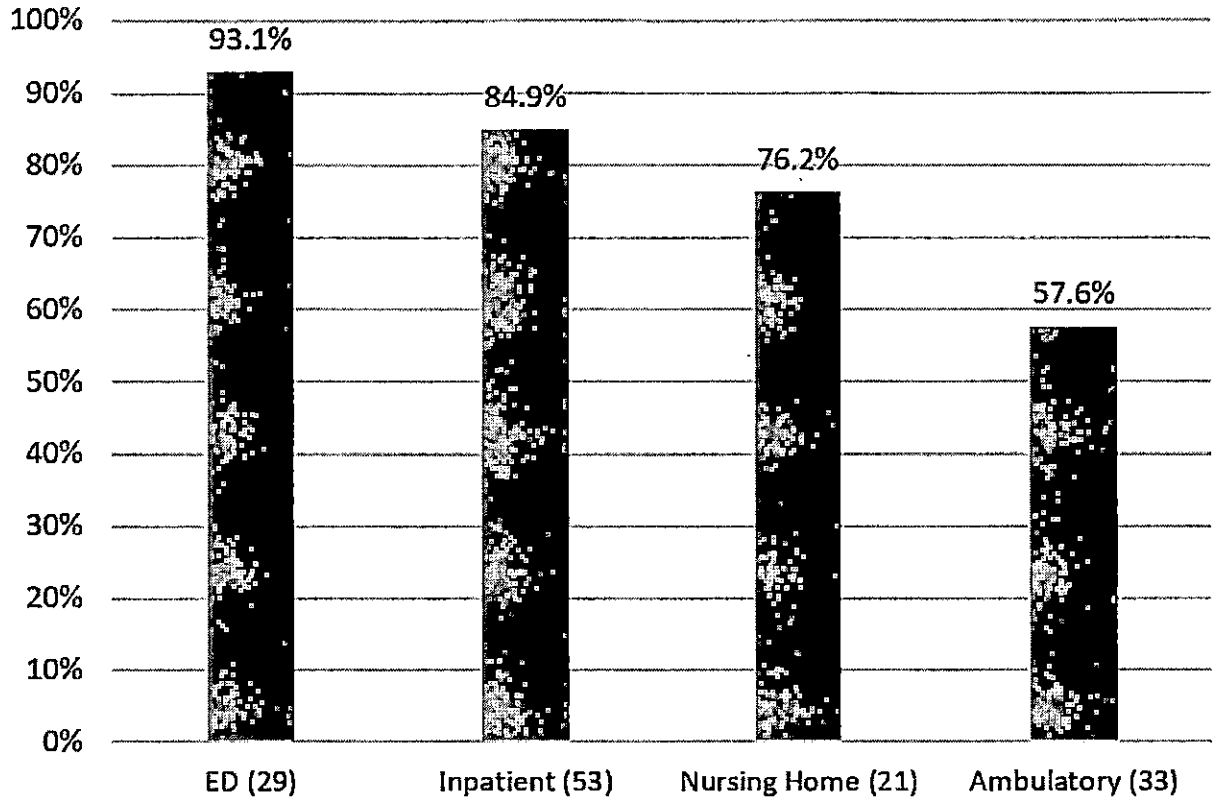


Figure 3: Where did violence occur? (N=159)

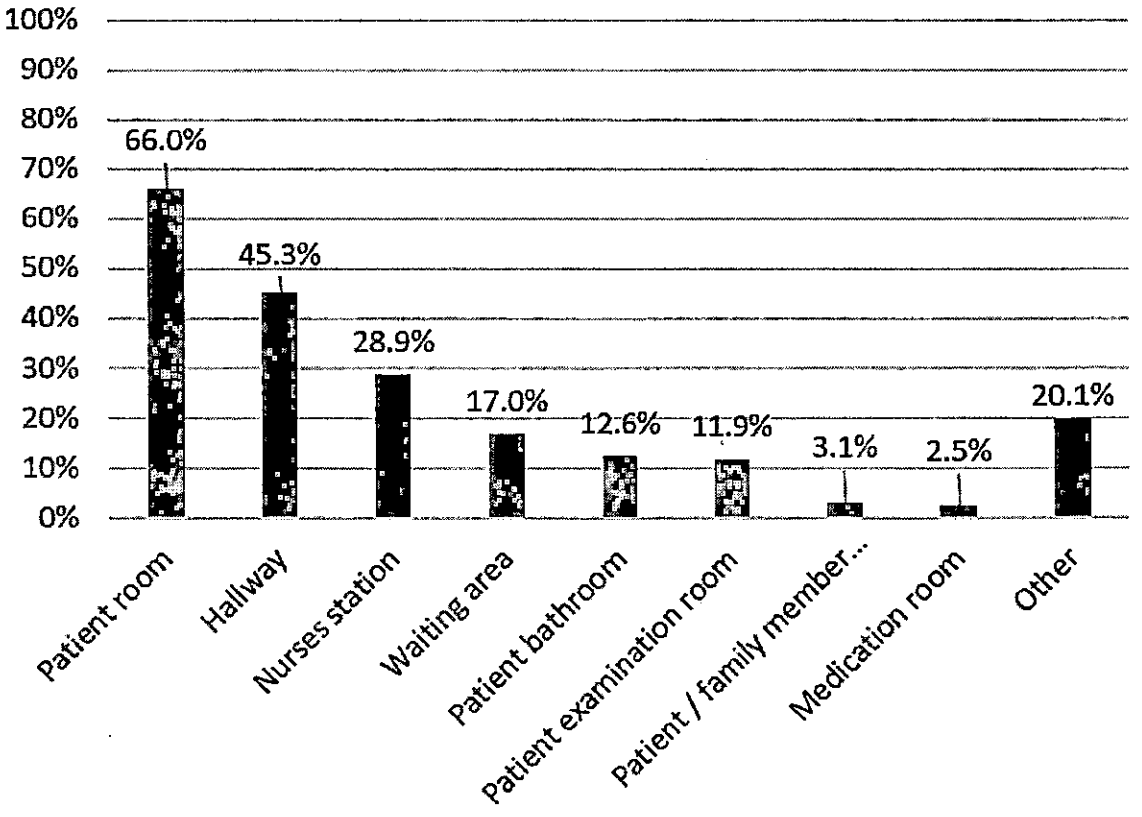
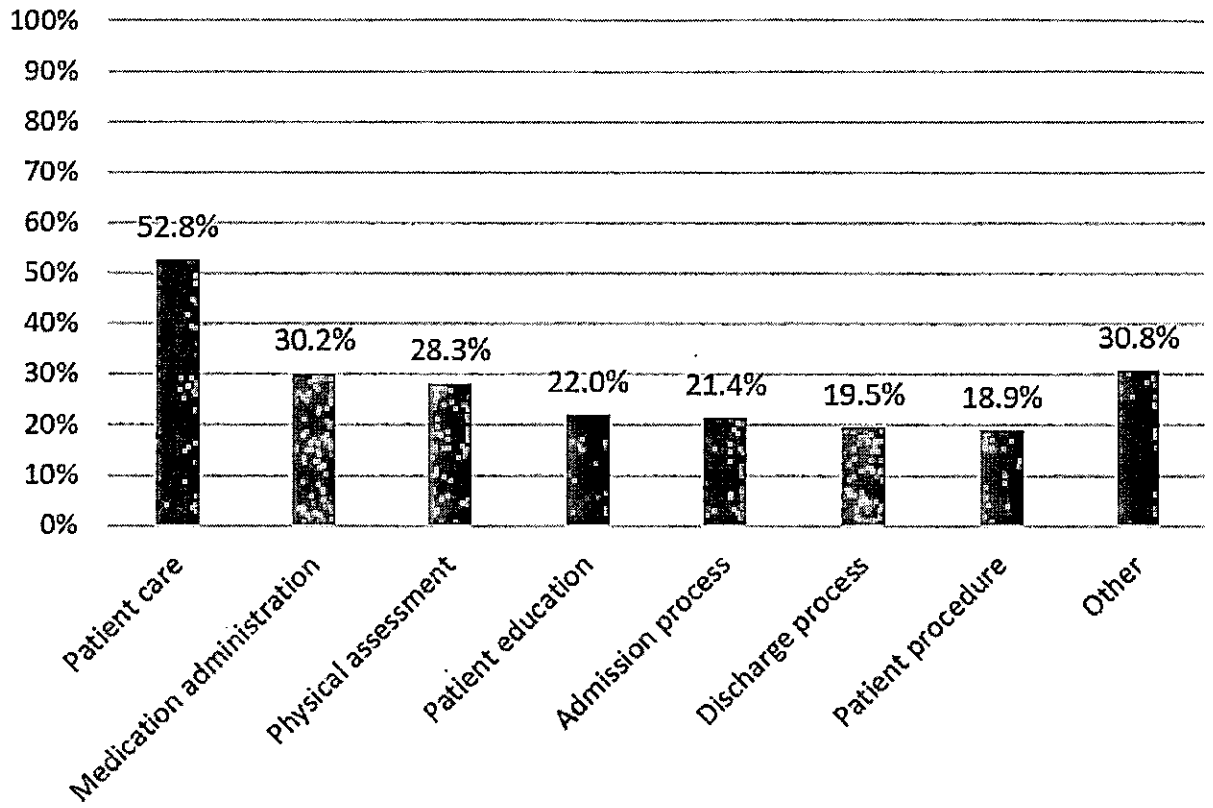


