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Review of Confidential Consultation Report Prepared for Bergen Regional Medical Center by Joint Commission Resources, June – August 2013

Executive Summary

Joint Commission Resources (JCR) was hired to evaluate the Workplace Violence Prevention Program at Bergen Regional Medical Center (BRMC) as a result of an Occupational Safety and Health (OSHA) violation and widespread concern from employees, union representatives, and the community at large. Workplace violence in healthcare facilities is a recognized hazard that has caused death and serious harm to employees and patients as documented in the JCR report. In contrast to the presentation made on September 8, 2016, the JCR report outlines almost 50 specific recommendations for action in a matrix entitled Appendix A, B, and C. The recommendations include major deficiencies in the BRMC Workplace Violence Prevention Program. These include several violations of the New Jersey workplace violence law.[1]

The gaps listed within the JCR report's appendices include inadequate risk assessments; a weak process for conducting root cause analysis of incidents; and no evidence that site specific analyses have been conducted for staff who work with potentially violent people. Unfortunately, the report does not group the recommendations or provide any guidance on how to proceed in prioritizing the deficiencies for action.

Furthermore, the JCR report failed to evaluate and summarize the severity of the workplace violence experience at BRMC. Typically, this is done by evaluating injury and workers' compensation data as well as looking at use of restraint and seclusion, overtime, incident reports, and in the absence of data, conducting staff surveys to capture a picture of the extent of the problem. In addition, while staff receive some training upon hiring and annually thereafter, it is far less than is provided at best practice institutions.

This analysis of the report first addresses a critical omission in the JCR report, the need to use Joint Commission standards as a benchmark. Secondly, we list and explain the deficiencies that JCR found in the BRMC Workplace Violence Prevention Program.

[1] N.J.A.C.8:43E-11, Violence Prevention in Healthcare Facilities

Finally, we then list other omissions in the JCR report, including review of important data sources and a list of steps to take to address the creation of an effective workplace violence prevention program at BRMC.
It is critical that the Bergen County Improvement Authority (BCIA) ensure that BRMC work with the union representatives and other stakeholders to ensure that a process is established to address these deficiencies and that these problems are addressed with the urgency with which they deserve.

Benchmarks

JCR evaluated the BRMC Workplace Violence Prevention Policy using the New Jersey law, guidance from ECRI Institute, and the OSHA *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*. The benchmarks should have included relevant Joint Commission standards, as well as best practices. Joint Commission standards are listed below. OSHA and New Jersey law are minimum requirements and do not necessarily reflect "best practices." For example, with almost 50 recommendations to act upon, meeting quarterly is not sufficient to resolve the problems in a timely basis. However, the New Jersey law calls for a minimum of quarterly meetings.

Joint Commission Standards:

EC.02.01.01, EP 1 The hospital manages safety and security risks. The hospital identifies safety and security risks associated with the environment of care that could affect patients, staff, and other people coming into the hospital's facilities.

EC.02.01.01, EP 3 The hospital takes action to minimize or eliminate identified safety and security risks.

LD 02.04.01 The hospital manages conflict between leadership groups to protect the quality and safety of care.

LD.03.01.01 Leaders create and maintain a culture of safety and quality throughout the hospital.

LD.03.01.01, EP 3 Leaders provide opportunities for all to participate in safety and quality initiatives.

LD.03.06.01, EP 3 Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services.

LD.04.04.05, EP 6 The leaders provide and encourage the use of systems for blame-free internal reporting.

APR.09.04.01 "The hospital provides care, treatment, services, and an environment that poses no risk of an 'Immediate Threat to Health or Safety'

Joint Commission Resources Findings

The Lack of an Effective Workplace Violence Prevention Committee

The absence of an effective workplace violence committee that affords genuine worker involvement in the development, implementation, and evaluation of a program is a significant gap between the New Jersey law and BRMC's Workplace Violence Prevention Program. This is key because it establishes the process in which risks are identified and then corrected.

The New Jersey law requires a joint labor-management workplace violence committee to be established under N.J.A.C. 8:43E-11.4. BRMC management has implemented a joint labor-management workplace violence prevention committee, holding quarterly meetings open to all staff. This process has excluded the unions from participating in the duties of the committee in a meaningful way. Involving the union leadership is required under the New Jersey law, recommended by OSHA, and also the JC Leadership standards. [2] This has stifled effective risk assessment, program implementation, and decision making, while giving the illusion that workers have input into the workplace violence prevention program. [3]

At BRMC, John Regina, Director of Human Services, oversees the committee and Marja Alexandre, a nurse educator, was appointed by management to chair it. This is a violation of the New Jersey law that requires the chair to be selected by the Committee members.[4] Furthermore, having personnel from clinical leadership on the Committee is essential to addressing clinical risk factors such as patient treatment plans, programming, staffing, and acuity.

