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Environment of Care | Emergency Management | Life Safety

Clarifications and Expectations

With The Joint Commission's Director of Engineering, George Mills

What the CMS *Life Safety Code* Waivers Mean for You

Getting your questions answered

The Centers for Medicare & Medicaid Services (CMS) has recently granted a series of categorical waivers for requirements in the 2000 edition of the National Fire Protection Association's (NFPA's) *Life Safety Code*®* (LSC). These waivers were announced in a memorandum released by CMS on August 30, 2013 (Survey and Certification, S&C 13-58-LSC). The Joint Commission was instrumental in helping CMS to identify the need for and content of these waivers. Overall, the waivers are designed to protect the physical environment while preserving hospital resources and maintaining life safety.

The Joint Commission was asked by CMS to identify requirements in the *Life Safety Code* that would have an immediate benefit to patient care and safety. In addition, The Joint Commission also requested that four earlier actions, named originally in S&C 12-21-LSC, now be classified as categorical waivers.

Categorical waivers differ from conventional waivers in that

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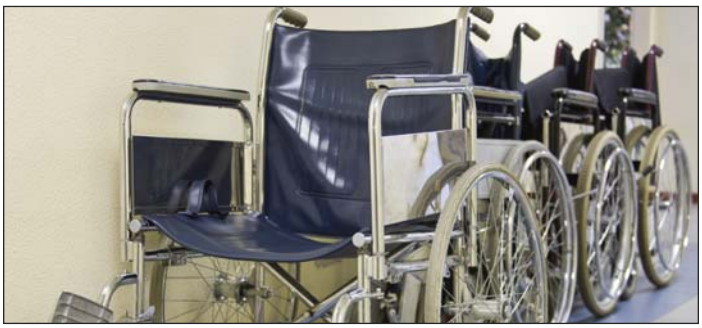

One of the CMS categorical waivers allows wheeled equipment in the egress corridor under certain conditions.

Inside

Joint Commission Resources

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To contact the Standards Interpretation Group with standards questions, phone 630-792-5900.

Test your STANDARDS IQ

The Questions

Time to get sharp on The Joint Commission EC standards and essential information. Use this feature to beef up your knowledge, as a quick reminder of what you already know or to help educate your staff on a variety of EC, EM, and LS standards and information. You'll find the answers (if you don't already know them) on page 11. Okay, ready? Test your knowledge!

1. Which one of the following does not need to be addressed in a written fire plan?
   a. How to sound fire alarms
   b. How to contain smoke and fire
   c. The name and manufacturer of the fire extinguishers used in the building
   d. Evacuation plans

2. A nursing and rehabilitation center accreditation program (formerly long term care) organization's Emergency Operations Plan should discuss the role of internal security personnel and of community security agencies, including police, sheriff, and National Guard.
   True or false?

3. A hospital must test new fire and smoke dampers within one year of installation. After that, how frequently should the organization test?
   a. Every two years
   b. Every three years
   c. Every four years
   d. Every six years

4. A critical access hospital should inventory its emergency supplies and resources every other year.
   True or false?

5. For laboratory programs, how long must a laboratory keep information on medical equipment performance testing and function checks?
   a. Six months
   b. One year
   c. Two years
   d. Five years

How did you do? Check the answer key on page 11.

(continued from page 1)

initiating a categorical waiver is not related to a survey event but may be elected at any time.† To satisfy CMS's conditions related to categorical waivers, organizations are required to:

1) Document their decision to use a categorical waiver(s). If a waiver involves a specific requirement in the Joint Commission's Life Safety (LS) standards chapter, an organization must annotate the "Additional Comments" field of the basic building information (BBI) in the electronic Statement of Conditions (E-SOC). However, if the requirements involve the Environment of Care (EC) standards chapter, an organization must document the decision in its EC committee minutes or an equivalent place.

2) Notify Joint Commission and CMS surveyors at the beginning of a survey that they have chosen to declare a categorical waiver. This is critical. It is not acceptable for an organization to wait until after it receives a *Life Safety Code* citation to notify the surveyor that it wishes to declare a categorical waiver.

While categorical waivers are straightforward, organizations should be aware of a few nuances. The following Q&A takes a closer look and answers organizations' frequently asked questions.

Q Why is this set of categorical waivers significant?

A: These particular CMS categorical waivers apply to specific requirements found in the *Life Safety Code*. Both The Joint Commission and CMS require compliance with the 2000 edition of the *Life Safety Code* as well as with other NFPA standards associated with that edition. In some cases, compliance with the 2000 edition is costly to organizations, whereas later editions of the *Code* have aligned requirements with those that are more cost effective while still ensuring patient safety.