Figure 4: What activities were underway? (N=159)



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.

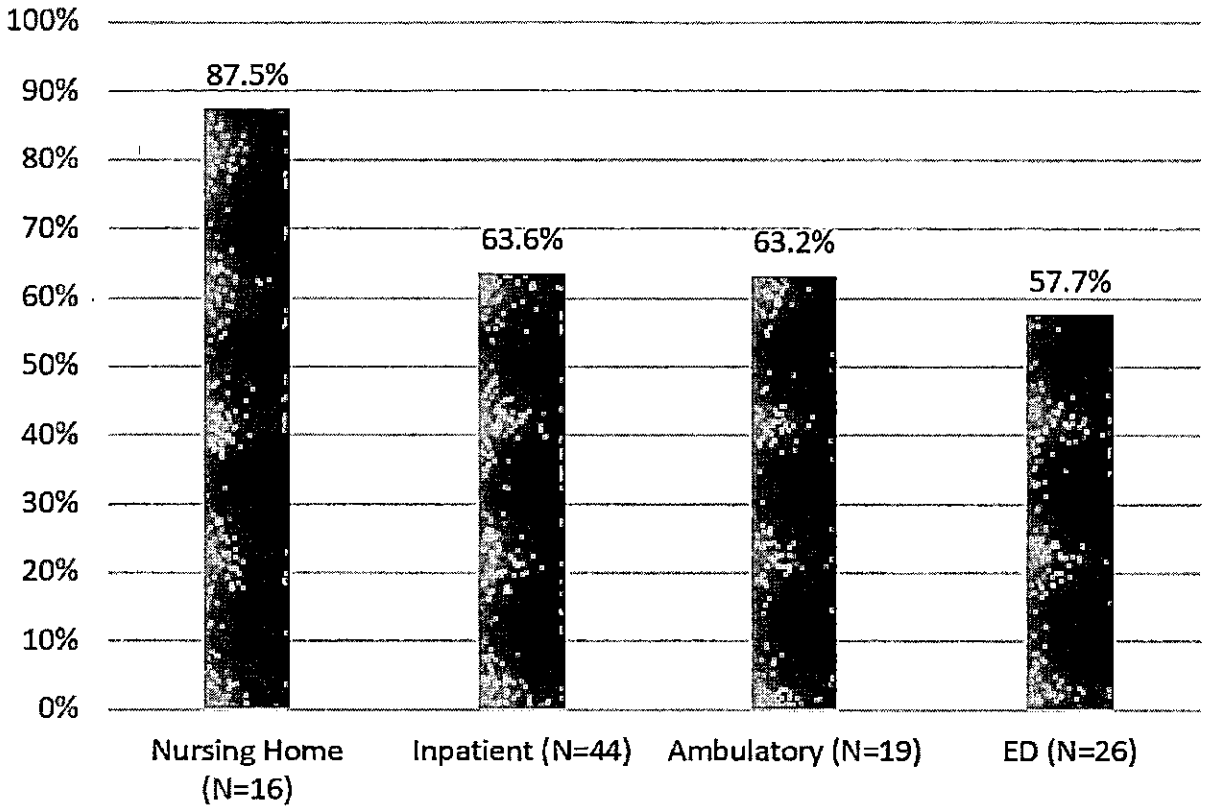
In addition to harm to the care provider, these events put patients at risk as well. When asked what healthcare activities were underway when the aggression took place, Figure 4 shows that respondents identified respondents identified a range of activity areas. Over half reported patient care (53% of 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.

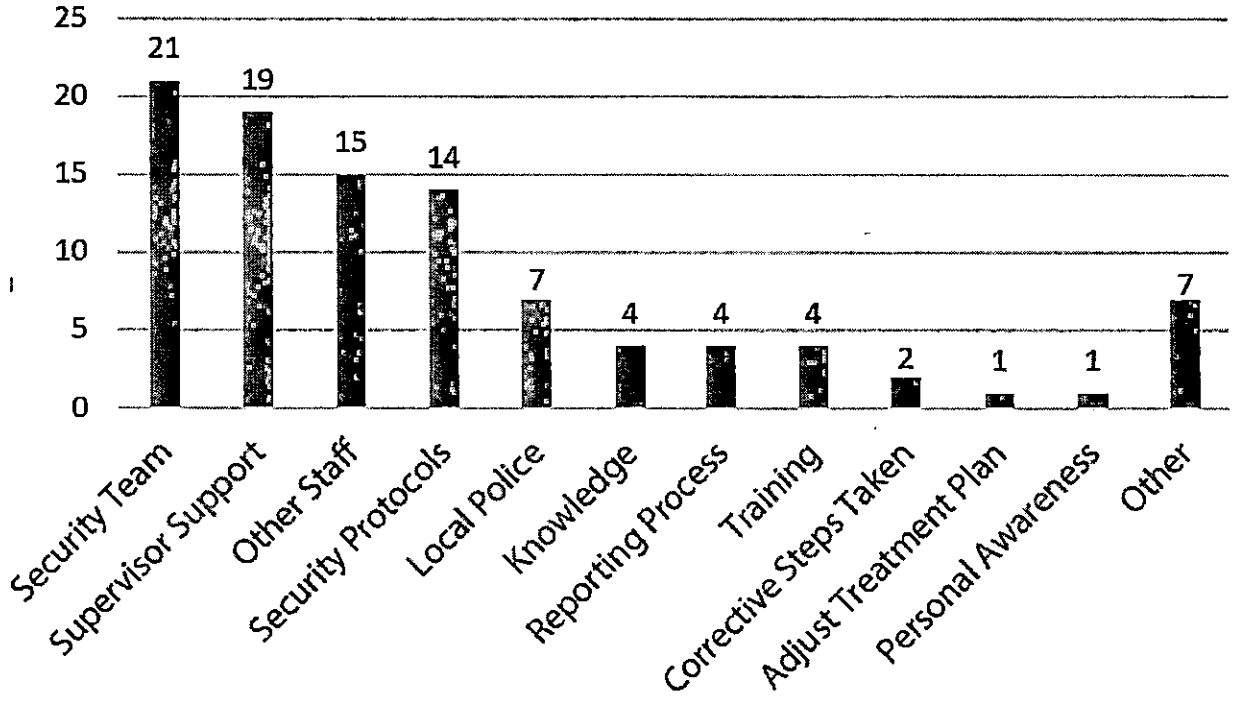
Table 1 - Experience of Violence by Presence of Protective Factors

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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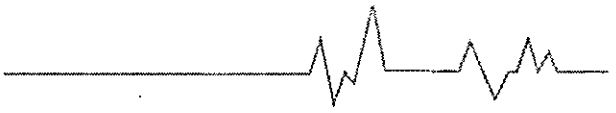

Appendix: Survey Tool

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.)