The minimum duties of the committee are explicitly stated within the law. The violence prevention committee shall complete an annual violence risk assessment to analyze risk

[2] N.J.A.C. 8:43E-11.4 (e) requires the administration to consult with the one or more collective bargaining agents regarding the selection of the healthcare worker committee members.
[3] Given that there is no standing committee, it is unclear who was interviewed as committee representatives.
[4] N.J.A.C 8:43E-11.4(c) The workplace violence committee shall select a chairperson from among its members.

factors for workplace violence and to identify patterns of violence. They do this by analyzing incident reports and aggregated data, by conducting site inspections and job task analyses. They must develop a written workplace violence prevention plan and submit it to facility administration. The prevention plan should outline policies, procedures, and responsibilities and must be updated annually. These duties cannot be accomplished by people who occasionally attend a quarterly open meeting.

The committee is responsible for providing recommendations to the facility for methods to reduce identified risks based on findings of the violence risk assessment. They must review the design and layout of the facility to ensure safe, secure work areas and to prevent entrapment of workers. This work requires commitment and dedication by a designated committee, not an ad hoc collection of people at an open meeting.

The training program also falls under the jurisdiction of the workplace violence prevention committee. They must develop, review annually, evaluate, and revise the training content and methods. In addition, they work on strategies to encourage staff to report all incidents of workplace violence and develop the procedures for reporting incidents. The JCR report notes that the BRMC plan omits having the workplace violence prevention committee review the plan annually.[5]

Lastly, the committee reviews incident investigation reports in order to identify trends and make recommendations to prevent similar incidents. This is currently being done by a subcommittee of the Workplace Violence Prevention Committee that meets weekly. This arrangement meets the requirements of the New Jersey law. However, the report repeatedly notes that the Workplace Violence Plan lacks a rigorous process for root cause analysis of workplace violence incidents, resulting in inadequate analysis of incidents.

The Workplace Violence Prevention Plan

The JCR report recommends that BRMC consolidate various written policies into one plan. Most of the policies are contained within two documents, the Workplace Violence Prevention Policy HR-41 and the BRMC Workplace Violence Prevention Plan. There are another seven related policies that should also be integrated into the workplace violence prevention program.[6] Having multiple policies and procedures that are duplicative or contradictory is not only inefficient, but ineffective.

[5] Joint Commission Resources Consulting, *Confidential Consultation Report Prepared for Bergen Regional Medical Center*, Appendix A, Item 14.
[6] Ibid, Appendix A, Item 21.

Written Procedures

The JCR report identifies BRMC failing to provide written procedures to implement key components of the Workplace Violence Prevention Plan including recordkeeping, incident reporting, incident investigation, risk evaluation methods, and a post-incident response system.[7] These are significant omissions that impede a systematic program to reduce the incidence of workplace violence.

The JCR report recommends developing formal processes for conducting root cause analysis and risk assessments. Root cause analysis is a step-by-step process for looking at all the immediate and underlying causes of an incident in order to identify realistic solutions to those problems. Risk assessments require systematic analysis of quantitative data, incident reports, inspection of the work-site, and staff and patient interviews.

Risk Analysis/Hazard Assessment

JCR also documented BRMC's failure to conduct job task analyses.[8] The New Jersey law requires the committee conduct job task analyses for staff who work with potentially violent persons in order to identify ways to reduce risk. Examples of risk assessment include examining the prevalence of weapons among patients and visitors, staff working in isolation, lack of training, the impact of staffing, and the appropriate number of security guards. The lack of effective risk assessment is a critical omission as preventive measures are implemented based on identified risks.

Post-Incident Response

While JCR noted that workers knew how to report workplace violence incidents, a gap was identified in the need for building "leadership and administrative support into the post-incident review process." Management's follow-up actions to analyze and respond to the incidents are lacking or at least unclear.

JCR recommended streamlining and standardizing the incident reporting form. Workers identified that "near misses" are no longer being captured, a critical gap in the current reporting form. Lastly, several staff reported a lack of organizational support following an incident. The JCR recommended developing a more robust program for providing emotional support to victims and witnesses, such as an in-house response team. Such a program is required under N.J.A.C. 8:43E-11.13.

[7] Ibid, Appendix A, Items 22-24, 85.
[8] Ibid, Appendix A, Item 31.

Physical Plant Risk Assessment

The JCR report documents several issues that need to be addressed to improve the safety of the environment.[9] For example, in the Emergency Department there is a need for a comprehensive risk assessment and the report listed nine specific safety risks that have not been addressed, including a lack of security cameras. The report questions the sufficiency of security staffing in the Emergency Department, noting that the medical side and the waiting room are at risk when security is called to the behavioral health side. Other issues throughout the facility include inconsistency in the placement of working security cameras and panic buttons. HPAE members report that the basement and the loading dock are not secured and that outsiders use those points to get in.

