

# Guidelines For Management of Disruptive and/or Abusive Patients

*A Guide for Chronic Dialysis Facilities*

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Prepared By

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## I. Introduction

### Purpose

The purpose of these guidelines is to reduce the incidence of disruptive/abusive patient behavior that occurs in dialysis facilities and to guide staff in dealing with it appropriately and consistently. These guidelines are not a standard or regulation. They are advisory in nature, informational in content, and are intended for use by facility staff seeking to provide a safe and therapeutic environment. **This document is not intended as a substitute for a specific policy tailored to a particular facility.**

### Background Information

ESRD Network 18 receives calls from facility staff for guidance in dealing with disruptive and/or abusive patient behavior. We are also contacted by patients to complain about their rights, their care, and to report being “discharged” from their facility. Requests for assistance in dealing with disruptive and/or abusive behavior have risen dramatically over the last several years. Other Networks have reported a similar trend.

ESRD Network 18 has **no formal policy** regarding involuntary discharge of disruptive and/or abusive patients. Providers are guided by Federal Regulation Section 405.2138[b][2], which requires that patients be transferred or discharged only for the following reasons:

- Medical reasons
- The patient’s welfare or that of other patients, or
- Nonpayment of fees (except as prohibited by Title XVII of the Social Security Act), and that patients be given advance notice to ensure orderly transfer or discharge.

The Federal Regulations leave interpretation to each individual. The terms ‘medical reasons’, ‘patient welfare’, and ‘advance notice’ are not defined, though the clear intent is to allow for the transfer or discharge of patients in some instances. It is also clear that the law requires notice and appropriate assistance with transfer. However, the **ultimate goal in these situations is to avoid involuntary discharge.** ESRD Network 18 provides education to facility staff and patients, resource materials, and consultative assistance to facility staff towards achieving this outcome.

It is hoped that the enclosed information and tools become a catalyst and a resource for facility leadership to review and discuss ways to prevent and resolve conflict in dialysis facilities.

## II. Six Steps to Management of a Disruptive/Abusive Patient

### Step 1: Policy Regarding Disruptive/Abusive Patients

Each dialysis facility should have a written policy regarding management of disruptive and abusive patient behavior.

- The policy should address the behavior of the patient, and their family/friends on the entire premises of the dialysis facility, not just inside waiting room and treatment area
- The policy should include steps to be taken in the event of threatening or violent behavior
- The policy should prohibit patients and staff from carrying weapons and the facility will post “No Weapons Allowed” signs on its doors
- The policy should address the guidelines not to initiate treatment, to terminate treatment and/or terminate the patient relationship for abusive/violent patients
- All staff should receive orientation and continued education to ensure that these situations are handled appropriately and consistently

### Step 2: Agreement of Expectations

Initiate an agreement of expectations with the patient as your first step in management of their behavior. A positive patient-facility relationship is necessary for efficient and effective treatment. Open, ongoing, two-way communication is the core of a healthy patient-facility relationship. Clearly defined expectations between the patient and the dialysis facility can provide a foundation for preventing conflict situations. The Agreement of Expectations should specify:

- the patient expectations of the facility
- the facility expectations of the patient
- specific actions to be taken when one or the other is not met

A sample Agreement of Treatment Expectations is attached as Appendix C. It is recommended that the Agreement of Expectations be reviewed at each patient care conference or as needed. If the patient’s behavior becomes disruptive, a more specific behavior contract may be developed for the patient.

If you are admitting a patient that has previously been involuntarily discharged from a facility we suggest that you consider establishing an agreement of expectations at the time of acceptance or at the first scheduled treatment.

### Step 3: Rules of Conduct

Written rules of conduct for patients and staff should be established in each facility. When setting these rules, it is important to keep in mind that:

- These rules apply to *all patients at all times*
- All staff must enforce the rules with all patients uniformly and consistently
- All Staff should be able to explain the purpose of all rules to patients and family members
- Rules of conduct should indicate intolerance for violence and threats of violence
- Patients should be informed that verbally abusive or threatening behavior is unacceptable and could lead to involuntary discharge

### Step 4: Team Meeting To Develop A Plan Of Action

Even with an Agreement of Expectations in place, problems may occur. The interdisciplinary team should arrange a conference with the patient to discuss the behavioral problem and develop a plan to resolve it. Members of the interdisciplinary team should at least include the patient, patient's physician or the medical director, the social worker, the nurse manager and, if necessary, the administrator. A family member or patient's representative, HMO renal case manager, and others should also be included if appropriate.

During this meeting the staff and patient should:

- Identify specific problems and distinguish from symptoms
- Identify contributing factors
- Identify possible solutions
- State the expectations of each other

Follow up the meeting with a letter to the patient summarizing the outcome of the meeting and what is expected of him/her and what they can expect from the facility. A written plan to correct the problem should be developed and signed by the patient and staff. The patient care staff should be informed of the plan to be used in dealing with the specific behavior(s). Thorough documentation of the specific behavior(s) that are being displayed and the steps taken to correct the problem is essential.

The following suggestions may enhance the chances for a successful outcome of the team meeting:

- The meeting should be planned in advance and well thought out
- All participants should understand and agree on the purpose and desired outcome of the meeting
- Staff members attending the patient conference should meet in advance to discuss all aspects of the meeting
- Approach the meeting with a calm and positive attitude

The purpose of the meeting is not to “threaten” the patient into behavioral compliance but to gain information, provide information, and find a way to work together for the patient’s well being.

### **Step 5: Behavioral Contract**

A patient behavioral contract can be a very useful *corrective action* tool. The purpose of this document is to define behavior(s) that must change if a patient wishes to continue dialyzing at the facility. It is a tool that should be used only after the patient has been previously educated, counseled on his/her behavior(s), and did not meet the conditions of the agreement of expectations.

If the problem continues, the treatment team (including the HMO renal case manager, if applicable) should meet with the patient one more time. A family member or patient representative should be invited to attend. The team and the patient should try again to identify possible reasons for the continuing behavior(s) and potential solution(s). A behavioral contract should be developed which outlines specific patient and staff responsibilities related to the behavior(s) identified and consequences for violation of this agreement document. Consider including a psychiatric evaluation (or alternate care from an appropriate mental health care professional) in the agreement. The behavioral contract should be a written document containing the following:

- A clear description of the problem behavior and why it is unacceptable
- The expectation for improvement of the patient’s behavior
- Responsibilities of the dialysis staff to the patient
- Timeline(s) for improvement
- Action(s) that will be taken if the timeline(s) are not met
- A statement that the patient’s continued negative behavior will cause the dialysis facility to begin the involuntary discharge process, and when it will begin

The patient, the physician, and a facility management representative should sign the agreement. If the patient refuses to sign the agreement, a witness should co-sign with documentation that the patient had refused.

When establishing timelines, a minimum of 30 days should be allowed for the behavior to improve.

Meetings with the patient should be scheduled during non-dialysis times.

All proceedings involved in instituting the behavioral contract should be documented and kept as a part of the patient's medical record

When considering a behavior contract please be sure to notify and consult with your legal department/risk management.

### **Step 6: Involuntary Discharge**

If all forms of intervention have been exhausted, the facility may decide to end the facility-patient relationship. This should only occur as a last resort in resolving the situation. Before proceeding, the facility should have the following documentation in the patient's medical record:

- Specific problem behavior(s)
- The impact of the patient's behavior on other patients and the staff
- All steps taken by the facility to attempt resolution of the problem
- The patient's response to the steps taken

### **Final Steps**

When the decision to involuntarily discharge has been made, the following steps should be taken:

- The facility should inform legal counsel of the decision to involuntarily discharge and the reason(s) for it
- Notify the patient in writing. Send copies of the letter to the patient via certified mail, return receipt requested, and via regular mail, or present to the patient in person
- A last treatment date is set in writing. The patient must be given reasonable notice, thirty (30) days is generally appropriate

- Assure the patient that the facility will continue to provide treatment up to the termination date period, unless patient behavior warrants immediate discharge
- Provide a list of facilities for the patient to contact for placement
- Emphasize to the patient the importance of finding another facility and/or physician for continued care
- Inform the patient that the facility is available to assist with placement and will transfer medical records to other facilities with consent
- The Administrator/Medical Director should ensure that all steps taken are consistent with federal regulations, state law, and corporate/facility policy

Once a facility decides to involuntarily discharge service to a patient, the physician may or may not decide to discharge the patient from his/her service. If the physician decides to end his/her relationship, a separate letter should be written to inform the patient. This letter should include the last date of treatment, specific reason(s) for ending his relationship with the patient, and a list of other nephrologists and phone numbers for the patient to contact. If physician decides to *keep* the patient he/she is assuming partial responsibility for placing the patient in another facility where he/she has admitting privileges.