Cameron Lapine

From: Carlene Ferrier <carleneferrier@comcast.net>
Sent: Monday, March 7, 2022 5:26 PM
To: Becky Whitley; Tom Sherman; Kevin Avard; Jeb Bradley; James Gray; Cameron Lapine
Subject: SN 459

Good evening H&HS Committee Members,

I am writing to express my support for SB 459 which would require healthcare facilities to implement and maintain workplace violence prevention programs and establish the workplace safety commission.

As a nurse for more than thirty years in various settings, I can tell you I have felt unsafe many times in my career. I also believe workplace violence is contributing to nurses leaving the field and it would be great to have more data on that.

Thank you,

Carlene Ferrier MPH, RN, NEA-BC

Cameron Lapine

From:	Shaun Thomas <Shaun.Thomas@DEMERS-PRASOL.COM>
Sent:	Tuesday, March 8, 2022 4:03 PM
To:	Jeb Bradley; James Gray; Tom Sherman; Becky Whitley; Kevin Avard; Cameron Lapine
Cc:	jebebrad@metrocast.net; Thomas Sherman; Pam DiNapoli
Subject:	SB459 Tomorrow
Attachments:	SB 459-FN Letter of support.docx; violence_in_health_care_oct_2021_final (1).pdf; PastedGraphic-7.tiff

Dear Chairman Bradley and members of the Senate HHS Committee:

Demers & Prasol represents the NH Nurses' Association (NHNA). I am writing on behalf of NHNA to respectfully urge your support of SB459, relative to a health care facility workplace violence prevention program. SB459 is a bipartisan bill recommended/supported by the SB100 Committee to Study Workplace Safety in Health Care Settings, that is also supported by stakeholders (thanks to the determined, untiring efforts of Chairman Gray, as well as Sens. Sherman and Rosenwald). NHNA worked closely with Sen. Sherman, the NH Hospital Association, ConvenientMD Urgent Care, and the NH Health Care Quality and Safety Commission in together drafting Sections 1-3, to put policy and reporting systems in place to address the adverse effects of healthcare workplace violence on the quality and safety of patient care. This is of major importance to NHNA and consistent with the NH Healthcare Violence Prevention Workgroup's recommendations coming out of their October 2021 pilot study on "Violence & Aggression in Health Care" (attached, and below is the introductory paragraph to the Executive Summary). Healthcare workplace violence has major consequences and these improvements are needed to reduce risk and keep staff and patients safe. NHNA Executive Director Pam DiNapoli will be there to testify tomorrow but attached for your reference are copies of her written testimony and the pilot study. NHNA is ready and willing to assist you however we can to move SB459 forward and address this serious public health issue. If you have any questions or concerns, or need additional information, please don't hesitate to contact me.

Thank you!

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).

Shaun P. Thomas
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New Hampshire
State Council

Emergency Nurses Support SB 459-FN

March 8, 2022

Dear Chairman Bradley and members of the Senate Health and Human Services Committee:

On behalf of the New Hampshire Emergency Nurses Association, we are writing to encourage support of SB 459-FN, a bipartisan bill which addresses workplace violence. Violence in emergency departments (EDs) has been at epidemic levels for many years and continues to escalate.

In 2020, U.S. Bureau of Labor Statistics (BLS) reported 15,210 injuries involving days away from work due to "intentional injury by another person" in health care and social assistance settings.[1] This represented 76% of the total (20,050) for all industries. In 2018, the BLS found that health care and social service workers were five times more likely to experience workplace violence than other workers.

Emergency nurses are at even high risk because of the 24-hr accessibility and an already stressful environment. Overcrowding, long wait times, and boarding of patients with psychiatric illnesses increase stress levels for patients, families, and staff in emergency departments. In addition, workplace violence in the ED has increased during the stress of the Covid-19 pandemic. [2]

Most emergency nurses, including us, have been the victims of workplace violence propagated by patients or family members. We are at risk every shift we work. A survey of 1,000 ENA members found that 86% had been the victim of workplace violence in the preceding three years, with family members and visitors as likely to perpetrate abusive behavior as patients. Nearly 20% of emergency nurses reported that they experience workplace violence frequently.[3]

Violence against nurses may exacerbate the shortage of experienced emergency nurses. The stress of workplace violence can contribute to job dissatisfaction. It can cause low worker morale, high rates of sick time, and shorten lengths of employment. One-third of respondents to ENA's survey responded they had considered leaving their ED or emergency nursing because of ED violence.[3]

The New Hampshire State Council of the Emergency Nurses Association respectfully requests your support of Senate Bill 459-FN, an act relative to a healthcare facility workplace violence prevention program.

Thank you for the opportunity to provide written testimony on this bill.

Stacey Savage, President
Wolfeboro, NH
stacey.savage@gmail.com

Jean A. Proehl, Government Affairs Chairperson
Cornish, NH
Jean.proehl@gmail.com

REFERENCES

1. Bureau of Labor Statistics. (2020). TABLE R4. Number of nonfatal occupational injuries and illnesses involving days away from work by industry and selected events or exposures leading to injury or illness, private industry, 2020. From *Case and Demographic Characteristics for Work-related Injuries and Illnesses Involving Days Away From Work.* https://www.bls.gov/iif/oshcdnew2020.htm
2. National Nurses Unites. (2021). *Workplace Violence and Covid-19 in Health Care.* https://www.nationalnursesunited.org/sites/default/files/nnu/documents/1121_WPV_HS_Survey_Report_FINAL.pdf
3. Gacki-Smith, J. et al. (2009). Violence against nurses working in U.S. emergency departments. *Journal of Nursing Administration, 39*, 340-349.

Cameron Lapine

From: Julie Gilston <elvis95@comcast.net>
Sent: Tuesday, March 8, 2022 6:20 PM
To: Jeb Bradley; James Gray; Tom Sherman; Becky Whitley; Kevin Avard; Cameron Lapine
Subject: SB 459FN

Greetings. As a NH RN I would like to voice my support for SB459FN. Thank you for your time.
Julie Gilston

SB 459-FN: Testimony Regarding Workplace Violence in Healthcare

My name is Katherine Engalichev. I am a graduate nursing student at the University of New Hampshire as well as a volunteer EMT for McGregor EMS in Durham, NH. Last year, I both witnessed and was the victim of workplace violence while employed by Portsmouth Regional Hospital as a Mental Health Technician.

Working night shift on an inpatient behavioral health unit was eye-opening in many ways. I knew that it would not be an easy job. However, I was unprepared for the institutional negligence that resulted in substandard safety measures for staff and, ultimately, violence and injury. I experienced physical violence on my very first night shift on the Behavioral Health Unit at Portsmouth Hospital. Over the following nine months I continued to witness assaults on coworkers, some of which resulted in lasting injury, and all of which interrupted patient care and damaged the therapeutic environment for the other patients on the unit. In March of 2021, I was personally injured by a violent patient and spent the six weeks thereafter without the use of my right hand.

The immense tragedy I intend to illustrate here is not my personal trauma, nor the injuries sustained by my coworkers, but rather the repeated failure of a system and of a multi-billion-dollar organization within that system to keep its personnel safe. In my experience, security staffing was limited and spread thin throughout the hospital. The one or two security officers available to respond to a behavioral code at any given time would be responding from hospital-wide patrol, which often left nurses and techs on the unit to manage a physically violent patient by themselves for several minutes. Even when security arrived, they were only able to act as another body in the restraint process. There was no standardized protocol in place for accessing law enforcement, and staff could expect pushback from administrators when law

enforcement was called to assist. Without regulatory governance, workplace violence prevention was left to individual staff members. The hospital also did not provide any semblance of post-incident support for victims of violence. Safety is not an institutional priority at Portsmouth Hospital, and given the corporate healthcare structure of HCA, legislation is likely to be the only effective motivator to ensure change both in Portsmouth and across the state going forward.

Thank you for your time,

Katherine Engalichev

Workplace Violence Testimony

Good morning, Mr. Chairman, and committee Senators. Thank you for taking the time to consider this important legislation.

My name is John Patti, and I am the Executive Director of Support Services at Catholic Medical Center, and a retired Sergeant from the Manchester Police Department.