Site inspections should be conducted routinely in a clear and systematic way to identify risk factors in the physical environment. A checklist should be established with a procedure to ensure that corrective actions are taken on a timely basis and a responsible person is held accountable for follow up.

Staffing

The JCR did not focus on safe staffing, even though interviewed staff provided input that inadequate staffing is a problem. Staff have reported that they are unable to get assistance based on patient acuity when more staff are needed. BRMC has laid off most certified recreational and occupational therapists, resulting in nursing staff having to coordinate these activities on top of their nursing duties. The lack of activities results in boredom and conflict among patients and residents, potentially leading to violence.

The JCR recommends that staffing should be reviewed using established metrics. The New Jersey law requires that the written workplace violence plan identify methods to reduce identified risks, including inadequate staffing.[10] Assessing staffing levels is also recommended in the Joint Commission standards and by OSHA and ECRI Institute.[11], [12], [13]

The JCR report documents that security guards are posted in the main entrance, Emergency Department, and Long-Term Care, but not in the Behavioral Health Unit,

[9] Ibid, p. 5.
[10] N.J.A.C. 8:43E-11.6 (d)
[11] *Confidential Consultation Report Prepared for Bergen Regional Medical Center, Joint Commission Resources Consulting*, 2016, Appendix B, Item 14.
[12] *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers*, U.S. Department of Labor, 2015.
[13] LD.03.06.01, EP 3

which includes the Detoxification areas. Security guards make rounds in Behavioral Health, but they are not posted in this high-risk area.[14]

Training

The JCR's staff interviews revealed the need for additional and higher quality training. Staff reported that training scenarios do not always reflect their actual workplace risks for violence. Some staff have by-passed the computer-based training. The JCR made recommendations for more hands-on, participatory training, differentiated to the needs of staff in different departments. Recommendations included more education on communications strategies and how to avoid provoking patients. These recommendations are in line with the OSHA guidance. Best practices include training in recognizing the early warning signs of patient agitation, de-escalation skills, and hands on defensive maneuvers. BRMC provides much less training than best practice institutions. In best practice institutions, up to three days are devoted to this initial training and one day for refresher training, as these skills require hands on practice and are critical to preventing and managing patient crisis situations.

Omissions in the JCR Evaluation

The Joint Commission Resources Consulting report fails to acknowledge that serious incidents have occurred. The report states, "The high risk of *potential for workplace violence* at BRMC has resulted in Occupational Safety and Health Administration (OSHA) and New Jersey Department of Human Services workplace inspections. Such inspections have triggered controversial media attention."[15] These statements fail to acknowledge the severity of the incidents that prompted OSHA to issue a Hazard Alert Letter in 2014 and a General Duty Clause citation in 2015.

The report does not include a review of injury reports and logs, workers' compensation data, and other sources of data that are fundamental to evaluating the scope and severity of the assault problem. This data analysis is key to identifying trends over time and also identifying trends in certain high risk units. Furthermore, establishing an ongoing system for evaluating these trends is a key component of an effective evidence based workplace violence prevention program.

[14] *Confidential Consultation Report Prepared for Bergen Regional Medical Center, Joint Commission Resources Consulting*, 2016, Appendix A, Item 43.

[15] Ibid, p. 1.

Conclusion—Priorities for Action

The JCR evaluation is a good start in identifying gaps and deficiencies in the BRMC's Workplace Violence Prevention Program. However, the following steps are urgently needed to effectively address violence against staff and also patient to patient violence:

1. Further evaluation should be done to identify the scope of the problem by identifying violence related injury incident rates, lost work time rates, and severity rates as well as evaluating related workers' compensation costs, overtime use, agency and per diem staffing, and the use of restraint and seclusion.

2. An implementation plan should start with the reestablishment of the Workplace Violence Committee so that it meets the requirements of the NJ Law, OSHA Guidelines, and Joint Commission standards. The Committee should meet frequently, initially at least biweekly, to develop an action plan to address the JCR recommendations.

3. The reestablished committee should group and prioritize the JCR recommendations.

4. Accountability should be established in the action plan by naming responsible people and timelines for completion.

5. Committee members assigned to tasks shall be released to participate in the development of the missing workplace violence program elements.

6. Development of a robust risk assessment and risk management process should be given priority to ensure that ongoing risks are identified and controlled.

7. An evaluation of the progress of BRMC and its affiliated unions should be provided within 6 months and 12 months to the Committee.

8. Resources necessary to expedite this work should be assigned to ensure that staff and patient safety gaps are addressed on a timely basis.