### **Immediate Discharge**

Patients may be involuntarily discharged immediately from the physician and/or dialysis facility if their behavior(s) endangers the safety of staff or other patients. It is imperative that facility policy stipulates specific behaviors that will be grounds for immediate involuntary discharge. The Facility may notify the patient verbally but should follow-up with written documentation. Patients must be made aware of this policy during initial orientation and subsequently as appropriate. The facility should send a letter by same-day service/ overnight delivery and via regular mail, or contact the patient by phone.

If the facility elects to immediately discharge a patient, the facility should follow all of the guidelines detailed in final steps except that the patient will be notified that the discharge is immediate, no further treatment will be provided.

### **III. Issues To Consider**

Involuntary discharge should not be used by the facility to remove a patient who is non-compliant with diet, medication, etc. Only when a patient's physician ends the relationship for non-compliance, and no other physician with staff privileges at the facility is willing to accept the patient, will involuntary discharge be acceptable. In this case, the facility is not discharging the patient but is unable to provide services to the patient without a physician.

Physicians have a responsibility to direct and support the steps leading to involuntary discharge. It is not the responsibility of the dialysis staff to end the physician/patient relationship. That is within the purview of the attending physician, and the circumstances leading to the severing of the relationship must be clearly documented. Once the decision has been made to end the relationship, the patient must be given adequate notice and assistance in locating a new physician. Generally, a minimum of 30 days is considered to be adequate notice.

The major court cases (Payton v. Weaver and Brown v. Bower) regarding termination of dialysis services to extremely difficult or dangerous patients have found that physicians are not liable when all reasonable attempts have been made by the physician or facility to correct the situation.

ESRD Network 18 recommends that all threats or acts of violence be taken seriously and reported to the police. The intensity of the threat may require that the police or security guards be present during each treatment until transfer takes place.

It is strongly recommended that legal counsel review any policy regarding disruptive/abusive patients before it is implemented.

Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), protect the disabled from discrimination. Within the context of this law, ESRD patients are considered disabled. When the decision is made to involuntarily discharge a patient for disruptive and/or abusive behavior, it is critical that the decision and the actions leading up to the decision are thoroughly documented. The documentation should show that facility actions were in response to the patient's behavior.

Law enforcement should be contacted when physical aggression occurs, or severe threats of harm are made. Serious episodes where a patient behaves in a blatantly violent manner should not be tolerated. The Occupational Safety and Health Act of 1970 (OSHA) makes it the responsibility of the facility to ensure the safety of their staff and patients.

## IV. Recommended Educational Activities

### Education of Patients

The following education is recommended for ALL patients and/or family members at initiation of dialysis, annually, and as needed:

- Patient rights and responsibilities
- Facility policy for handling harassment, disruptive, and abusive behavior
- Facility policy on violence and/or threats of violence

- Facility's patient policies and procedures i.e. eating during treatment, unsupervised children, use of bathroom, etc.
- Examples of unacceptable behaviors

### Education of Facility Staff

The following is recommended for ALL new hires and as an annual required in-service program:

- Professional behavior and boundaries
- Patient rights and responsibilities
- The nature of disruptive and abusive behavior in individuals with a chronic disease
- Examples of unacceptable patient and staff behaviors
- Facility policy and strategies for handling harassment, disruptive, and abusive behavior
- Therapeutic communication techniques
- Facility policies and procedures

## V. Examples of Unacceptable Behavior

**Verbal actions:** use of obscenities, use of curse words, shouting, screaming, name calling, racial or derogatory remarks, and sexual/suggestive remarks.

**Physical actions:** actual or perceived violent/threatening behavior, throwing of objects, hitting staff, yanking out needles, blood spray, spitting, abuse of drugs and/or alcohol, pinching, slapping, touching staff inappropriately, stalking.

**Threats:** Written or verbal. Display of or threat to use a weapon.

**Interference with facility operations:** unauthorized visitors; manipulation of dialysis machines; slanderous and/or libelous statements regarding staff, the operation of the facility, or other patients in the facility; destruction of equipment; trespassing into unauthorized areas.

## VI. Review of Involuntary Discharge

Procedural suggestions in carrying out a patient involuntary discharge:

1. Document episodes of threatening, abusive, inappropriate patient behavior in as much detail as possible.
2. Convene a team meeting with patient and physician, informing the patient that his behavior is unacceptable and will not be tolerated.
3. Enter into a written agreement, which establishes expected behavior and delineates the terms of the agreement, including what the consequences will be if the agreement is broken. The evaluation period should be at least 30 days.
4. If the behaviors continue at the end of the evaluation period, the patient is furnished a written summary of his behaviors and what the consequences will be.
5. If the facility has chosen involuntary discharge as a consequence, the patient is informed in writing of the last date of treatment. It is suggested that a patient receive a 30-day notice.

In cases involving a patient who has engaged in physically menacing behaviors against another patient or staff member (actual physical assault or credible threats of assault), the local authorities should be called immediately, and immediate discharge may be required or facility actions should reflect reasonable efforts to ensure patient and facility welfare.

6. The facility must furnish, in writing, the names of other treatment facilities and provide assistance, if needed in making transfer arrangements.

## VII. Acknowledgments

**Working with Noncompliant and Abusive Patients**, Mid-Atlantic Renal Coalition-ESRD Network 5.

**Access To Care Position Statement**, Southeastern Kidney Council-ESRD Network 6.

**Southeastern Kidney Council Recommendations for Dealing with Disruptive and/or Abusive Behavior**, Southeastern Kidney Council-ESRD Network 6.

**A Facility Guide to Termination of Dialysis Services**, TransPacific Renal Network-ESRD Network 17.

**Guidelines and Resources to Improve Communications and Develop Expectations Between Renal Professionals and Their Renal Patients**, The End Stage Renal Disease Network of Texas, Inc.

**Dealing with Challenging Dialysis Patient Situations**, Mary Rau-Foster, RN BS ARM JD, Foster Seminars and Communications LLC.

## Appendix A

### Board of Directors Statement Harassment, Abuse, and Threats

## BOARD OF DIRECTORS STATEMENT HARASSMENT, ABUSE AND THREATS

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All individuals have the right to be safe and protected from harassment, abuse and threats. It is the responsibility of those who own, manage and provide professional services in dialysis centers to safeguard the health, welfare, and rights of their patients, employees, medical staff, and visitors.

The following actions are intolerable if they result in real or perceived harm to the victim, bystanders and witnesses:

- Acts of physical violence
- Actual or implied threats
- Sexual or emotional harassment

Prompt recognition and response by the Medical Director and/or Chief Executive Officer is critical to protect all concerned individuals and the orderly provision of dialysis services.

The Board of Directors of the Southern California Renal Disease Council, Inc. recommends that dialysis facility management provide the following:

- Organizational commitment to a policy of zero tolerance for workplace violence, verbal and nonverbal threats, and related actions
- A policy on prohibition of weapons and firearms
- Dissemination of such policies to staff and patients/patient representatives
- Initial orientation and ongoing training for all staff in violence prevention programs
- Guidelines for patient rights/responsibilities that establish clear behavioral expectations
- Guidelines for procedures not to initiate treatment, to terminate treatment and/or to terminate the relationship with violent/abusive patients
- Procedures to summon local police or private security personnel when appropriate

OSHA provides voluntary, generic safety and health programs management guidelines for all employers to use as a foundation for their safety and health programs, which should include a work place violence prevention program. \*OSHA Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, US Department of Labor, Occupational Safety and Health Administration. OSHA 3148, 1996.