1) I would like to begin by thanking everyone who was involved in the bipartisan process of developing the language in the bill that you have in front of you. I very much appreciate their patience and input. Those involved include Senators Gray, Rosenwald, and Sherman, and Representatives, Greene, McMahon, and Litchfield. We also received helpful input from the ACLU, NAMI, the DRC, NH Attorney General's Office, the NH Chiefs of Police Association, Paula Minnehan and the NHHA, and the many hospital staff members throughout the state.

2) When I was hired as the Director of Security at CMC, I was astonished at the behavior of some of the patients, and what the clinical staff endure. I often tell the clinical staff that they don't have to tolerate incivility or criminal behavior, and try to compare the behavior to other situations, such as being out in the public or at a restaurant. If someone was treating them that way, they wouldn't stand for that, and just because the patient is within our four walls, doesn't mean they are allowed to behave without consequence.

3) If you are not aware, assaults and workplace violence at healthcare facilities has been an increasing concern for healthcare workers. Depending on what publication you read, the stats indicate that healthcare workers are 4 to 5 times more likely than other private industry employees to be the victim of workplace violence. There are many studies, including some from OSHA that show the prevalence of assaults in these settings. Part of the work that went into this bill focused on the need for collecting relevant data to support the need for a Workplace Violence Prevention Program for healthcare facilities throughout the state. This data will be used to support a commission to review and analyze healthcare workplace violence and safety issues that are affecting our healthcare workers and organizations.

4) As the Executive Director overseeing security, I am aware of the reports of assault on our employees. On many occasions we would call the police to report an assault on a healthcare employee, only to be told by the police that they would not make a warrantless arrest, but rather, apply for an arrest warrant. Imagine how frightening it is for our healthcare workers who

are victims of an assault, and then have to remain in close proximity with that person to provide care to them.
I believe the decision not to arrest is based upon the language in the current statute under NH RSA 594:10, which reads in part: *if not immediately arrested,... such person will cause further personal injury or damage to property*. This language essentially requires the officer to predict future behavior of the suspect in order to make the warrantless arrest. In my opinion, not making an arrest at that juncture places the victim in peril, requiring another assault for a warrantless arrest to be made. This equates to a pattern of abuse.

5) With the unique perspective of having been on both sides of this issue, I wanted to amend the language to provide the police with more clarity in the statute which would give them greater confidence in making a warrantless arrest, while at the same time, providing our healthcare workers a measure of safety and assurance.

6) The result of this endeavor was the amended language to RSA 594:10 which now clearly authorizes the police to make an arrest without a warrant for an assault against a healthcare worker.

Thank you for allowing me this opportunity to address this matter, and I would again like to thank everyone who was involved with this effort.

Reported Assaults on Healthcare Workers

Jan. 2020 – June 2021: (18 month period) 671 reported assaults from 13 hospital security departments tracking the data.

Cameron Lapine

From: MARY LAST_NAME <mariabruja@comcast.net>
Sent: Tuesday, March 8, 2022 6:37 PM
To: Becky Whitley; Tom Sherman; Kevin Avard; Jeb Bradley; James Gray; Cameron Lapine
Subject: Support for SB 459FN

I am contacting you to enlist your support for SB 459FN whose hearing is scheduled for March 9, 2022. I am a NH licensed RN who has practiced in numerous health care settings since 1994. While any RN can provide anecdotal evidence of injury to themselves or others during the course of their careers, what needs to be established in NH is a reporting system that provides the data needed to support solutions to this problem.
The establishment of a health care workplace safety commission will address the barriers to reporting incidences of workplace violencethat impact the ability not only of RN's but also of health care workers in general to report incidences of workplace violence and address the root causes.

Cameron Lapine

om: Deb <debgoodrum@aol.com>
Sent: Wednesday, March 9, 2022 8:27 AM
To: Jeb.Bradley@leg.state.nh.us <Jeb.Bradley@leg.state.nh.us>; James.Gray@leg.state.nh.us < James.Gray@leg.state.nh.us>; Tom.Sherman@leg.state.nh.us < Tom.Sherman@leg.state.nh.us>; Becky.Whitley@leg.state.nh.us < Becky.Whitley@leg.state.nh.us>; Kevin.Avard@leg.state.nh.us < Kevin.Avard@leg.state.nh.us>; cameron.lapine@leg.state.nh.us < cameron.lapine@leg.state.nh.us>
Subject: Bill 459

Good morning,
I would like to submit my support for this bill as I am a nurse who has witnessed a violent patient choke my fellow colleague to unconsciousness, and then he/she returned to her room without any sense of remorse of what occurred. If this had happened at Walmart, the person would have been arrested and taken to jail. Instead this violent patient was put in a room with a security officer and a tech to "keep a watch" on her due her violent outbursts. This sends a message to general public accosting healthcare workers is allowed and "just part of the job."
Thank you
Debra Goodrum, RN, BSN
Dartmouth Hitchcock Emergency Department
Lebanon, NH

Committee, thank you for reading my testimony regarding SB 459-FN. I am Stacey Carroll, Director of Emergency Management and EMS Coordinator at Southern NH Health in Nashua. Chair of our Workplace Violence Prevention Committee. Lieutenant Colonel in the Army Reserve. I appreciate your time.

It was 0230, and the banging and yelling coming from room 332 was terrifying. This is a 34yo male, here with an abscess to his arm he needed surgery for. He's withdrawing but had been ok. Emily had just called her supervisor and security for help because he was smoking in the bathroom and had a needle and a dirty spoon. These were disposed of but now he's more angry and throwing chairs around his room. She calls a Code Gray (for security to come running), and the supervisor. All the 'what ifs' run through Emily's 27yo head. What if he comes out here? What if he hurts the patient next door? Can I call the police? He's withdrawing, he's screaming and swearing, has already told me to get the f*%k out. The supervisor arrives and he calls her a fat c&#t and that he is going to find her and kill her. Bonnie has worked the Emergency Department at night for almost 20 years. Agnes, a 41yo, comes in at 2330 complaining that that tattoo artist pushed too hard on her shoulder and its dislocated. As there is a code blue in progress, the ED is busy. Agnes is impatient. An LNA enters to see if she needs anything and is met with quite foul language. "Get out of my room f#$king white girl, I don't need some nurse wanna be. I need an X-ray." The LNA does her best to calm and redirect to no avail. Bonnie brings Agnes a sling and meds for pain. Agnes is pacing around the room yelling. "What took so long you f%^ing slob, can't you even do your job right? Not like your job is hard just get me my f$#ing X-ray." Bonnie also tries deescalation. She even notes that deescalation failed and she was sending another nurse in to try. The doctor attempted to see Agnes, but by then she was then parading in the hall of the ED screaming that all the "f%4ing nigg#s in this place gonna die because they suck here" along with other screams and swears. Nurses try to shut rooms to other patients. Security is there as well.
Around 2000, an ambulance brought a patient into the ED for an overdose. Awake now, they bring her to a room. She is angry that she isn't high anymore. She has a prosthetic leg, which she pulls off and swings at staff, hitting an LNA. Her leg is removed from her possession by Eileen who reiterates our zero tolerance policy. The patient continues to berate, spit at and swear at Eileen. The ambulance came to pick her up, and bring her home. The ambulance company returned to report to Eileen that the patient had continued to threaten Eileen and her family the entire way home.

Committee, the top two stories happened just this past weekend. I know as I'm our Workplace Violence Prevention Chair and receive all our occurrence reports. This isn't an unusual event or weekend sadly. What am I happy about is that our culture at Southern NH Health is really about zero tolerance and our staff know to write occurrence reports. That

last scenario happened about 2 years ago - but it's a perfect example of one that goes right. I want you to put yourself in Emily, Bonnie and Eileen's shoes. How terrifying. Especially in a time when staffing is so short, that back up is hard to find. Including in the security department.

