Trajectories

Aim For Excellence

MARCH 2018 ■ Broadening the Culture of Safety: Addressing Workplace Violence

In 2016, the Missouri Hospital Association launched its S.A.F.E.R. initiative to provide resources under the following five pillars.

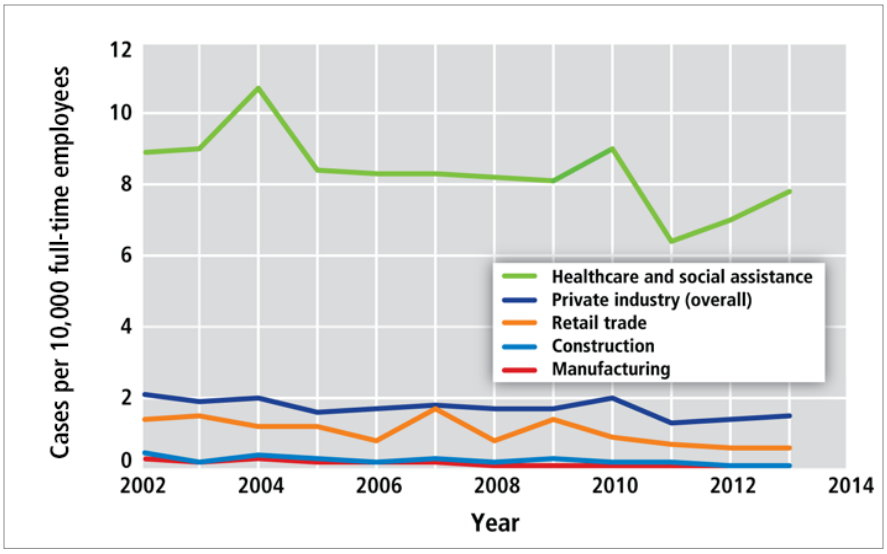
S – Safe culture of zero violence
A – Approaches to evidence-based safe care and resiliency
F – Facts to drive decision-making
E – Educate using evidence and best-practices
R – Regulatory reform to support safe workplaces

S.A.F.E.R. provides education and assistance to hospitals on workplace and community violence, as well as patient safety and life safety.

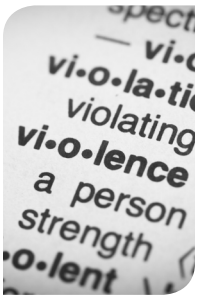
MHA
MISSOURI HOSPITAL ASSOCIATION

Introduction

Increasingly, violent acts against health care workers are highlighted in daily headlines and industry publications. Upon closer inspection, this attention is justified, as nationally, hospitals and health care providers are four times more likely to be victims of violence in the workplace compared to all other industries, according to the U.S. Bureau of Labor Statistics.[i]



Source: Bureau of Labor Statistics data for intentional injuries caused by humans, excluding self-inflicted injuries.



The Occupational Safety and Health Administration defines workplace violence as 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. It can affect and involve employees, clients, customers and visitors.[ii]

Nationally, hospitals and health care providers are **FOUR TIMES** more likely to be victims of violence in the workplace compared to all other industries.

In Missouri, hospitals are experiencing record high accounts of violence against their workforce. Aggressive behavior, verbal threats and physical assaults have become commonplace, which has led to an increase in violence within hospitals, often directed at caregivers. Once perceived as exempt from such behavior, the environment in hospitals has changed as a result of several contributing factors.

- Individuals with behavioral health conditions are seeking care in acute care hospitals because there is a lack of capacity in the state's behavioral health system.
- Patients or families are under the influence of substances or are seeking drugs.
- Patients or families are in the midst of a domestic conflict.
- Patients are coming to the hospital with weapons or controlled substances.
- The presence of law enforcement to transport a patient, execute a warrant or collect evidence heightens an already tense exchange.
- Gang or criminal activity from the community continues in the emergency department when an individual is seeking care.

A fall 2017 listening tour of Missouri hospital staff provided additional perspective. Eight different MHA member groups representing 225 physicians, executive leadership and clinical, human resources, security and front-line staff participated in an interactive presentation to identify the challenges and possible resources. The following summarizes the listening tour findings.