Medicare regulations address patient transfers and discharges: 42 C.F.R. 405. 2138(b)(2) "All patients treated in the facility...are transferred or discharged only for medical reasons or for the patient's welfare, or that of other patients, or for nonpayment of fees (except as prohibited by title XVIII of the Social Security Act), and are given advance notice to ensure orderly transfer or discharge."

## Appendix B

### Guidelines For Preventing Workplace Violence for Health Care and Social Service Workers

# **Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers**

U.S. Department of Labor  
Alexis M. Herman, Secretary

Occupational Safety and Health Administration  
Charles N. Jeffress, Assistant Secretary

OSHA 3148  
1998 (Revised)

## Notice

These guidelines are **not** a new standard or regulation. They are advisory in nature, informational in content, and are intended for use by employers seeking to provide a safe and healthful workplace through effective workplace violence prevention programs adapted to the needs and resources of each place of employment. The guidelines are not intended to address issues related to patient care. The guidelines are performance-oriented and the implementation of the recommendations will be different based upon an establishment's hazard analysis.

Violence inflicted upon employees may come from many sources — i.e., patients, third parties such as robbers or muggers — and may include co-worker violence. These guidelines address only the violence inflicted by patients or clients against staff. It is suggested, however, that workplace violence policies indicate a zero-tolerance for violence of any kind.

The Occupational Safety and Health Act of 1970 (OSH Act)<sup>1</sup> mandates that, in addition to compliance with hazard-specific standards, all employers have a general duty to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm. OSHA will rely on Section 5(a) of the OSH Act, the “General Duty Clause,”<sup>2</sup> for enforcement authority. Employers can be cited for violating the General Duty Clause if there is a recognized hazard of workplace violence in their establishments and they do nothing to prevent or abate it. Failure to implement these guidelines is not in itself a violation of the General Duty Clause of the OSH Act. OSHA will not cite employers who have effectively implemented these guidelines.

Further, when Congress passed the OSH Act, it did so based on a finding that job-related illnesses and injuries were imposing both a hindrance and a substantial burden upon interstate commerce, “in terms of lost production, wage loss, medical expenses, and disability compensation payments.”<sup>3</sup>

At the same time, Congress was mindful of the fact that workers' compensation systems provided state specific remedies for job-related injuries and illnesses. Issues on what constitutes a compensable claim and what the rate of compensation should be were left up to the states, their legislatures, and their courts to determine. Congress acknowledged this point in Section 4(b)(4) of the OSH Act, when it stated categorically: “Nothing in this chapter shall be construed to supersede or in any manner affect any workmen's compensation law . . . .”<sup>4</sup> Therefore, these non-mandatory guidelines should not be viewed as enlarging or diminishing the scope of work-related injuries and are intended for use in any state and without regard to whether the injuries or fatalities, if any, are later deemed to be compensable.

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<sup>1</sup> Public Law 91-596, December 29, 1970; and as amended by P.L. 101-552, Section 3101, November 5, 1990.

<sup>2</sup> “Each employer shall furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.”

<sup>3</sup> 29 U.S.C. 651(a).

<sup>4</sup> 29 U.S.C. 653(b)(4).

## Acknowledgments

Many persons, including health care, social services, and employee assistance experts; researchers, educators; unions, and other stakeholders; OSHA professionals; and the National Institute for Occupational Safety and Health (NIOSH) contributed to these guidelines.

Also, several states have developed relevant standards or recommendations, such as the California OSHA (CAL/OSHA), *CAL/OSHA Guidelines for Workplace Security*, and *Guidelines for Security and Safety of Health Care and Community Service Workers*; the Joint Commission on Accreditation of Health Care Organizations, *1995 Accreditation Manuals for Hospitals*; Metropolitan Chicago Healthcare Council, *Guidelines for Dealing with Violence in Health Care*; New Jersey Public Employees Occupational Safety and Health (PEOSH), *Guidelines on Measures and Safeguards in Dealing with Violent or Aggressive Behavior in Public Sector Health Care Facilities*; and the State of Washington Department of Labor and Industries, *Violence in Washington Workplaces, and Study of Assaults on Staff in Washington State Psychiatric Hospitals*. Information is available from these and other agencies to assist employers.

## Introduction

For many years, health care and social service workers have faced a significant risk of job-related violence. Assaults represent a serious safety and health hazard for these industries, and violence against their employees continues to increase.

OSHA'S new violence prevention guidelines provide the agency's recommendations for reducing workplace violence developed following a careful review of workplace violence studies, public and private violence prevention programs, and consultations with and input from stakeholders. OSHA encourages employers to establish violence prevention programs and to track their progress in reducing work-related assaults. Although not every incident can be prevented, many can, and the severity of injuries sustained by employees reduced. Adopting practical measures such as those outlined here can significantly reduce this serious threat to worker safety.

### **OSHA'S Commitment**

The publication and distribution of these guidelines is OSHA'S first step in assisting health care and social service employers and providers in preventing workplace violence. OSHA plans to conduct a coordinated effort consisting of research, information, training, cooperative programs, and appropriate enforcement to accomplish this goal.

The guidelines are **not** a new standard or regulation. They are advisory in nature, informational in content, and intended for use by employers in providing a safe and healthful workplace through effective violence prevention programs, adapted to the needs and resources of each place of employment.

### **Extent of Problem**

Today, more assaults occur in the health care and social services industries than in any other. For example, Bureau of Labor Statistics (BLS) data for 1993 showed health care and social service workers having the highest incidence of assault injuries (BLS, 1993). Almost two-thirds of the nonfatal assaults occurred in nursing homes, hospitals, and establishments providing residential care and other social services (Toscano and Weber, 1995).

Assaults against workers in the health professions are not new. According to one study (Goodman et al., 1994), between 1980 and 1990, 106 occupational violence-related deaths occurred among the following health care workers: 27 pharmacists, 26 physicians, 18 registered nurses, 17 nurses' aides, and 18 health care workers in other occupational categories. Using the National Traumatic Occupational Fatality database, the study reported that between 1983 and 1989, there were 69 registered nurses killed at work. Homicide was the leading cause of traumatic occupational death among employees in nursing homes and personal care facilities.

A 1989 report (Cannel and Hunter) found that the nursing staff at a psychiatric hospital sustained 16 assaults per 100 employees per year. This rate, which includes any assault-related injuries, compares with 8.3 injuries of **all** types per 100 full-time workers in all industries and 14.2 per 100 full-time workers in the construction industry (BLS, 1991). Of 121 psychiatric hospital workers sustaining 134

injuries, 43 percent involved lost time from work with 13 percent of those injured missing more than 21 days from work.

Of greater concern is the likely underreporting of violence and a persistent perception within the health care industry that assaults are part of the job. Underreporting may reflect a lack of institutional reporting policies, employee beliefs that reporting will not benefit them, or employee fears that employers may deem assaults the result of employee negligence or poor job performance.

### **Risk Factors**

Health care and social service workers face an increased risk of work-related assaults stemming from several factors, including:

- The prevalence of handguns and other weapons—as high as 25 percent<sup>5</sup> — among patients, their families, or friends. The increasing use of hospitals by police and the criminal justice systems for criminal holds and the care of acutely disturbed, violent individuals.
- The increasing number of acute and chronically mentally ill patients now being released from hospitals without follow-up care, who now have the right to refuse medicine and who can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others.
- The availability of drugs or money at hospitals, clinics, and pharmacies, making them likely robbery targets.
- Situational and circumstantial factors such as unrestricted movement of the public in clinics and hospitals; the increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members; long waits in emergency or clinic areas, leading to client frustration over an inability to obtain needed services promptly.
- Low staffing levels during times of specific increased activity such as meal times, visiting times, and when staff are transporting patients.
- Isolated work with clients during examinations or treatment.
- Solo work, often in remote locations, particularly in high-crime settings, with no back-up or means of obtaining assistance such as communication devices or alarm systems.

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<sup>5</sup>According to a 1989 report (Wasserberger), 25 percent of major trauma patients treated in the emergency room carried weapons. Attacks in emergency rooms in gang-related shootings as well as planned escapes from police custody have been documented in hospitals. A 1991 report (Goetz et al.) also found that 17.3 percent of psychiatric patients searched were carrying weapons.

