

Environmental Strategies Safe Work Environments

- Environmental Assessment
- Administrative Strategies
- Risk Reduction



An organization's Environmental Strategies involve these three areas.

- ✓ Environmental Assessment
- ✓ Administrative Strategies
- ✓ Risk Reduction

Objectives

1. Participants will increase their knowledge and understanding of processes of environmental assessment.
2. Participants will increase their knowledge and understanding of processes of administrative strategies.
3. Participants will increase their knowledge and understanding of processes of risk reduction.

REPORTING

In the VHA, it is estimated that only 20% of workplace violence incidences are actually reported.



We tend to ignore events that we don't feel are significant. We justify this by saying, "No one really got hurt." "He didn't really mean what he said."

The result is we don't make the report.

This is putting ourselves, other co-workers, visitors, and other VA services throughout your state and the country at risk to experience the same or worse behaviors.

Remember, past behavior is a strong predictor of future behavior.

Documentation will help organizations and management follow PMDB policies.

Our follow-through in documentation of all verbal & physical incidents is a KEY element.

Environmental Strategies

- Management Commitment and Employee Involvement
- Worksite Analysis
- Training and Education
- Screening Potential Employees and Volunteers
- Analysis of Security
- Level of Violence in the Community

- Commitment from all levels of an organization is essential with the ongoing measures of prevention of violence in the workplace.
- Annual environmental assessments - refer to samples in resource section, from OSHA and PMDB National Task Force.
- Commitment for qualified trainers and staff's participation in training programs - awareness & intervention skills.
- HR- screening with background checks, interviewing skills. How are your volunteers screened? Also, include your volunteers in the PMDB awareness and verbal intervention skills modules.
- Involve security and safety manager regarding security measures prior to renovation and office moves.
- Consider the community and level of violence in your area or the area for a satellite office.



Routinely assess your work area for items which could be used as **weapons** (they accumulate!). Examples: staplers, coffee mugs, vases, paper weights, loose pictures on the wall.



- Set up work areas to be open & visible - so you are able to see your co-workers, entrances & exits. Example: Convenience stores used to have large signs of weekly specials in their windows. They now have discontinued this practice, so anything that takes place inside (robbery) is visible from the parking lot or street.
- Consider the furniture arrangement in office or area - do not block yourself in your office. Keep yourself closest to the door & the visitor deep in the room. Also consider the flow of traffic in waiting areas.

Environmental Suggestions

- Good Lighting
- Landscaping
- Deep Set-In Reception Desks
- Adequate Staffing
- Liaison Established with Local Police



Good lighting, interior & exterior, is one of the best deterrents in preventing crime.

Clerks / receptionists are our front line staff - reception areas with deep, set-in counters are less likely for someone to lean over and grab staff.

Also consider Plexiglas windows to speak through for high risk areas.

Landscaping - As a rule, maintain tree branches six feet from the ground, and shrubs at three feet high. This maximizes visibility.

Reporting Mechanisms



- Uniform Offence Reports
- Reports of Contact
- Safety Reports / Police Reports
- Patient Incident Reports
- Workers Comp Reports
- OSHA Injury-Illness Report
- Web Page / Code Orange Reporting

- Presently, the VA does not have a uniform reporting or tracking system of violence in the workplace. This is being addressed at a national level, with NIOSH (National Institute for Occupational Safety & Health) and OSHA, such as re-vamping the code orange reporting.
- Above is a list of different reporting mechanisms.
- In addition, we have provider alerts in the electronic patient records on potentially violent individuals (alerts are not reporting mechanisms). These are essential in assisting co-workers, on a VISN and a national level, regarding potentially violent individuals.

Administrative Strategies

- Commitment by Management and Union Partnership
- Policies on Zero Tolerance for Violence
- Require Employees to Report Verbal Threats and Physical Assaults
- PMDB Facility Policy
- Administration Supportive of PMDB Training

- National Violence in the Workplace Policy is being finalized in headquarters 2001-2002.
- Collaboration with management and union partnerships on violence in the workplace is essential in providing the resources and commitment of staff with PMDB policies, to provide a safe environment for our veterans and staff.
- Note : Sample of PMDB facility policies in manual - resources section. In addition, OSHA provides suggestions for organizational policies.
- Mandatory training, high risk areas, for medical centers:
- Executive Leadership, ER/ICU, Transitional Care, Community Based Outpatient Clinics (CBOCS), Behavioral Health, MAA's (note: train all staff in these areas, including clerks, house keeping, dietetics, etc.).

Administrative Strategies

- Data Collection and Evaluation
- Post-Incident Response and Evaluation
- PMDB Facility Team
- Debriefing and Treatment for All Employees Involved in Workplace Violence Incidence

- See OSHA tracking and reporting documents in Module 9.
- Refer to your facility PMDB policy if applicable.
- Identify members of your PMDB facility team.
- Next 2 slides we will expand on the PMDB facility team and de-briefing incidents.

PMDB Facility Team

- Team Responsibilities
- PREVENTION is the KEY



Remember, **prevention is the Key**. In the next section, we will discuss specific methods for de-escalating potentially violent situations.

- PMDB facility team is responsible to provide support staff in their dealing with disruptive situations throughout the facility.
- Focus of the team should be on resolving the crisis in a safe manner for both patient and staff.
- The review committee should be a multidisciplinary team with both professional and administrative members. The multi-disciplinary group may comprise of security, safety manager, PMDB trainer, HR/Education, Quality, Executive Leadership, and clinical staff.
- Review/critiques of crisis situations should be **fact-finding** and not **fault-finding**.
- The committee members should be knowledgeable about JCAHO and OSHA standards.

De-Briefing Incidents



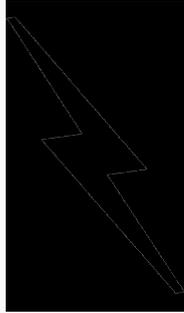
Assessment

1. Fact Finding, not Fault Finding
2. Critical Incident Stress Debriefing – Staff and Witnesses
3. Referrals to EAP or Trauma Crisis Counseling

Triggered by the facility PMDB Team, Executive Leadership, Security or Safety Manager. The importance of incident assessment and documentation.

- The purpose of the assessment is to discover what occurred. Not to judge or critique what occurred but to discover what happened during an event. Fact finding, rather than fault finding.
 1. Medical care for all individuals involved if needed.
 2. Critical Incident de-briefing for staff who were involved in or witnessed the incident. Stress de-briefing is performed by trained staff, within your facility or requested from external source (EES Birmingham, AL). De-briefing needs to be provided within 48 hours of the incident.
 3. Referral to Employee Assistance Program for employees or community program if visitors or family members involved.
- Referrals for trauma counseling when appropriate.

Risk Management



- Assessment of Environment
- Data Analysis
- Reduction

Reducing the odds...

- Collaboration with security, performance & quality, safety manager, PMDB facility team, and Executive Leadership, Human Resources, and unions.
- Reduce the potential weapons in the environment
- Physical security of facility
- Active PMDB facility team
- All employees are aware of policies,
- Employees required to report all incidents.
- Reduction - Annual PMDB training

Organizational Processes:

- Patient Safety
- Performance and Quality
- Root Cause Analysis or Aggregate Reviews
- Board of Investigations
- Refer to patient safety web site for updated information, data, and resources.