During orientation to the hospital, our workplace violence team gives a 30 min talk on zero tolerance. The first question I ask is for them to raise their hands when I get to a word that fits them. I ask, "In your healthcare career so far, have you been hit, bit, slapped, punched, kicked, spit at, sworn at, touched inappropriately." The response is the same for six years now. 95% of hands go up along with people throwing multiple hands and feet in the air. Most are laughing, because it's a known secret that of course you've been hit. The only ones that don't are new LNAs that haven't worked yet. Notice I don't ask if they've been assaulted. Because I'd get 25% of them to respond. Healthcare workers have been bred to accept being hurt at work because our patients are sick. That needs to change. It is NOT part of their job. I've had so many new staff come after class to tell me horror stories about their experiences at other hospitals and healthcare agencies, yes mostly in NH, about how their leadership didn't care. How someone was blamed for getting themselves punched in the face by a patient. How they were asked what they'd do differently next time to not get hurt. One nurse cried, hugging me, and said if this was truly our culture here she'd never leave. She's still here.

Our healthcare workers need you to care. If their leaders aren't prepared to do this themselves, we need your assistance to stand this up. Please consider SB 459FN. NH leads the way in so many areas. When I presented this topic at the DNV national conference in Nov, I was met by so many people from different states asking how to get this program running in their hospital. If a small community hospital in Nashua can do this, everyone else can. They need your guidance and assistance to implement it.

As a wrap up from those stories this weekend, and a summation of what we do to protect staff: Emily was terrified. The doctor came up to talk with the patient with security present. The patient would not listen. After assessment, the hospital decided to administratively discharge the patient. The patient would not leave, so Nashua Police came to assist security in having him leave our property. He is now flagged in our medical record system for verbal and physical assault. The director of the floor put Emily in contact with our peer support system if she wanted it.
Bonnie removed herself from the situation and asked security to step in. Nashua Police was called when Agnes was trying to leave through locked doors to our triage area. She stated she wanted to leave AMA but was refusing to leave, NPD escorted her out. Agnes is flagged for verbal assault in our medical record system. Eileen wrote an occurrence report at 0330

when she left work. By 1130 she met with risk, security, our VP of facilities and Nashua Police. She received a temporary restraining order, and eventually a permanent one. The patient can still come to the ED under EMTALA laws, but cannot ask about Eileen. Eileen changed her names on social media, cut her hair, had security walk to and from her car, and was always keeping a watchful eye if she appeared. This tormented Eileen for some time. And she agrees that she would've just brushed it off as part of the ED experience had I not instilled occurrence reporting in her head.

Help us make sure other hospitals are doing the same. Our staff deserve your protection. As a note, the only line within the bill I disagree with is under section V. Annual Report. We should not be 'by name' releasing staff names to any agency for privacy reasons. Job title classification should suffice. The state should be managing program supervision, not by name management. Feel free to contact me for follow up testimony. DNV is at our hospital doing a regulatory visit, so I could not attend in person.

Stacey Carroll MSN, RN, CCRN-K, NHDP-BC
Director, Emergency Management
Southern NH Health
Email: stacey.carroll@snhhs.org
Cell: 978-505-0500

Debra Martone

From:	Shaun Thomas <Shaun.Thomas@DEMERS-PRASOL.COM>
Sent:	Monday, March 21, 2022 1:56 PM
To:	Gary Daniels; John Reagan; Lou D'Allesandro; Chuck Morse; Bob Giuda; Cindy Rosenwald; Erin Hennessey; Debra Martone
Cc:	Pam DiNapoli
Subject:	SB459
Attachments:	SB 459-FN Letter of support.docx; violence_in_health_care_oct_2021_final (1).pdf; PastedGraphic-7.tiff

Dear Chairman Daniels and members of the Senate Finance Committee:

Demers & Prasol represents the NH Nurses' Association (NHNA). I am writing on behalf of NHNA to respectfully urge your support of SB459, relative to a health care facility workplace violence prevention program, which passed the Senate last week on a voice vote following a 5-0 vote out of the Health and Human Services Committee. SB459 is a bipartisan bill recommended/supported by the SB100 Committee to Study Workplace Safety in Health Care Settings, that is also supported by stakeholders (thanks to the efforts of Chairman Gray, as well as Sens. Rosenwald and Sherman). NHNA worked closely with the NH Hospital Association, ConvenientMD Urgent Care, and the Foundation for Healthy Communities in together drafting Sections 1-3, to put policy and reporting systems in place to address the adverse effects of healthcare workplace violence on the quality and safety of patient care. This is of major importance to NHNA and consistent with the NH Healthcare Violence Prevention Workgroup's recommendations coming out of their October 2021 pilot study on "Violence & Aggression in Health Care" (attached, and below is the introductory paragraph to the Executive Summary). Healthcare workplace violence has major consequences and these improvements are needed to reduce risk and keep staff and patients safe. I have attached for your reference NHNA Executive Director Pam DiNapoli's written testimony to Health and Human Services and the pilot study. NHNA is ready and willing to assist you however we can to move SB459 forward and address this serious public health issue. If you have any questions or concerns, or need additional information, please don't hesitate to contact me.

Thank you!

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).

Shaun P. Thomas
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Dear Chairman Bradley and members of the Senate Health and Human Services 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
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(603)225-3783
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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

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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]

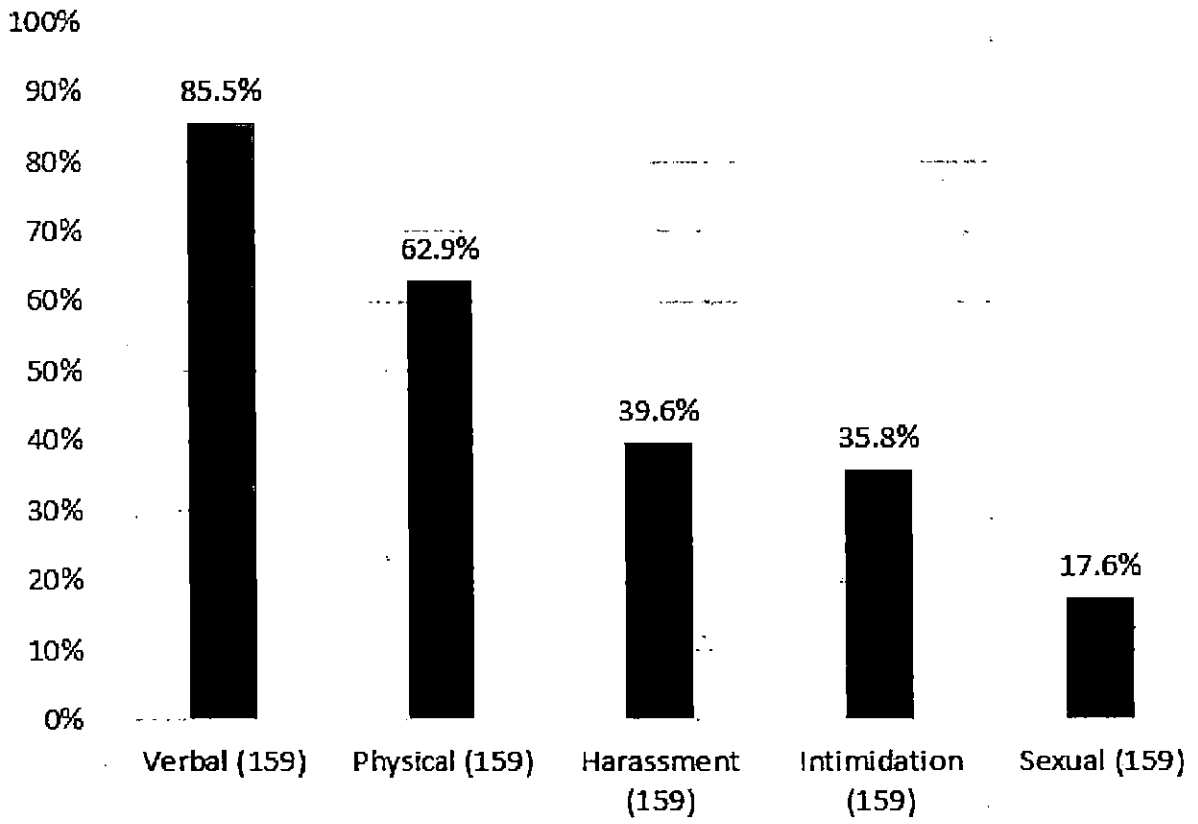
Incidence of Violence Among Healthcare Providers