- Lack of training of staff in recognizing and managing escalating hostile and assaultive behavior.
- Poorly lighted parking areas.

## Overview of Guidelines

In January 1989, OSHA published voluntary, generic safety and health program management guidelines for all employers to use as a foundation for their safety and health programs, which can include a workplace violence prevention program.<sup>6</sup> OSHA'S violence prevention guidelines build on the 1989 generic guidelines by identifying common risk factors and describing some feasible solutions. Although not exhaustive, the new workplace violence guidelines include policy recommendations and practical corrective methods to help prevent and mitigate the effects of workplace violence.

The goal is to eliminate or reduce worker exposure to conditions that lead to death or injury from violence by implementing effective security devices and administrative work practices, among other control measures.

The guidelines cover a broad spectrum of workers who provide health care and social services in psychiatric facilities, hospital emergency departments, community mental health clinics, drug abuse treatment clinics, pharmacies, community care facilities, and long-term care facilities. They include physicians, registered nurses, pharmacists, nurse practitioners, physicians' assistants, nurses' aides, therapists, technicians, public health nurses, home health care workers, social/welfare workers, and emergency medical care personnel. Further, the guidelines may be useful in reducing risks for ancillary personnel such as maintenance, dietary, clerical, and security staff employed in the health care and social services industries.

## Violence Prevention Program Elements

There are four main components to any effective safety and health program that also apply to preventing workplace violence, (1) management commitment and employee involvement, (2) worksite analysis, (3) hazard prevention and control, and (4) safety and health training.

### Management Commitment and Employee Involvement

Management commitment and employee involvement are complementary and essential elements of an effective safety and health program. To ensure an effective program, management and front-line employees must work together, perhaps through a team or committee approach. If employers opt for this strategy, they must be careful to comply with the applicable provisions of the National Labor Relations Act.<sup>7</sup>

<sup>6</sup>OSHA's Safety and Health Program Management Guidelines (Fed Reg 54 (16):3904-3916, January 26, 1989), provide for comprehensive safety and health programs containing these major elements. Employers with such programs can include workplace violence prevention efforts in that context.

<sup>7</sup>Title 29 U.S.C., Section 158(a)(2).

Management commitment, including the endorsement and visible involvement of top management, provides the motivation and resources to deal effectively with workplace violence, and should include the following:

- Demonstrated organizational concern for employee emotional and physical safety and health.
- Equal commitment to worker safety and health and patient/client safety.
- Assigned responsibility for the various aspects of the workplace violence prevention program to ensure that all managers, supervisors, and employees understand their obligations.
- Appropriate allocation of authority and resources to all responsible parties.
- A system of accountability for involved managers, supervisors, and employees.
- A comprehensive program of medical and psychological counseling and debriefing for employees experiencing or witnessing assaults and other violent incidents.
- Commitment to support and implement appropriate recommendations from safety and health committees.

Employee involvement and feedback enable workers to develop and express their own commitment to safety and health and provide useful information to design, implement, and evaluate the program.

Employee involvement should include the following:

- Understanding and complying with the workplace violence prevention program and other safety and security measures.
- Participation in an employee complaint or suggestion procedure covering safety and security concerns.
- Prompt and accurate reporting of violent incidents.
- Participation on safety and health committees or teams that receive reports of violent incidents or security problems, make facility inspections, and respond with recommendations for corrective strategies.
- Taking part in a continuing education program that covers techniques to recognize escalating agitation, assaultive behavior, or criminal intent, and discusses appropriate responses.

## Written Program

A written program for job safety and security, incorporated into the organization's overall safety and health program, offers an effective approach for larger organizations. In smaller establishments, the program need not be written or heavily documented to be satisfactory. What is needed are clear goals and objectives to prevent workplace violence suitable for the size and complexity of the workplace operation and adaptable to specific situations in each establishment.

The prevention program and start-up date must be communicated to all employees. At a minimum, workplace violence prevention programs should do the following:

- Create and disseminate a clear policy of zero- tolerance for workplace violence, verbal and nonverbal threats, and related actions. Managers, supervisors, co-workers, clients, patients, and visitors must be advised of this policy.
- Ensure that no reprisals are taken against an employee who reports or experiences workplace violence.<sup>8</sup>
- Encourage employees to promptly report incidents and to suggest ways to reduce or eliminate risks. Require records of incidents to assess risk and to measure progress.
- Outline a comprehensive plan for maintaining security in the workplace, which includes establishing a liaison with law enforcement representatives and others who can help identify ways to prevent and mitigate workplace violence.
- Assign responsibility and authority for the program to individuals or teams with appropriate training and skills. The written plan should ensure that there are adequate resources available for this effort and that the team or responsible individuals develop expertise on workplace violence prevention in health care and social services.
- Affirm management commitment to a worker- supportive environment that places as much importance on employee safety and health as on serving the patient or client.
- Set up a company briefing as part of the initial effort to address such issues as preserving safety, supporting affected employees, and facilitating recovery.

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<sup>8</sup>Section 11 (c)(1) of the OSHA Act, which also applies to protected activity involving the hazard of workplace violence as it does for other health and safety matters: "No person shall discharge or in any manner discriminate against any employee because such employee has filed any complaint or instituted or caused to be instituted any proceeding under or related to this Act or has testified or is about to testify in any such proceeding or because of the exercise by such employee on behalf of himself or others of any right afforded by this Act."

## **Worksite Analysis**

Worksite analysis involves a step-by-step, common sense look at the workplace to find existing or potential hazards for workplace violence. This entails reviewing specific procedures or operations that contribute to hazards and specific locales where hazards may develop.

A “Threat Assessment Team,” “Patient Assault Team,” similar task force, or coordinator may assess the vulnerability to workplace violence and determine the appropriate preventive actions to be taken. Implementing the workplace violence prevention program then may be assigned to this group. The team should include representatives from senior management, operations, employee assistance, security, occupational safety and health, legal, and human resources staff.

The team or coordinator can review injury and illness records and workers’ compensation claims to identify patterns of assaults that could be prevented by workplace adaptation, procedural changes, or employee training. As the team or coordinator identifies appropriate controls, these should be instituted.

The recommended program for worksite analysis includes, but is not limited to, analyzing and tracking records, monitoring trends and analyzing incidents, screening surveys, and analyzing workplace security.

## **Records Analysis and Tracking**

This activity should include reviewing medical, safety, workers’ compensation and insurance records — including the OSHA 200 log, if required — to pinpoint instances of workplace violence. Scan unit logs and employee and police reports of incidents or near-incidents of assaultive behavior to identify and analyze trends in assaults relative to particular departments, units, job titles, unit activities, work stations, and/or time of day. Tabulate these data to target the frequency and severity of incidents to establish a baseline for measuring improvement.

## **Monitoring Trends and Analyzing Incidents**

Contacting similar local businesses, trade associations, and community and civic groups is one way to learn about their experiences with workplace violence and to help identify trends. Use several years of data, if possible, to trace trends of injuries and incidents of actual or potential workplace violence.

## **Screening Surveys**

One important screening tool is to give employees a questionnaire or survey to get their ideas on the potential for violent incidents and to identify or confirm the need for improved security measures. Detailed baseline screening surveys can help pinpoint tasks that put employees at risk. Periodic surveys — conducted at least annually or whenever operations change or incidents of workplace violence occur — help identify new or previously unnoticed risk factors and deficiencies or failures in work practices, procedures, or controls. Also, the surveys help assess the effects of changes in the work processes (see Appendix A for a sample survey used in the State of Washington). The periodic review process should also include feedback and follow-up.

Independent reviewers, such as safety and health professionals, law enforcement or security specialists, insurance safety auditors, and other qualified persons may offer advice to strengthen programs. These experts also can provide fresh perspectives to improve a violence prevention program.