When asked to rank the perceived threat of the following scenarios, participants identified the following priorities.

1. **behavioral health patient boarding in non-psychiatric facilities** *(more prevalent in rural settings)*
2. **violent patient encounters** *(more prevalent in urban and metropolitan areas)*
3. **law enforcement drop-offs that create holding and/or elopement concerns**
4. **search and confiscation of narcotics**
5. **search and confiscation of weapons**
6. **law enforcement presence to execute warrants on patients/visitors onsite**

Member feedback also identified the following themes, which will require ongoing education and resources.

- **continue to advocate for balance and alignment of regulations and enforcement between OSHA and CMS**
- **identification and dissemination of "best practice" policies related to:**
  - warrantless blood draws
  - use of security/law enforcement worn-body cameras
  - appropriate and permissible use of TASERs (Thomas A. Swift's Electric Rifle)
  - reporting violent incidents to law enforcement
- **development of education and training related to:**
  - front-line staff competency of related organizational policies
  - de-escalation skills for a variety of patient and visitor profiles
  - management of substance-related encounters among patients and their visitors
  - prevention of sexual violence against health care employees
  - incorporating security personnel into the care team
  - joint training with local law enforcement and emergency medical services related to transitioning patients between disciplines to strengthen existing, collaborative relationships
- **development of criteria to evaluate hospital safety and security programs**
- **data to monitor trends and evaluate initiatives**

Regulatory Landscape

Hospitals are responsible for the safety of their patients and staff. The Centers for Medicare & Medicaid Services outlines this requirement, with primary focus on the patient, in § 482.13(c)/Standard: *Privacy and Safety*, stating the patient has the right to personal privacy, to receive care in a safe setting and be free from all forms of abuse or harassment.[iii]

As employers, hospitals must comply with the General Duty Clause of the Occupational Safety and Health Act, requiring they provide employees with a place of employment that is "free from recognized hazards that are causing or are likely to cause death or serious harm."[iv] While no OSHA requirement specifically references workplace violence, OSHA has published several industry resources and advocates on the issue. There is speculation that OSHA is exploring a standard on workplace violence in health care, following a 2016 public call for information. Further, a statement on organizational safety culture – linking patient and worker safety, states the following. "The burden and cost of poor patient safety, a leading cause of death in the United States, has been well-documented and now is a major focus for most health care institutions. Less well-known is the elevated incidence of work-related injury and illness among health care workers that occurs in the work setting, and the impact these injuries and illnesses have on the workers, their families, health care institutions and ultimately on patient safety. It is not surprising that patient and worker safety often go hand-in-hand and share organizational safety culture as their foundation."[v]

There are recognized gaps between the OSHA and CMS requirements that hospitals must meet. In a situation where the violent perpetrator is the patient, hospital staff have difficulty protecting themselves and the patient while demonstrating compliance with CMS' Conditions of Participation. MHA has made initial progress in advocating for fair surveys from CMS related to these issues to ensure consistent and appropriate application of the requirements. **After hearing of two specific concerns from our membership, MHA drew attention to surveyors requiring staff terminations to satisfy plans of correction, as well as the inappropriate requirement to implement clinical hold policies. CMS responded favorably, to our comment and we continue to monitor surveys for anticipated relief.** Additional work remains as there is a recognized opportunity to align the CMS and OSHA rulebooks to provide consistent and complementary guidance to hospitals to foster a safe environment to receive and provide care.

CMS' final rule on emergency preparedness, implemented in November 2017 across 17 provider and supplier types, also impacts efforts to reduce workplace violence. At the core of the requirement, participating providers are required annually to conduct a hazard vulnerability assessment to identify pertinent threats to the health care organization.[vi] The results of the assessment are intended to guide the organization's planning, training and improvement activities. The industry's expectation is for the top three threats identified in the organizational risk assessment to be addressed by written plan, staff training and in an annual evaluative exercise to demonstrate staff competence. The 2018 Emergency Preparedness and Safety Program Assessment identified that of 123 participating hospitals, 66 indicated workplace violence and/or violent behavior falls within their top three organizational threats.

1 2 3

54% of participating hospitals indicate that workplace violence and/or violent behavior fall within their top three organizational threats.