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

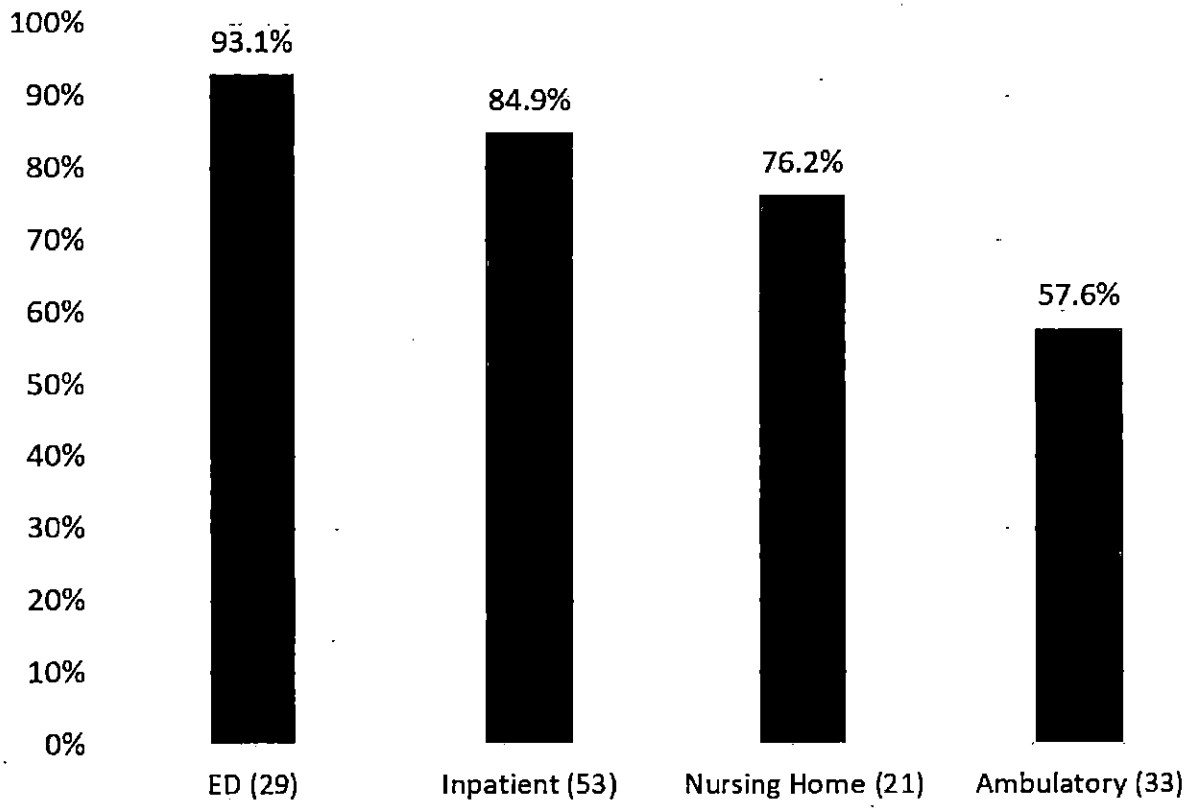


Figure 3: Where did violence occur? (N=159)

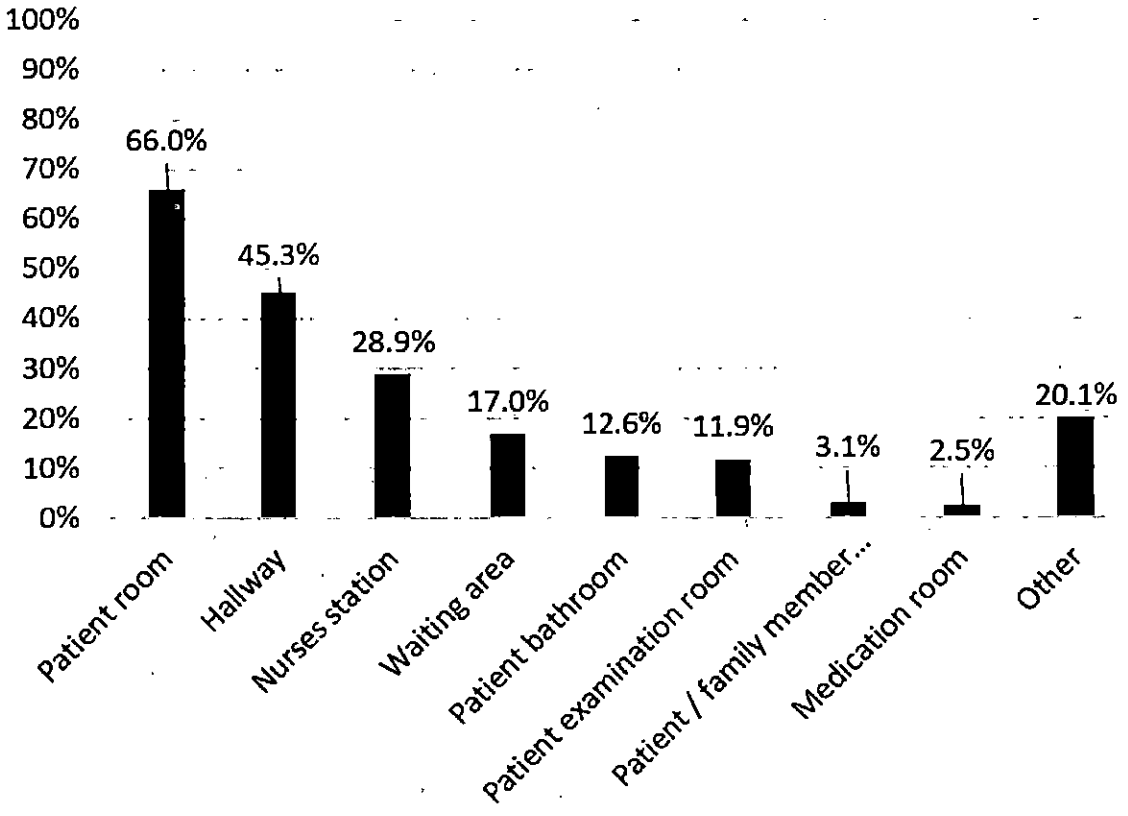
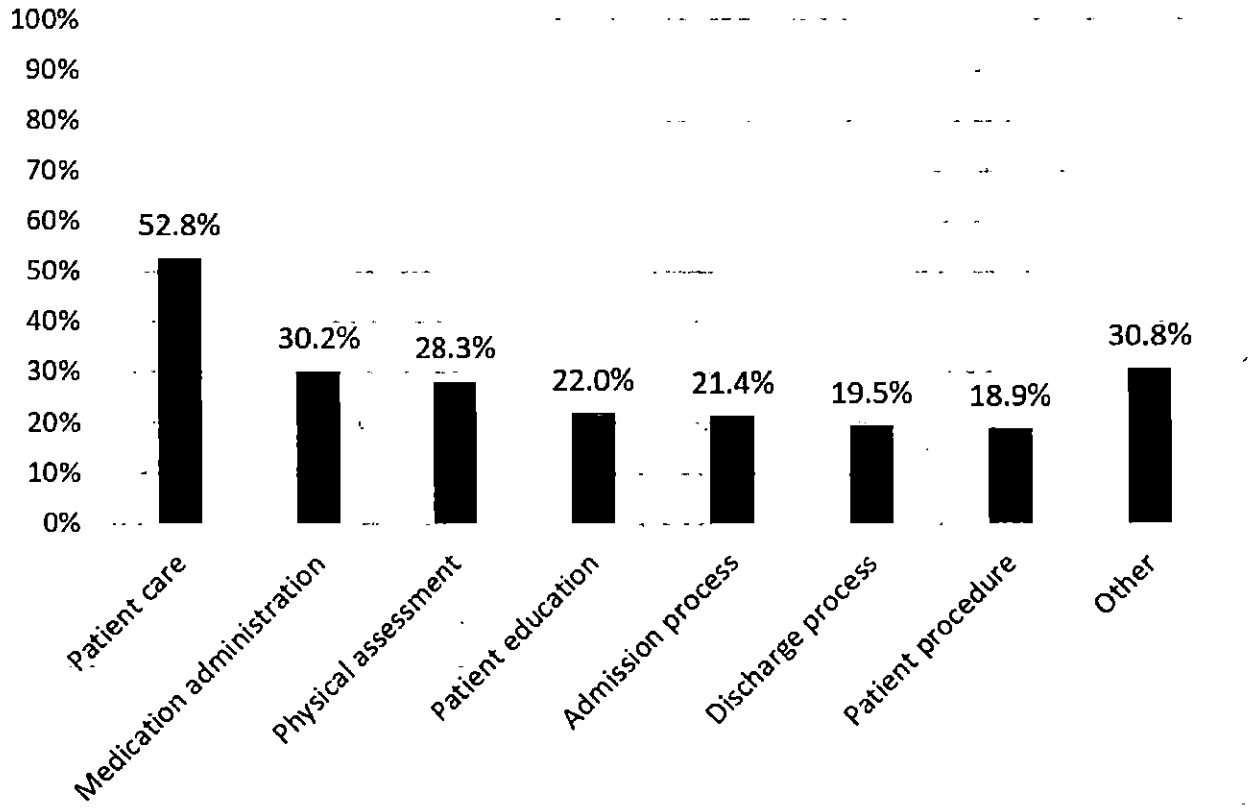