### **Workplace Security Analysis**

The team or coordinator should periodically inspect the workplace and evaluate employee tasks to identify hazards, conditions, operations, and situations that could lead to violence. To find areas requiring further evaluation, the team or coordinator should do the following:

- Analyze incidents, including the characteristics of assailants and victims, an account of what happened before and during the incident, and the relevant details of the situation and its outcome. When possible, obtain police reports and recommendations.
- Identify jobs or locations with the greatest risk of violence as well as processes and procedures that put employees at risk of assault, including how often and when.
- Note high-risk factors such as types of clients or patients (e.g., psychiatric conditions or patients disoriented by drugs, alcohol, or stress); physical risk factors of the building; isolated locations/job activities; lighting problems; lack of phones and other communication devices, areas of easy, unsecured access; and areas with previous security problems. (See sample checklist for assessing hazards in Appendix B.)
- Evaluate the effectiveness of existing security measures, including engineering control measures. Determine if risk factors have been reduced or eliminated, and take appropriate action.

### **Hazard Prevention and Control**

After hazards of violence are identified through the systematic worksite analysis, the next step is to design measures through engineering or administrative and work practices to prevent or control these hazards. If violence does occur, post-incident response can be an important tool in preventing future incidents.

### **Engineering Controls and Workplace Adaptation**

Engineering controls, for example, remove the hazard from the workplace or create a barrier between the worker and the hazard. There are several measures that can effectively prevent or control workplace hazards, such as those actions presented in the following paragraphs. The selection of any measure, of course, should be based upon the hazards identified in the workplace security analysis of each facility.

- Assess any plans for new construction or physical changes to the facility or workplace to eliminate or reduce security hazards.

- Install and regularly maintain alarm systems and other security devices, panic buttons, hand-held alarms or noise devices, cellular phones, and private channel radios where risk is apparent or may be anticipated, and arrange for a reliable response system when an alarm is triggered.
- Provide metal detectors — installed or hand-held, where appropriate — to identify guns, knives, or other weapons, according to the recommendations of security consultants.
- Use a closed-circuit video recording for high-risk areas on a 24-hour basis. Public safety is a greater concern than privacy in these situations.
- Place curved mirrors at hallway intersections or concealed areas.
- Enclose nurses' stations, and install deep service counters or bullet-resistant, shatter-proof glass in reception areas, triage, admitting, or client service rooms.
- Provide employee "safe rooms" for use during emergencies.
- Establish "time-out" or seclusion areas with high ceilings without grids for patients acting out and establish separate rooms for criminal patients.
- Provide client or patient waiting rooms designed to maximize comfort and minimize stress.
- Ensure that counseling or patient care rooms have two exits.
- Limit access to staff counseling rooms and treatment rooms controlled by using locked doors.
- Arrange furniture to prevent entrapment of staff. In interview rooms or crisis treatment areas, furniture should be minimal, lightweight, without sharp corners or edges, and/or affixed to the floor. Limit the number of pictures, vases, ashtrays, or other items that can be used as weapons.
- Provide lockable and secure bathrooms for staff members separate from patient-client, and visitor facilities.
- Lock all unused doors to limit access, in accordance with local fire codes.
- Install bright, effective lighting indoors and outdoors.
- Replace burned-out lights, broken windows, and locks.
- Keep automobiles, if used in the field, well-maintained. Always lock automobiles.

## Administrative and Work Practice Controls

Administrative and work practice controls affect the way jobs or tasks are performed. The following examples illustrate how changes in work practices and administrative procedures can help prevent violent incidents.

- State clearly to patients, clients, and employees that violence is not permitted or tolerated.
- Establish liaison with local police and state prosecutors. Report all incidents of violence. Provide police with physical layouts of facilities to expedite investigations.
- Require employees to report all assaults or threats a supervisor or manager (e.g., can be confidential interview). Keep log books and reports of such incidents to help in determining any necessary actions to prevent further occurrences.
- Advise and assist employees, if needed, of company procedures for requesting police assistance or filing charges when assaulted.
- Provide management support during emergencies. Respond promptly to all complaints.
- Set up a trained response team to respond to emergencies.
- Use properly trained security officers, when necessary, to deal with aggressive behavior. Follow written security procedures.
- Ensure adequate and properly trained staff for restraining patients or clients.
- Provide sensitive and timely information to persons waiting in line or in waiting rooms. Adopt measures to decrease waiting time.
- Ensure adequate and qualified staff coverage at all times. Times of greatest risk occur during patient transfers, emergency responses, meal times, and at night. Locales with the greatest risk include admission units and crisis or acute care units. Other risks include admission of patients with a history of violent behavior or gang activity.
- Institute a sign-in procedure with passes for visitors, especially in a newborn nursery or pediatric department. Enforce visitor hours and procedures.
- Establish a list of “restricted visitors” for patients with a history of violence. Copies should be available at security checkpoints, nurses’ stations, and visitor sign-in areas. Review and revise visitor check systems, when necessary. Limit information given to outsiders on hospitalized victims of violence.

- Supervise the movement of psychiatric clients and patients throughout the facility.
- Control access to facilities other than waiting rooms, particularly drug storage or pharmacy areas.
- Prohibit employees from working alone in emergency areas or walk-in clinics, particularly at night or when assistance is unavailable. Employees should never enter seclusion rooms alone.
- Establish policies and procedures for secured areas, and emergency evacuations, and for monitoring high-risk patients at night (e.g., open versus locked seclusion).
- Ascertain the behavioral history of new and transferred patients to learn about any past violent or assaultive behaviors. Establish a system—such as chart tags, log books, or verbal census reports — to identify patients and clients with assaultive behavior problems, keeping in mind patient confidentiality and worker safety issues. Update as needed.
- Treat and/or interview aggressive or agitated clients in relatively open areas that still maintain privacy and confidentiality (e.g., rooms with removable partitions).
- Use case management conferences with co-workers and supervisors to discuss ways to effectively treat potentially violent patients.
- Prepare contingency plans to treat clients who are “acting out” or making verbal or physical attacks or threats. Consider using certified employee assistance professionals (CEAPs) or in-house social service or occupational health service staff to help diffuse patient or client anger.
- Transfer assaultive clients to “acute care units,” “criminal units,” or other more restrictive settings.
- Make sure that nurses and/or physicians are not alone when performing intimate physical examinations of patients.
- Discourage employees from wearing jewelry to help prevent possible strangulation in confrontational situations. Community workers should carry only required identification and money.
- Periodically survey the facility to remove tools or possessions left by visitors or maintenance staff which could be used inappropriately by patients.
- Provide staff with identification badges, preferably without last names, to readily verify employment.

- Discourage employees from carrying keys, pens, or other items that could be used as weapons.
- Provide staff members with security escorts to parking areas in evening or late hours. Parking areas should be highly visible, well-lighted, and safely accessible to the building.
- Use the “buddy system,” especially when personal safety may be threatened. Encourage home health care providers, social service workers, and others to avoid threatening situations. Staff should exercise extra care in elevators, stairwells and unfamiliar residences; immediately leave premises if there is a hazardous situation; or request police escort if needed.
- Develop policies and procedures covering home health care providers, such as contracts on how visits will be conducted, the presence of others in the home during the visits, and the refusal to provide services in a clearly hazardous situation.
- Establish a daily work plan for field staff to keep a designated contact person informed about workers’ whereabouts throughout the workday. If an employee does not report in, the contact person should follow-up.
- Conduct a comprehensive post-incident evaluation, including psychological as well as medical treatment, for employees who have been subjected to abusive behavior.

### **Post-Incident Response**

Post-incident response and evaluation are essential to an effective violence prevention program. All workplace violence programs should provide comprehensive treatment for victimized employees and employees who may be traumatized by witnessing a workplace violence incident. Injured staff should receive prompt treatment and psychological evaluation whenever an assault takes place, regardless of severity. (See sample hospital policy in Appendix C). Transportation of the injured to medical care should be provided if care is not available on-site.

Victims of workplace violence suffer a variety of consequences in addition to their actual physical injuries. These include short and long-term psychological trauma, fear of returning to work, changes in relationships with co-workers and family, feelings of incompetence, guilt, powerlessness, and fear of criticism by supervisors or managers. Consequently, a strong follow-up program for these employees will not only help them to deal with these problems but also to help prepare them to confront or prevent future incidents of violence (Flannery, 1991, 1993; 1995).