Program Evaluation and Improvement

Assessing the risk related to workplace violence is a necessary first step to building a strong safety and security program. Conducting an all-hazard risk assessment allows organizations to evaluate the likelihood, consequence and organizational readiness for a series of incidents impacting the organization. Accurate data collection and reporting is essential to appropriately inform the assessment process. For example, an active shooter within a health care facility is a low frequency, high consequence event. Violence or aggression toward a caregiver, although underreported, occurs at a higher frequency. Leadership must recognize the high consequence nature of these events, as well. Successful security programs leverage shared learning opportunities and implement policies, procedures and training programs to address both.

If unresolved, ongoing incidents of workplace violence will diminish morale and increase workers' compensation claims, days away from work, and, potentially, employee errors, which will compromise quality metrics. Studies show that the consequences of workplace violence increase the potential for medical errors or adverse events.[vii] Front-line staff need to have the awareness and skills to recognize similarities among responses to an active shooter and an aggressive patient, as well as distinguish the differences to successfully implement an appropriate and effective response.

123 hospitals participated in the 2018 Emergency Preparedness and Safety Program Assessment.

According to the 2018 Emergency Preparedness and Safety Program Assessment, out of 123 respondents, 82 hospitals identify front-line care staff as responsible for the initial response to incidents of workplace violence. While 50 hospitals identify the security team as the responsible entity and 27 rely on a response team for an initial response to workplace violence, front-line staff must maintain the skills to recognize and alert these resources.

Who is responsible for the initial response to an incident of workplace violence? *(Select all that apply.)*

	Percent of Respondents	Number of Respondents
Front-line care staff	**66.67%**	**82**
Security staff	**40.65%**	**50**
Response team	**21.95%**	**27**

The Role and Presence of Security in the Environment of Care

Delineating the role and engagement of the security team is a priority action for hospital executive, clinical and operational leadership. This should include a comprehensive risk management program with proactive mitigation procedures. Missouri hospitals utilize several methods to provide a security presence within their organizations. While just over a majority — 58 percent — employ security as hospital personnel, 21 percent contract externally for services and a little more than 2 percent utilize on-duty officers from their jurisdiction. With security staff readily available, safety and security programs must address timely notification and specific responsibilities of each team member when responding jointly to an escalating situation.

What method(s) does your hospital use to staff security personnel? *(Select all that apply.)*

	Percent of Respondents	Number of Respondents
Employ security workforce as hospital personnel	**58.54%**	**72**
Use contract agency, other than jurisdictional public safety, to provide security workforce	**13.01%**	**16**
Have a formal relationship with jurisdictional public safety to contract with off-duty officers	**8.13%**	**10**
Have a formal relationship with jurisdictional public safety to have on-duty officers present on hospital campus	**2.44%**	**3**
Do not employ security personnel	**27.64%**	**34**

When a front-line caregiver recognizes symptoms of agitation in a patient or visitor, de-escalation techniques should be implemented immediately to reduce the risk of an adverse outcome. In Missouri, 55 percent of hospitals identify nursing staff, 52 percent identify security staff and 32 percent identify all staff to receive training to respond as part of their de-escalation program.

123 hospitals participated in the 2018 Emergency Preparedness and Safety Program Assessment.

Which staff are identified for training and respond to de-escalation?

	Percent of Respondents	Number of Respondents
Security staff	**52.03%**	**64**
Nursing staff	**55.28%**	**68**
All staff	**31.71%**	**39**

As the incident escalates, the security team should facilitate a seamless transition as they enter the response, to not further disrupt an already tense situation. To remedy this, some hospitals have embedded security personnel into the formal care team to prevent the need to introduce an external player in a high intensity situation. Others have implemented community policing models, where security staff round on their designated units to foster better relationships with the care team, patients and visitors.

Does your hospital provide dedicated security officers in your emergency department 24 hours per day, seven days per week?

	Percent of Respondents	Number of Respondents
Yes	**21.14%**	**26**
No	**78.86%**	**97**

Does your hospital include security personnel as part of the formal care team?

	Percent of Respondents	Number of Respondents
Yes	**21.14%**	**26**
No	**54.47%**	**67**
N/A	**24.39%**	**30**

Does your hospital use a community policing model to maintain a security presence in care settings?