Figure 4: What activities were underway? (N=159)



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.

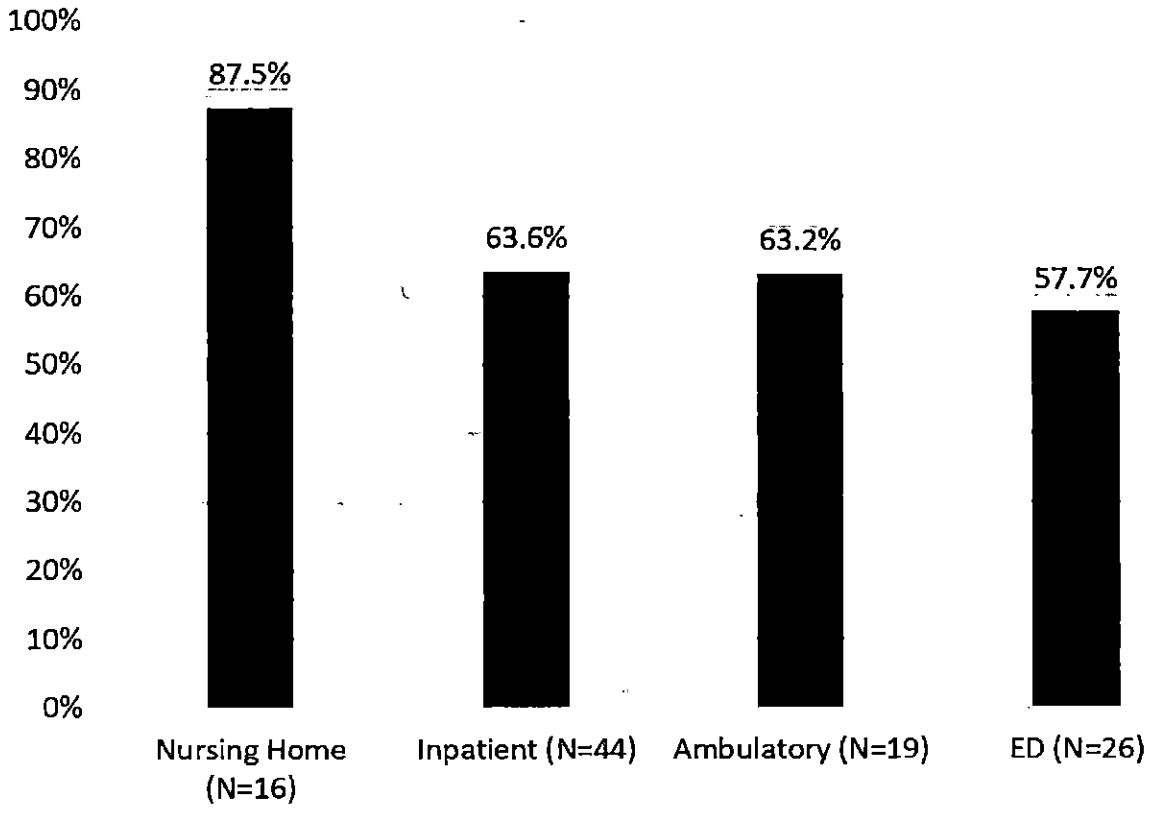
In addition to harm to the care provider, these events put patients at risk as well. When asked what healthcare activities were underway when the aggression took place, Figure 4 shows that respondents identified respondents identified a range of activity areas. Over half reported patient care (53% of 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.

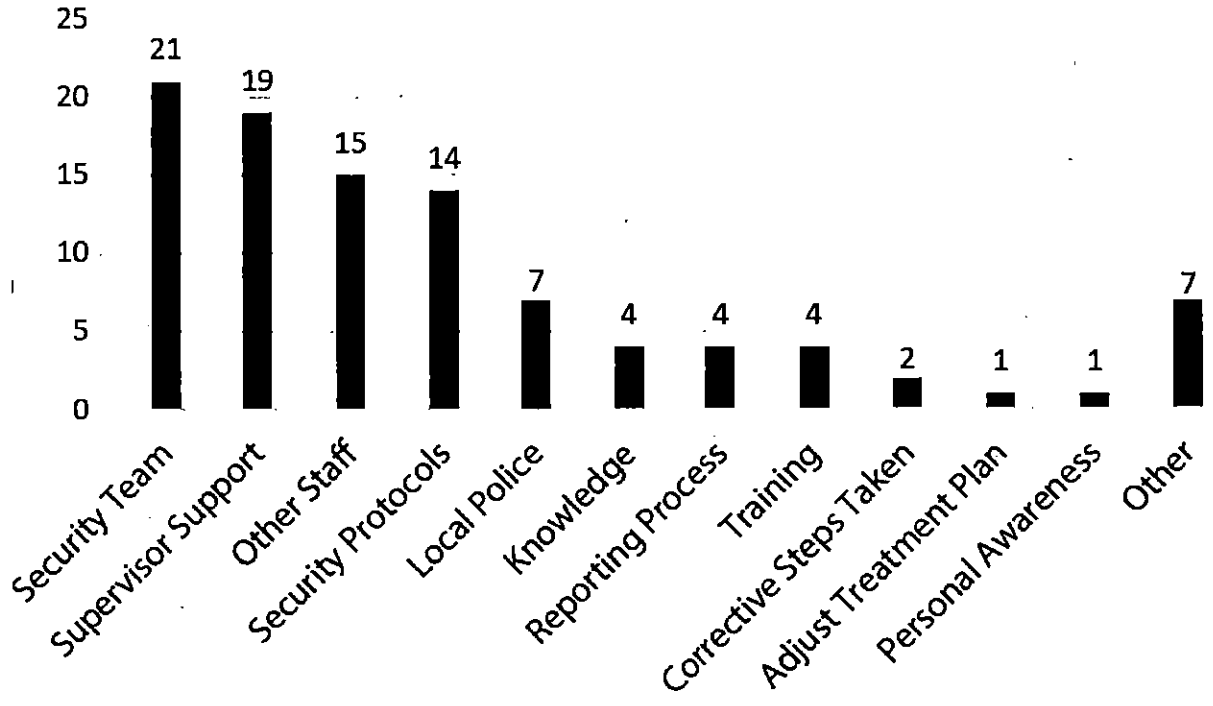
Table 1 - Experience of Violence by Presence of Protective Factors

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.)