There are several types of assistance that can be incorporated into the post-incident response. For example, trauma-crisis counseling, critical incident stress debriefing, or employee assistance programs may be provided to assist victims. Certified employee assistance professionals, psychologists, psychiatrists, clinical nurse specialists, or social workers could provide this counseling, or the employer can refer staff

victims to an outside specialist. In addition, an employee counseling service, peer counseling, or support groups may be established.

In any case, counselors must be well trained and have a good understanding of the issues and consequences of assaults and other aggressive, violent behavior. Appropriate and promptly rendered post-incident debriefings and counseling reduce acute psychological trauma and general stress levels among victims and witnesses. In addition, such counseling educates staff about workplace violence and positively influences workplace and organizational cultural norms to reduce trauma associated with future incidents.

## Training and Education

Training and education ensure that all staff are aware of potential security hazards and how to protect themselves and their co-workers through established policies and procedures.

### **All Employees**

Every employee should understand the concept of “universal Precautions for Violence,” i.e., that violence should be expected but can be avoided or mitigated through preparation. Staff should be instructed to limit physical interventions in workplace altercations whenever possible, unless there are adequate numbers of staff or emergency response teams and security personnel available. Frequent training also can improve the likelihood of avoiding assault (Carnel and Hunter, 1990).

Employees who may face safety and security hazards should receive formal instruction on the specific hazards associated with the unit or job and facility. This includes information on the types of injuries or problems identified in the facility and the methods to control the specific hazards.

The training program should involve all employees, including supervisors and managers. New and reassigned employees should receive an initial orientation prior to being assigned their job duties. Visiting staff, such as physicians, should receive the same training as permanent staff. Qualified trainers should instruct at the comprehension level appropriate for the staff. Effective training programs should involve role playing, simulations, and drills.

Topics may include Management of Assaultive Behavior Professional Assault Response Training; police assault avoidance programs, or personal safety training such as awareness, avoidance, and how to prevent assaults. A combination of training maybe used depending on the severity of the risk.

Required training should be provided to employees annually. In large institutions, refresher programs may be needed more frequently (monthly or quarterly) to effectively reach and inform all employees.

The training should cover topics such as the following:

- The workplace violence prevention policy.
- Risk factors that cause or contribute to assaults.
- Early recognition of escalating behavior or recognition of warning signs or situations that may lead to assaults.
- Ways of preventing or diffusing volatile situations or aggressive behavior, managing anger, and appropriately using medications as chemical restraints.
- Information on multicultural diversity to develop sensitivity to racial and ethnic issues and differences.
- A standard response action plan for violent situations, including availability of assistance, response to alarm systems, and communication procedures.
- How to deal with hostile persons other than patients and clients, such as relatives and visitors.
- Progressive behavior control methods and safe methods of restraint application or escape.
- The location and operation of safety devices such as alarms systems, along with the required maintenance schedules and procedures.
- Ways to protect oneself and coworkers, including use of the “buddy system.”
- Policies and procedures for reporting and recordkeeping.
- Policies and procedures for obtaining medical care, counseling, workers’ compensation, or legal assistance after a violent episode or injury.

### **Supervisors, Managers, and Security Personnel**

Supervisors and managers should ensure that employees are not placed in assignments that compromise safety and should encourage employees to report incidents. Employees and supervisors should be trained to behave compassionately towards coworkers when an incident occurs.

They should learn how to reduce security hazards and ensure that employees receive appropriate training. Following training, supervisors and managers should be able to recognize a potentially hazardous situation and to make any necessary changes in the physical plant, patient care treatment program, and staffing policy and procedures to reduce or eliminate the hazards.

Security personnel need specific training from the hospital or clinic, including the psychological

components of handling aggressive and abusive clients, types of disorders, and ways to handle aggression and defuse hostile situations.

The training program should also include an evaluation. The content, methods, and frequency of training should be reviewed and evaluated annually by the team or coordinator responsible for implementation. Program evaluation may involve supervisor and/or employee interviews, testing and observing, and/or reviewing reports of behavior of individuals in threatening situations.

## Recordkeeping and Evaluation of the Program

Recordkeeping and evaluation of the violence prevention program are necessary to determine overall effectiveness and identify any deficiencies or changes that should be made.

### Recordkeeping

Recordkeeping is essential to the success of a workplace violence prevention program. Good records help employers determine the severity of the problem, evaluate methods of hazard control, and identify training needs. Records can be especially useful to large organizations and for members of a business group or trade association who “pool” data. Records of injuries, illnesses, accidents, assaults, hazards, corrective actions, patient histories, and training, among others, can help identify problems and solutions for an effective program.

The following records are important:

- OSHA Log of Injury and Illness (OSHA 200). OSHA regulations require entry on the Injury and Illness Log of any injury that requires more than first aid, is a lost-time injury, requires modified duty, or causes loss of consciousness.<sup>9</sup> (This applies only to establishments required to keep OSHA logs.) Injuries caused by assaults, which are otherwise recordable, also must be entered on the log. A fatality or catastrophe that results in the hospitalization of 3 or more employees must be reported to OSHA within 8 hours. This includes those resulting from workplace violence and applies to all establishments.
- Medical reports of work injury and supervisors’ reports for each recorded assault should be kept. These records should describe the type of assault, i.e., unprovoked sudden attack or patient-to-patient altercation; who was assaulted; and all other circumstances of the incident. The records should include a description of the environment or location, potential or actual cost, lost time, and the nature of injuries sustained.

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<sup>9</sup>The Occupational Safety and Health Act and recordkeeping regulations in Title 29 Code of Federal Regulations (CFR), Part 1904 provide specific recording requirements that comprise the framework of the occupational safety and health recording system (BLS, 1986a). BLS has issued guidelines that provide official Agency interpretations concerning the recordkeeping and reporting of occupational injuries and illnesses (BLS, 1986B).

- Incidents of abuse, verbal attacks or aggressive behavior-which may be threatening to the worker but do not result in injury, such as pushing or shouting and acts of aggression towards other clients-should be recorded, perhaps as part of an assaultive incident report. These reports should be evaluated routinely by the affected department. (See sample incident forms in Appendix D ).
- Information on patients with a history of past violence, drug abuse, or criminal activity should be recorded on the patient's chart. All staff who care for a potentially aggressive, abusive, or violent client should be aware of their background and history. Admission of violent clients should be logged to help determine potential risks.
- Minutes of safety meetings, records of hazard analyses, and corrective actions recommended and taken should be documented.
- Records of all training programs, attendees, and qualifications of trainers should be maintained.

## Evaluation

As part of their overall program, employers should evaluate their safety and security measures. Top management should review the program regularly, and with each incident, to evaluate program success. Responsible parties (managers, supervisors, and employees) should collectively reevaluate policies and procedures on a regular basis. Deficiencies should be identified and corrective action taken.

An evaluation program should involve the following:

- Establishing a uniform violence reporting system and regular review of reports.
- Reviewing reports and minutes from staff meetings on safety and security issues.
- Analyzing trends and rates in illness/injury or fatalities caused by violence relative to initial or "baseline" rates.
- Measuring improvement based on lowering the frequency and severity of workplace violence.
- Keeping up-to-date records of administrative and work practice changes to prevent workplace violence to evaluate their effectiveness.
- Surveying employees before and after making job or worksite changes or installing security measures or new systems to determine their effectiveness.
- Keeping abreast of new strategies available to deal with violence in the health care and social service fields as these develop.

- Surveying employees who experience hostile situations about the medical treatment they received initially and, again, several weeks afterward, and then several months later.
- Complying with OSHA and state requirements for recording and reporting deaths, injuries, and illnesses.
- Requesting periodic law enforcement or outside consultant review of the worksite for recommendations on improving employee safety.

Management should share workplace violence prevention program evaluation reports with all employees. Any changes in the program should be discussed at regular meetings of the safety committee, union representatives, or other employee groups.

### **Sources of Assistance**

Employers who would like assistance in implementing an appropriate workplace violence prevention program can turn to the OSHA Consultation service provided in their state. Primarily targeted at smaller companies, the consultation service is provided at no charge to the employer and is independent of OSHA'S enforcement activity. (See Appendix E.)