	Percent of Respondents	Number of Respondents
Yes	**51.22%**	**63**
No	**48.78%**	**60**

Partnering With Law Enforcement

All facilities have the responsibility to foster relationships with law enforcement; however, based on the presence or absence of security staff on-site, each relationship may look different. While just over 70 percent of hospitals have some form of security presence on-site, 28 percent of Missouri hospitals do not employ security staff at all. In these situations, the facility's relationship with local law enforcement should be more comprehensive to ensure law enforcement has clear expectations of when and how they are contacted, as well as to facilitate safe transitions through mutually developed and implemented standard operating procedures.

Regional Workshops

Community Partnerships and the Patient: Understanding the Legal Environment

8 a.m. Thursday, April 12, 2018
Blue Springs, Mo.

8 a.m. Thursday, April 26, 2018
Springfield, Mo.

11:30 a.m. Tuesday, May 1, 2018
St. Peters, Mo.

8 a.m. Thursday, May 10, 2018
Cape Girardeau, Mo.

The International Association for Healthcare Security and Safety August 2017 guideline, "Collaborating with Law Enforcement,"[viii] reinforces the importance of a collaborative partnership, outlining effective practices health care facilities should employ to establish and strengthen existing partnerships. Routine meetings, joint training and exercises, and established policies for sharing information are included in the publication as suggested strategies.

In Missouri, hospitals indicate that relationships with their local law enforcement partners are strong. When asked during the fall 2017 listening tour, 93 percent of respondents indicated their perception of strong working relationships. To build on this foundation, in partnership with the Missouri Department of Public Safety and Healthcare Services Group, MHA will host regional workshops (see sidebar) in spring 2018 to provide joint training on the regulations and requirements that hospitals, emergency medical services and law enforcement must follow to promote safe patient hand-offs.

Mitigation Tools

In addition to personnel resources, there are a variety of mitigation strategies to address violence in the health care setting. Ranging from low-cost tangible tools to high-dollar infrastructure investments, hospitals must evaluate their risks and determine the strategies that will provide the greatest return on investment. Determining what tools are used by the security team is an organizational decision derived in part by the risk assessment, patient population, hospital mission, leadership philosophy and board of trustees. It is less important what tools are implemented and more important that a hospital develop a sustainable, comprehensive program that includes adequate training and policy awareness, including detailed procedures on when to utilize each resource during a response.

The effort hospitals make to project a welcoming environment to their patients and visitors, permitting open and often unrestricted access, poses a challenge to the security team. Safety strategies in a health care facility must be evident to relay a sense of security, without generating fear or creating undue burden. Crime prevention through environmental design is a method often deployed in health care during construction or remodeling phases to facilitate improved security without compromising patient access or sending a negative message to visitors. Simple, low-cost measures, such as manicured landscaping, fresh paint and well-lit parking lots, entrances and hallways deter menacing activity. Staffed information desks and rounding security, when employed, also relay a non-verbal message that the environment is being monitored and is safe. During renovations, many hospitals have remodeled all patient care rooms to designate an area for family and an area for the nursing staff, separated by the patient's bed, which allows the clinical team direct, unrestricted access to the exit if their safety is compromised.

Securing facility access and controlling the perimeter often is the most challenging and costly investment a hospital will undertake. In many hospitals, lockdown procedures remain manual, requiring quick action by multiple staff members. New or retrofitted facilities have migrated to automated lockdown procedures, controlled from one or two critical vantage points.

123 hospitals participated in the 2018 Emergency Preparedness and Safety Program Assessment.