Voting Sheets

Senate Health and Human Services Committee
EXECUTIVE SESSION RECORD
2021-2022 Session

Bill # SB 459-FN

Hearing date: 3-9-22

Executive Session date: 3-9-22

Motion of: Committee Amendment **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard	X		X	X	
Sen. Sherman	X	X		X	
Sen. Whitley	X			X	

Motion of: OTPA **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard	X	X		X	
Sen. Sherman	X		X	X	
Sen. Whitley	X			X	

Motion of: _____ **Vote:** _____

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Reported out by: Sen. Gray

Notes: _____

Senate Finance Committee

EXECUTIVE SESSION

Bill # SB 459-FN

Hearing date: SB 459-FN

Executive session date: 03/22/22

Motion of: OTP VOTE: 5-0

Made by Senator:	Daniels	☐	**Seconded by Senator:**	Daniels	☐	**Reported by Senator:**	Daniels	☑
	Reagan	☑		Reagan	☐		Reagan	☐
	Giuda	☐		Giuda	☐		Giuda	☐
	Rosenwald	☐		Rosenwald	☑		Rosenwald	☐
	D'Allesandro	☐		D'Allesandro	☐		D'Allesandro	☐
	Morse	☐		Morse	☐		Morse	☐
	Hennessey	☐		Hennessey	☐		Hennessey	☐

Motion of: _____ VOTE: _____

Made by Senator:	Daniels	☐	**Seconded by Senator:**	Daniels	☐	**Reported by Senator:**	Daniels	☐
	Reagan	☐		Reagan	☐		Reagan	☐
	Giuda	☐		Giuda	☐		Giuda	☐
	Rosenwald	☐		Rosenwald	☐		Rosenwald	☐
	D'Allesandro	☐		D'Allesandro	☐		D'Allesandro	☐
	Morse	☐		Morse	☐		Morse	☐
	Hennessey	☐		Hennessey	☐		Hennessey	☐

Committee Member	*Present*	Yes	No	*Reported out by*
Senator Daniels , Chairman	☑	☑	☐	☑
Senator Reagan, Vice-Chair	☑	☑	☐	☐
Senator Giuda	☒	☐	☐	☐
Senator Hennessey	☑	☑	☐	☐
Senator Rosenwald	☑	☑	☐	☐
Senator Morse	☒	☐	☐	☐
Senator D'Allesandro	☑	☑	☐	☐

Amendments: _____

Notes: _____

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Wednesday, March 9, 2022

THE COMMITTEE ON Health and Human Services

to which was referred **SB 459-FN**

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

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 5-0

AMENDMENT # 1051s

Senator James Gray
For the Committee

Cameron Lapine 271-2104

HEALTH AND HUMAN SERVICES

SB 459-FN, relative to a health care facility workplace violence prevention program.
Ought to Pass with Amendment, Vote 5-0.
Senator James Gray for the committee.

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Wednesday, March 23, 2022

THE COMMITTEE ON Finance

to which was referred **SB 459-FN**

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

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS

BY A VOTE OF: 5-0

Senator Gary Daniels
For the Committee

Deb Martone 271-4980

General Court of New Hampshire - Bill Status System

Docket of SB459

Docket Abbreviations

Bill Title: relative to a health care facility workplace violence prevention program.

Official Docket of **SB459.**:

Date	Body	Description
2/22/2022	S	**Introduced** 02/16/2022 and Referred to Health and Human Services; **SJ 4**
2/23/2022	S	**Hearing:** 03/09/2022, Room 101, LOB, 09:00 am;
3/9/2022	S	Committee Report: Ought to Pass with Amendment **#2022-1051s**, 03/17/2022; **SC 11**
3/17/2022	S	Committee Amendment **#2022-1051s**, AA, VV; 03/17/2022; **SJ 5**
3/17/2022	S	**Ought to Pass with Amendment** 2022-1051s, MA, VV; Refer to Finance Rule 4-5; 03/17/2022; **SJ 5**
3/23/2022	S	Committee Report: Ought to Pass, 03/31/2022; **SC 13**
3/31/2022	S	**Ought to Pass:** MA, VV; OT3rdg; 03/31/2022; **SJ 7**
4/1/2022	H	Introduced 03/31/2022 and referred to Health, Human Services and Elderly Affairs
4/4/2022	H	Public Hearing: 04/12/2022 09:30 am LOB 205-207
4/14/2022	H	Executive Session: 04/12/2022 09:30 am LOB 205-207
4/14/2022	H	Majority Committee Report: Ought to Pass **(Vote 12-9; RC) HC 15** P. 18
4/14/2022	H	Minority Committee Report: Inexpedient to Legislate
4/21/2022	H	FLAM **#2022-1678h** (Reps. Layon, Perez): AA **RC** 182-146 04/21/2022 **HJ 10**
4/21/2022	H	**Ought to Pass with Amendment** 2022-1678h: MA **RC** 264-64 04/21/2022 **HJ 10**
4/21/2022	H	Referred to Finance 04/21/2022 **HJ 10**
4/22/2022	H	Division Work Session: 04/22/2022 03:00 pm LOB 210-211
4/22/2022	H	Division Work Session: 04/25/2022 01:00 pm LOB 210-211
4/22/2022	H	Division Work Session: 04/26/2022 11:30 am LOB 210-211
4/26/2022	H	==CONTINUED== Division Work Session: 04/27/2022 11:30 am LOB 210-211
4/22/2022	H	Executive Session: 04/27/2022 03:00 pm LOB 210-211
4/28/2022	H	Committee Report: Ought to Pass with Amendment **#2022-1871h** (Vote 18-2; RC)
5/5/2022	H	Amendment # 1871h: AA VV 05/04/2022 **HJ 11**
5/5/2022	H	**Ought to Pass with Amendment** 1871h: MA **RC** 220-87 05/04/2022 **HJ 11**
5/12/2022	S	Sen. Bradley Moved to Concur with the House Amendment, MA, VV; 05/12/2022; **SJ 12**
6/8/2022	H	Enrolled Bill Amendment **#2022-2104**-EBA: AA VV (in recess of) 05/26/2022 **HJ 14**
6/9/2022	S	Enrolled Bill Amendment **#2022-2104e** Adopted, VV, (In recess of 05/26/2022); **SJ 13**
6/15/2022	H	Enrolled (in recess of) 05/26/2022 **HJ 14**
6/15/2022	S	Enrolled Adopted, VV, (In recess 05/26/2022); **SJ 13**

7/26/2022	S	Signed by the Governor on 07/25/2022; Chapter 0340
7/26/2022	S	I. Section 4 Effective 03/01/2034
7/26/2022	S	II. Remainder Effective 07/01/2023

NH House	NH Senate

Other Referrals

June 6, 2022
2022-2104-EBA
05/08

Enrolled Bill Amendment to SB 459-FN

The Committee on Enrolled Bills 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 following amendment, and the recommendation that the bill as amended ought to pass.

FOR THE COMMITTEE

Explanation to Enrolled Bill Amendment to SB 459-FN

This enrolled bill amendment makes a technical correction.

Enrolled Bill Amendment to SB 459-FN

Amend RSA 151-J:5, III as inserted by section 2 of the bill by replacing line 2 with the following:

health care workplace safety commission and the health care quality and patient safety commission

Senate Inventory Checklist for Archives

Bill Number: SB 459-FN Senate Committee: HHS

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee

X All Calendar Notices

X Hearing Sign-up sheet(s)

X Prepared testimony, presentations, & other submissions handed in at the public hearing

X Hearing Report

___ Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

X - amendment # 1051s ___ - amendment #_____

___ - amendment #_____ ___ - amendment #_____

X Executive Session Sheet

X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment #_____ ___ - amendment #_____

___ - amendment #_____ ___ - amendment #_____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):

___ Enrolled Bill Amendment(s)

___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

X as amended by the senate ___ as amended by the house

___ final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Cameron M. Taffine 6-21-22

Committee Aide Date

Senate Clerk's Office HK

Senate Inventory Checklist for Archives

Bill Number: SB 459-FN **Senate Committee:** FINANCE

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee

___ All Calendar Notices

___ Hearing Sign-up sheet(s)

X Prepared testimony, presentations, & other submissions handed in ~~at the public hearing~~

___ Hearing Report

X Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

___ - amendment #_____ ___ - amendment #_____

___ - amendment #_____ ___ - amendment #_____

X Executive Session Sheet

X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment #_____ ___ - amendment #_____

___ - amendment #_____ ___ - amendment #_____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):

X Enrolled Bill Amendment(s) 2104EBA

___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

___ as amended by the senate X as amended by the house

X final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Debra A. Martin 06/27/22

Committee Aide **Date**

Senate Clerk's Office AK