OSHA'S efforts to assist employers combat workplace violence are complemented by those of NIOSH (1-800-35 -NIOSH) and public safety officials, trade associations, unions, insurers, human resource, and employee assistance professionals as well as other interested groups. Employers and employees may contact these groups for additional advice and information.

The Occupational Safety and Health Act and recordkeeping regulations in Title 29 Code of Federal Regulations (CFR), Part 1904 provide specific recording requirements that comprise the framework of the occupational safety and health recording system (BLS, 1986a). BLS has issued guidelines that provide official Agency interpretations concerning the recordkeeping and reporting of occupational injuries and illnesses (BLS, 1986b).

### **Conclusion**

OSHA recognizes the importance of effective safety and health program management in providing safe and healthful workplaces. In fact, OSHA'S consultation services help employers establish and maintain safe and healthful workplaces, and the agency's Voluntary Protection Programs were specifically established to recognize worksites with exemplary safety and health programs. (See Appendix E.) Effective safety and health programs are known to improve both morale and productivity and reduce workers' compensation costs.

OSHA'S violence prevention guidelines are an essential component to workplace safety and health programs. OSHA believes that the performance-oriented approach of the guidelines provides employers with flexibility in their efforts to maintain safe and healthful working conditions.

## Appendix C

### Sample Documents

## AGREEMENT OF TREATMENT EXPECTATIONS

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This is an agreement between two parties: the dialysis facility and the dialysis patient.

The purpose of this document is a positive one. It attempts to make clear the rights and responsibilities of both parties. It says *who* is to do *what*.

You may think it is unusual, and perhaps unnecessary, to have such an agreement, but an agreement between a dialysis facility and a patient is really no different than any other agreement for services.

We promise to treat your kidney failure to the best of our abilities, consistent with the standards of care in our community. You, in turn promise to be as understanding, cooperative, and responsible as possible.

This agreement can be used as a checklist for both parties to review from time to time, to see whether or not we both are doing what we said we would do.

Read this document carefully before you sign it. If there is something you do not agree with, talk it over with a member of the treatment team.

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I have read (or have had read to me) the “Agreement of Treatment Expectations” and fully understand its contents. I have been given an opportunity to ask questions.

Patient/Responsible Party: \_\_\_\_\_

If not Patient, Relationship to Patient: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Dialysis Facility Witness/Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

## Facility Responsibilities

We recognize that we have the responsibility to provide you with dialysis treatments that meet state and federal regulations and conform to the current dialysis-medical standards of care. Therefore, we will:

- Provide dialysis therapy in keeping with current dialysis guidelines and standards.
- Provide doctors, nurses, social workers, dietitians, and technicians who are trained, licensed, or certified in their professions to help in meeting your needs and monitor your quality of care.
- Assure that facility staff will respond to any problems that may occur during your treatments.
- Inspect, maintain and properly use the dialysis equipment to assure safe and efficient dialysis treatments.
- Practice universal precautions and other policies/procedures to prevent or control infections, and maintain a safe and sanitary environment.
- Participate in quality improvement activities and programs to ensure safe and quality care to all patients.

To educate you, your family members, or significant others about kidney disease and treatment options. Therefore, we will:

- Provide you with information about your kidney disease, its treatment and treatment options.
- Invite and encourage you to participate in all decisions involving both your short and long term plans of care.
- Provide you with information about infections and how to control or prevent them.
- Provide you with information about proposed procedures, treatment options, and their risks and benefits so that you may make an informed decision about these treatment options.
- Inform and educate you about the facility and our policies and procedures.

To encourage you to achieve the best quality of life possible considering your kidney disease.  
We will:

- Provide social work and nutrition counseling services appropriate for your needs.
- Inform you of where you can obtain services that we are unable to provide and to assist you, when possible, in obtaining those services.
- Assist you in developing a diet tailored to your medical and nutritional needs, lifestyle, culture, food preferences and budget.
- Assist you with adjusting psychologically and emotionally to dialysis, seeking rehabilitation options and locating financial resources.
- Assist you with arrangements for treatments at another dialysis facility when you are planning to travel.
- Provide educational opportunities regarding treatment options, diet, exercise, and other life enhancing practices.
- Inform you about outside interests or programs for kidney patients.

To provide a treatment environment that is safe for both patients and staff. We will:

- Respond to situation where visitors, family members, other patients, or staff members exhibit behavior deemed by the facility personnel to be hazardous to the safety and well being of everyone in the facility. This may include contacting the appropriate law enforcement authorities.
- Provide you with information about what to do in event of a disaster or emergency and you are unable to receive or continue your usual dialysis treatments
- Inform you about dialyzer reuse process, if applicable, how it's performed, potential complications, and benefits.

To treat you with respect, consideration, and dignity. We will:

- Introduce ourselves to you, and explain our responsibilities and duties.
- Attempt to get you on and off the dialysis machine within 15 minutes of your scheduled time. If we are unable to do so, we will provide an explanation.
- Assist you with trying to solve any problem(s) related to your treatment that you or your family bring to our attention.

- Maintain confidentiality of your communications and medical records.
- Provide a mechanism for you and other patients to communicate with each other, staff and management.
- Explain and post the facility's grievance procedure and identify other agencies that you can contact about problems if you prefer to do so.
- Ensure that no one will retaliate against you if you choose to file a grievance.
- Ensure that no staff member discriminate against you because of age, race, sex, medical disease or physical disability.
- Provide you with information about Medical Advance Directives and your right to make choices about continuing your dialysis treatments.
- Inform you about major changes in our facility management, policies and procedures as they relate to your treatment and care.
- Promptly transfer your records if and when you transfer to another dialysis facility.
- Make reasonable attempts to schedule your dialysis treatments and follow-up visits to meet your needs, as our scheduling demands allow.

### **Patient Responsibilities**

I understand and agree that it is important that I participate in the decisions about my health, treatment and care options. Therefore, I will:

- Learn about my kidney disease and its treatment.
- Provide accurate information about my medical and social history.
- Participate in the development of my dialysis care plan and follow the plan.
- Learn and understand laboratory test results and their relationship to my treatments and health.
- Notify my doctor or nurse of any changes in my health condition and status.
- Follow infection control procedures, both for myself and my visitors in the unit and at home.
- Comply with all my physicians' requests for office visits and referrals.

- Participate in activities or efforts leading to rehabilitation.
- Acknowledge that it is my responsibility to arrange for my own transportation and that assistance from the facility staff is available to help coordinate pick up and arrival times. I understand that neither the dialysis facility nor its staff members shall be responsible for providing transportation for me.
- Acknowledge and assume responsibility for any illness or injury that I sustain for failure to follow the recommendations of my doctor and staff members.
- Acknowledge that my failure to comply with my treatment times and schedule, medications diet and fluid restrictions, and other physician's orders may result in declining health, hospitalization and possibly in my death.

I agree to be knowledgeable regarding the facilities policies and procedures and follow them. Therefore, I will:

- Arrive on time for my scheduled treatment and remain on dialysis for the treatment time prescribed.
- Inform the facility if I am going to be late, or need to be rescheduled, with the understanding that being late, I may not receive my full treatment.
- Arrive free of the influence of illegal drugs, alcohol and without a weapon. I also agree to refrain from having them in my possession or using them while I am on the premises of this facility.
- Refrain from operating my dialysis equipment, removing or manipulating my needles unless I have been trained and have permission to do so.
- Cooperate with the staff member assigned to provide care to me. I understand that I cannot require specific staff members to care for me. If I'm uncomfortable with a specific staff member assigned to my care, I will make the clinic manager aware of my concern(s).
- Apply for Medicare, Medi-cal or other insurance programs when appropriate and to maintain coverage to the best of my ability.
- Inform the facility about personal changes such as address, phone number, marital status.
- Agree to bring my medications into the facility for review when requested to do so.

I agree to respect the rights of other patients and staff members. Therefore, I will:

- Treat other patients and staff members with respect, dignity and consideration.
- Respect the rights of other patients to have a safe, clean, calm, adequate treatment and treatment environment.
- Assure that my activities or my visitor's activities do not interfere with facility operations.
- Use the facility's grievance procedure to voice concerns or complaints.
- Agree to observe the law and understand that the consequences for breaking the law apply to my conduct inside and outside the facility.
- Refrain from any form of verbal abuse, physical abuse, or sexual harassment of other patients, staff or visitors.