Are your hospital security officers armed?	Percent of Respondents	Number of Respondents
Yes	38.21%	47
No	35.77%	44
N/A	26.02%	32

If your security officers are armed, please identify their defense equipment. *(Select all that apply.)*	Percent of Respondents*	Number of Respondents*
Firearm	35.38%	23
TASER	53.85%	35
Pepper spray	20.00%	13
Baton/stick	44.62%	29

**Out of 65 respondents.*

Do your security officers utilize body cameras?	Percent of Respondents	Number of Respondents
Yes, in all care settings	7.32%	9
Yes, outside of patient care settings	0.00%	0
No, body worn cameras are not allowed	36.59%	45
N/A	44.72%	55

Does your hospital have a written policy on the use of body cameras?	Percent of Respondents	Number of Respondents
Yes - Approved policy	9.76%	12
Yes - Draft policy	3.25%	4
No - No policy	86.99%	107

If yes, to whom does the policy apply?	Percent of Respondents*	Number of Respondents*
Law enforcement	31.25%	5
Hospital security personnel	37.50%	6
Both	31.25%	5

**Out of 16 respondents.*

123 hospitals participated in the 2018 Emergency Preparedness and Safety Program Assessment.

Do you use metal detectors at hospital entrances?	Percent of Respondents	Number of Respondents
Yes	11.38%	14
No	88.62%	109

If yes, please select the locations that apply.	Percent of Respondents	Number of Respondents
Emergency department entrances	39.29%	11
Main hospital entrances	17.86%	5
Staff only entrances	0.00%	0

Promoting a Culture of Safety

While hospital security programs may vary in size, resources and mitigation techniques, all programs require the full investment of the leadership team and engagement of the board. Leadership must demonstrate support for the safety of their workforce through tangible efforts, such as training and resources. More importantly, leaders must portray a vested interest in their staff to include setting and enforcing behavior expectations of all individuals, and receiving and acting upon incident reports involving aggression against staff.

Missouri hospitals report the following related to incident tracking and their review by leadership.

How are security incidents at your hospital reported and tracked?	Percent of Respondents	Number of Respondents
Formal reports	69.11%	85
Security logs	16.26%	20

Are security events reviewed with your hospital's senior leadership team?	Percent of Respondents	Number of Respondents
Yes	98.37%	121
No	1.63%	2

A recent publication by the American College of Healthcare Executives, "Leading a Culture of Safety: A Blueprint for Success," articulates the importance of leadership in achieving zero harm to patients, families and the workforce. "… every health care executive should prioritize enhancing the safety of patients and the workforce. As an industry, health care has taken steps in improving quality and patient safety. However, these small-scale, incremental improvements are not enough. Our immediate work requires a focus on safety, not just as a key improvement initiative, but as a core value that is fully embedded throughout our organizations and our industry."[ix]

Fulton State Hospital
Creating Hope Through Excellence

Recognizing an opportunity to better support their staff following a workplace injury due to violence, leadership from Fulton State Hospital implemented the Assaulted Staff Action Program[x] in 2012.

Q What is ASAP?

Developed by Dr. Raymond Flannery, ASAP is a voluntary, systemwide, peer-help, crisis intervention program to address the psychological aftermath of patient assaults on staff. Developed in Massachusetts, Department of Mental Health facilities, and implemented in multiple states and other countries, the ASAP program has been recognized as a "best practice" by both the United States Occupational Safety and Health Administration and the Canadian Ministry of Health. This program is offered to all applicable employees at no charge.

Q What is the program's philosophy?

ASAP is based on the philosophy that violence does not "come with the turf," as well as the following assumptions.

- Staff may experience trauma as a result of assaults.
- Staff victims are worthy of compassionate care.
- Peers facing a similar risk are in a better position to understand the fears of the victimized staff member.
- Communication about the event may result in less human suffering and better coping in the short-term and avoid longer lasting disruptions, including PTSD, in the longer term.

Q How is the program structured?

The program is comprised of three groups.

1. The first group includes first-line responders who are on-call and readily available to respond to the site where the incident has occurred, offer ASAP services and conduct individual crisis intervention through a prescribed process. These staff also are responsible for contacting the staff victim three days and ten days post incident.
2. The second group is the ASAP team supervisors. These staff provide second opinions to first responders, provide coverage in cases of multiple assaults and co-lead some of ASAP's group interventions.
3. The third group is comprised of team leaders responsible for overseeing the quality of all services provided, co-leading group interventions, providing initial and ongoing training to staff volunteers, and conducting team administrative duties.

Team members are drawn from all disciplines, commit for at least one year, and adhere to ASAP confidentiality requirements and all ASAP standards of practice and clinical practice.

Q What services are provided?

ASAP offers two intervention services. All interventions **are voluntary** for staff victims, and no victim is ever required to speak of the traumatic event, if the victim so chooses.

Individual crisis interventions for assaulted staff members
When an assault occurs and the charge nurse summons the on-call ASAP team member, the first-line responder goes directly on-site, checks that safety and any needed medical issues have been addressed, and reconstructs the facts of the assault. Then, the first responder introduces himself/herself to the employee victim, offers the ASAP intervention and assures the employee victim of complete confidentiality, unless the employee victim reports a crime. The responder then proceeds with the intervention. Follow-up is provided after three days and, again, after ten days.

CISD for patient-care sites
In the event that one patient assaults several staff and/or damages property in an isolated incident, ASAP employs a group crisis intervention. The group is co-lead by the team leader and/or the ASAP supervisors and includes all victims who want to participate.

Anna Luebbert, ASAP coordinator for Fulton State Hospital, reinforces the principles and return on investment of the program. "The program formally and systematically makes it a point to acknowledge that each employee's experience with assault needs to be recognized and treated with compassion." A recent survey of the program received the following comments from front-line staff — "I have seen many employees benefit from this service," and "Glad this is finally a priority for our staff."

Community-Based Violence and Its Impact on Hospitals

In reality, despite the investments made, hospital security programs are reactive, playing defense to what may enter their four walls. While the most successful programs will mitigate risks, they don't serve to reduce the causal factors. A recent report by the American Hospital Association, as a component of their Hospitals Against Violence initiative, took a closer look at the broader issue of community violence. The publication recognized that, "As key community stakeholders in antiviolence efforts, hospitals engage in prevention and preparedness activities, both to address the determinants of violence within their communities, and to be capable of responding appropriately when violence does occur. Further, health care workers face an increased risk of both physical and verbal abuse as they manage the complex needs of patients and visitors within their facilities. Many patients and visitors experience high-stress, emotionally-charged situations during their time in the hospital that can sometimes lead to aggressive behavior. As such, hospitals and health systems make significant investments in infrastructure, staff and training in order to keep their workers, patients and visitors safe."[xi] The research seeks to quantify the cost — not just financial — of community violence to health care providers. The report indicates that in 2017, $2.7 billion was invested by health care providers nationwide: $1.1 billion on security and training, $852 million in uncompensated care for victims of violence, $429 million toward costs associated with violence against health care providers and $280 million on preparedness and prevention.

Children's HOSPITAL • ST. LOUIS
BJC HealthCare

St. Louis Children's Hospital recognized the negative impact and likelihood for recurrence of interpersonal violence in the lives of children who have experienced or witnessed traumatic events resulting in hospitalization. In an effort to disrupt this cyclical behavior, the hospital launched the Victim of Violence Program[xii] in 2012, which recognizes that many children who have been the victim of interpersonal violence will go on to initiate violence toward others, leading to unsafe communities, further injury and death. Funded by St. Louis Children's Hospital Foundation, hospital staff partnered with the St. Louis Metropolitan Police Department and the St. Louis County Police Department, St. Louis City and County Family Courts, St. Louis Public Schools and St. Louis County school districts, and school social workers in St. Louis City. The program, serving children eight to 19 years of age, is offered initially to victims in the emergency department, with follow-up by an assigned mentor within 24 hours, either in the care setting or in the community, if discharged. Interest and willingness of the victim to continue the program prompts the scheduling of ongoing, mutually agreed upon meetings where goals and treatment plans are developed to process the reasons that led to the ED visit. Mentors also work with willing parents of the victim to provide mediation and therapeutic counseling as well as modeling of parenting skills.

Since 2014, the program has offered services to 156 children/individuals, noting that no program participant has returned for medical care related to an interpersonal violent encounter.

Building on the success of St. Louis Children's Hospital's Victim of Violence Program, the Institute for Public Health at Washington University in St. Louis launched the regional St. Louis Area Hospital-Based Violence Intervention Program, which aims to promote positive alternatives to violence and reduce the recidivism for interpersonal violence injury at the regional level. Partnering for this initiative are two academic institutions and St. Louis' four Level 1 trauma centers, as hospitals are "well positioned to interrupt the cycle of violence by intervening at a uniquely teachable moment when individuals have survived a violent injury," according to Victoria Anwuri, associate director of the Institute for Public Health.