If applicable, as *a self-care home patient*, I will:

- Be responsible for ordering and having adequate supplies for my treatment needs.
- Make and keep appointments with my treatment facility on a regular basis as required.
- Follow treatment plans.
- Carry out procedures within the rules established during training and not alter steps of procedures without first consulting with the physician or nurse.

## Letter Terminating Physician-Patient Relationship

Date

Name

Address

City, State, Zip Code

Dear **(Patient Name)**:

We have now had several conversations regarding your failure to comply with recommended medical treatment, and/or **(list the negative behaviors and/or actions)**. Your refusal to comply with my and the **(dialysis facility)** requests prevents me from helping you to achieve the quality of life that I believe you and every other patient deserves.

Your continued refusal to follow the treatment prescription and recommendations has made it difficult for me to continue our professional relationship. I cannot continue to assume responsibility for your care under such circumstances. Therefore, I am advising you of my decision to withdraw as your physician, effective **(day patient was notified of decision)**. Our physician/patient relationship will end thirty (30) days from this date **(last day of relationship)**. I have enclosed a list of physicians in the area. It is your responsibility to contact them and ask them to be accepted as a patient. **(name of your facility)** will be available to assist you by providing copies of your records to your new physician and dialysis facility.

You should understand that when I withdraw as your physician **(name of dialysis facility)** may no longer be legally able to provide dialysis service to you. I cannot stress enough the importance of making energetic attempts to find another physician and facility.

If the dialysis facility or I can be of any further assistance, please do not hesitate to contact either one of us. We wish you well and hope that you will be happy with your new physician and facility.

Sincerely,

**(Physician Signature)**

Cc: Medical Director  
Area Director (if corporate)  
ESRD Network 18

**Company or Facility Mission Statement**

## Letter Terminating Facility-Patient Relationship

Date

Address

City, State, Zip Code

RE:

Dear **(Patient Name)**:

The purpose of this letter is to inform you that you will no longer be able to receive **(hemodialysis or peritoneal dialysis)** services at **(name of your dialysis facility)**, effective thirty (30) days from the date of this letter. Your last treatment date will be **(date of last treatment)**.

This letter is the last step of a process that began on **(date when interventions were initiated)**. An agreement/contract was made at the time (copy attached) which required that you **(refrain or comply)** **(from/with)** the following **(list behaviors and/or actions)**. Over the past **(specify time period in question)** you have continued these unacceptable behaviors.

You have not complied with the requests given to you in the contract regarding your behavior/actions. The patient-health care provider relationship is one that must be based upon trust, understanding and mutual respect. If these elements are absent, it is very difficult to provide the type of care that you and every other patient deserve. Your continued behavior puts the safety and well being of the other patients at risk.

Therefore, **(name of facility)** has no choice but to end our relationship. Attached you will find a list of dialysis facilities where you might seek treatment. Your medical records will be transferred promptly at your request. If you are unable to transfer to another facility or become ill, please seek care at a local hospital emergency room.

The Southern California Renal disease Council, ESRD Network 18, has been informed of our decision and a copy of this letter has been faxed to them. You may contact them at any time at (800) 637-4767 or (323) 962-2020.

Sincerely,

**(Facility Administrator/Center Director Signature)**

Cc: Area Director (if corporate)  
ESRD Network 18

**Company or Facility Mission Statement**

## Contract Cover Letter Regarding the Disruptive/Abusive Patient

Date

Address

City, State, Zip Code

Dear (Ms. Doe):

As you know, there are a number of concerns regarding your continued care and outpatient treatment administered by the medical and nursing staff of (facility name).

In the past, you have been counseled regarding your behavior directed at staff members. There is a history of problems at (facility name). We are willing to continue to provide dialysis treatments if an agreement can be reached to insure that there will be no additional behavioral problems.

(Ms. Doe), it is our mission and desire to provide medical assistance to our patient in a professional manner. We understand that it is difficult to experience the types of problems you must face each day. We want to assist you, but we can only do as much for you as you will allow us to do. It is important to convey your complaints and concerns to us, but in an appropriate way.

The patient-physician-health care provider relationship is one that must be based upon trust, understanding and mutual respect. If these elements are absent, it is very difficult to provide the type of care that you and every other patient deserve. You can expect us to provide dialysis treatments delivered by qualified personnel in a safe environment.

We feel that if we are to continue providing services to you there must be an understanding of the terms and conditions for doing so. We have created a Patient Behavioral Contract so there will be a clear understanding of what we expect from you and what you may expect from us. You should also clearly understand that if the conditions of the agreement are not met, you will be given a 30 day notice of intent to terminate dialysis services with a list of other dialysis clinics and physicians (if necessary). Your administrator and nurse manager are presenting this letter to you. You have the opportunity to review both the letter and the contract, and to ask questions. We are looking forward to establishing a new relationship with you and we are confident that this can be done.

Please return the original with your signature. We will provide you with a copy for your records. Failure to agree to the provisions of this contract will result in a 30 day notice of intent to terminate dialysis services effective the date of this letter.

Sincerely,

MD, Medical Director

## Contract for Continued Provision of Dialysis Services

When to use this document: Use this document as a contract for patients who have been counseled about their disruptive and non-compliant behavior, but continue their unacceptable behavior. The following terms are meant as examples only. They will not be applicable to all patients. Please add terms that are applicable and delete those which are not.

I have been advised that due to my continued disruptive and non-compliant behavior, it may become necessary for my physician and this dialysis facility to end their relationship with me. The purpose of this agreement is to outline what will be expected of me so that this action will not have to be taken.

I, \_\_\_\_\_, agree to the following terms and conditions of and for treatment by my doctor(s), \_\_\_\_\_ M.D., and \_\_\_\_\_ (facility name).

1. I agree to be compliant in terms of my dialysis treatments, including being on time for treatments, sitting in my assigned seat, coming on the scheduled days, taking medications as prescribed by my doctor(s), and following other prescribed treatments. This includes, but is not limited to, the following:  
\_\_\_\_\_  
\_\_\_\_\_
2. I agree to refrain from, pulling, or threatening to pull, my dialysis needles from my access. (if applicable)
3. I agree to wear gloves while holding my needle sites after the dialysis staff has removed my needles. (if applicable)
4. I understand that this dialysis facility will not tolerate violence or the threat of violence of any kind. Therefore, I will refrain from attempting or threatening to kick, hit, or otherwise harm any staff member, patient, or visitors to this facility.
5. I will refrain from yelling or using profanity when addressing any staff member, patient or visitor to this facility. (if applicable)
6. I agree to express any concerns, complaints, questions, or issues that I may have regarding my treatment or care only to the proper person(s), as follows:  
\_\_\_\_\_ M.D., \_\_\_\_\_ M.D.,  
\_\_\_\_\_ Nurse Manager or \_\_\_\_\_ Administrator.

7. I understand that expressing my concerns to other patients and/or criticizing staff members in front of other patients is counterproductive and disruptive to the facility. I therefore will direct my remarks to the above noted persons.
8. I can expect that my complaints or concerns expressed to the above noted parties will be heard and investigated. All proper steps, if needed, will be taken promptly to address the situation, I can expect to receive a response from these persons or their representatives regarding their findings and the steps taken (if any) to correct any problems.
9. I understand that the staff members are professionals and I agree to relate to them as professionals. I likewise can expect to be treated in a professional manner by these individuals. If I have an issue with a staff member, I understand that I have the right to express my concerns to that individual. However, I do agree to do so in an appropriate place. I can expect to receive the same courtesy.
10. I also understand that the provision of care by the doctors and this dialysis facility is based upon my meeting the above conditions. If I violate any of the conditions, my relationship with the doctors and this facility may be terminated. If this becomes necessary, I may be given 30 days written notice of termination of services and a list of other dialysis facilities and physicians. It will then be necessary for me to arrange for treatment by other physicians at another dialysis facility.
11. I have had the opportunity to read this contract, to make comments, and to ask questions. I understand fully the consequences of failing to abide by the terms and conditions of my continued relationship with doctors and this facility.

\_\_\_\_\_  
Patient/Patient Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date