STL-HVIP Participants

- Washington University in St. Louis
- Saint Louis University
- Barnes-Jewish Hospital
- SSM Health Saint Louis University Hospital
- St. Louis Children's Hospital
- SSM Health Cardinal Glennon Children's Hospital

"St. Louis Children's is pleased to expand its pilot program with youth victims of violence through this funding," said Joan Magruder, president of St. Louis Children's Hospital, which has been running a scaled-down version of the intervention. **"We have seen how powerful intervention at a moment of crisis can be in changing the trajectory of lives. The Missouri Foundation for Health grant will enable us to test this intervention on a much larger scale, including both youth and adults — which we expect will have great impact on the community."**[xiii]

Suggested Citation

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Conclusion

Elimination of harm to patients and health care workers should stand side-by-side in importance. The goal should be that patients have access to high quality, safe and effective medical care. Similarly, health care workers should have access to support systems that provide adequate protection and intervention to permit them to deliver on the promise of high quality care.

Solutions to reduce workplace violence are not simple and straightforward. Successful strategies require systematic and multidisciplinary support from health care system and community leaders, public health officials, and legislators. National benchmarks to define the scope of the problem, as well as accurate data collection to relay the prevalence of such violence, also is necessary. To influence improvement, hospitals must implement programs that mitigate prevailing threats, to include training staff to respond appropriately, and investing in structural and technological safeguards. To be most successful, however, hospitals and their community partners must evaluate the contributing factors resulting in an increase in violent behavior and employ strategies to reduce violence overall. MHA's S.A.F.E.R. initiative continues to identify evidence-based practices to provide hospitals with the resources necessary to create safe environments for care.

References

[i] *Workplace Violence in Healthcare: Understanding the Challenge* (Publication). (n.d.). Retrieved from Occupational Safety and Health Administration website: https://www.osha.gov/Publications/OSHA3826.pdf

[ii] United States Department of Labor. (n.d.). Retrieved from https://www.osha.gov/SLTC/workplaceviolence/index.html

[iii] *Federal Register*, Condition of Participation: Patient's rights, § 42 CFR 482.13.

[iv] OSH Act of 1970, § 5 (United States Department of Labor 1970).

[v] United States Department of Labor. (n.d.). Retrieved from https://www.osha.gov/SLTC/healthcarefacilities/safetyculture.html

[vi] Emergency Preparedness Rule. (2018, January 05). Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

[vii] Rosenstein, A. H., & O'Daniel, M. (2005). Original Research: Disruptive Behavior and Clinical Outcomes: Perceptions of Nurses and Physicians. *American Journal of Nursing, 105*(1), 54-64. doi:10.1097/00000446-200501000-00025.

[viii] *Collaborating with Law Enforcement* (IAHSS Industry Guidelines). (2017, August). Retrieved from International Association for Healthcare Security and Safety website: http://www.iahss.org/default.asp?page=guidelines (member restriction)

[ix] Leading a Culture of Safety: A Blueprint for Success (Publication). (n.d.). Retrieved from The American College of Healthcare Executives and the NPSF Lucian Leape Institute website: http://www.npsf.org/page/cultureofsafety

[x] Excerpted from Raymond B. Flannery, Jr., Ph.D. materials

[xi] Van Den Bos, J., ASA, MAAA, Creten, N., FSA, MAAA, Davenport, S., & Roberts, M., MBA. (2017, July 26). *Cost of community violence to hospitals and health systems* (Rep.). Retrieved from Milliman Research Report /American Hospital Association website: https://www.aha.org/system/files/2018-01/community-violence-report.pdf

[xii] Victim of Violence Program. (2015, July 01). Retrieved from http://www.stlouischildrens.org/our-services/family-services/social-work-and-chaplaincy/victim-violence-program

[xiii] Schoenherr, N. (2018, January 23). Joining forces to stop cycle of violence in St. Louis. *The Source*. Retrieved from https://source.wustl.edu/2018/01/institute-public-health-receives-1-6-million-grant-form-regional-group-aimed-interrupting-cycle-violence/

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