CMS issued a Survey and Certification (S&C) letter on August 30, 2013, declaring that these categorical waivers could be implemented immediately.

Q What topics do the waivers address?

A: The waivers relate to seven distinct topic areas, with specific waivers targeted to various requirements in each area. The topics are shown in the sidebar above and discussed as follows.

- ***Openings in exit enclosures.*** Many existing buildings have mechanical rooms or spaces (such as penthouses) that only open directly into an exit enclosure, such as an exit stair. To bring these spaces into compliance with the 2000 edition of the *Life Safety Code*, an organization would need to construct a new exit enclosure that provides exiting from the unoccupied spaces. Building a compliant exit enclosure would typically be cost prohibitive, and, in many cases, not even possible. The CMS waiver tied to this topic permits organizations to keep existing openings in exit enclosures for mechanical equipment spaces, if those spaces are protected by fire-rated door assemblies. Note that organizations can only use the mechanical spaces cited by the waiver for non–fuel-fire mechanical equipment, and the spaces must not house any combustible materials. In addition, the spaces must be located in a fully sprinklered building. (*See* Standard LS.02.01.20, EP 32.)
- ***Emergency generators and standby power systems.*** Another CMS categorical waiver reduces the time an organization must annually test any diesel-powered emergency generator that does not meet monthly load level requirements. The NFPA 110 Technical Committee has determined that a 1.5-hour test (as opposed to the 2-hour test required by NFPA 110-1998 as cited in the 2000 edition of the *LSC*) is sufficient to detect problems with a generator and adequately test its reliability. By reducing the test time, it is estimated that an organization reduces emissions by at least 25%—thus helping to preserve the

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Seven CMS Waiver Topics (Plus Four)

The seven topics below are the subject of the new CMS categorical waivers. In addition, four other topics are listed that existed before but are now classified as "categorical."

- Openings in exit enclosures
- Emergency generators and standby power systems
- Doors
- Suites
- Extinguishing requirements
- Clean waste and patient record recycling containers
- Medical gas alarms

Plus four . . .

- Wheeled equipment in the egress corridor
- One alternative kitchen cooking arrangement open to the egress corridor per smoke compartment
- Direct vent gas fireplaces and solid fuel-burning fireplaces
- Combustible decorations on walls, doors, and ceilings

† In a conventional waiver, if CMS identifies a noncompliant life safety condition during a survey and writes a citation, the organization is then required to implement corrective action. At this point, if an organization feels it will have a difficult time implementing corrective action (or for other reasons), it may request a conventional waiver. However, in a categorical waiver, permission is received outside of any survey activity.

(continued from page 3)

environment. The total cost of the load bank test may also be reduced by approximately 25%, based on fuel savings and duration of the exercise. (*See* Standard EC.02.05.07, EP 5)

- ***Doors.*** Two CMS categorical waivers address the topic of doors. One allows for door locking arrangements in areas where patients a) have specific clinical needs (such as on a psychiatric or Alzheimer's unit); b) pose a security risk (such as a potentially violent patient in the emergency department); or c) require certain protective measures to ensure their safety (such as patients in a neonatal unit). Specifically acknowledging patient safety as associated with allowed locking arrangements is a change from the 2000 edition of the *Life Safety Code*. The second waiver permits more than one delayed egress lock to be installed in the path of egress. This is significant because an organization can now lock more than one exit access door along the egress path, allowing, for example, more than one unit to be secured. (*See* Standard LS.02.01.20, EP 1.)
- ***Suites.*** Suites are room and space groupings that function more efficiently than individual rooms off a corridor. To facilitate the use of suites, later editions of the *Life Safety Code* allow larger sleeping suites, up from 5,000 square feet in the 2000 edition to 7,500 square feet (and in certain conditions to 10,000 square feet). Suites are required to have one exit into an egress corridor in the 2000 *Life Safety Code*, but in later editions, one exit may be to an exit stair and the second required exit may be into a second compliant suite. From a patient care perspective, allowing the suite-to-suite configuration provides the patient with consistent care, as patient care equipment would be available in the second suite (rather than having to relocate the patient into the egress corridor to access equipment, for instance). The categorical waiver provides clarifying language specific to allowing the suite-to-suite separation, which is equivalent to a corridor separation. (*See* Standard LS.02.01.20, EP 18.)
- ***Extinguishing requirements.*** Another CMS categorical waiver reduces the required testing frequency for sprinkler system alarm devices and electric motor- driven fire pump assemblies. The 2000 *Life Safety Code* requires organizations to inspect, test, and maintain all automatic sprinkler and standpipe systems in accordance with the 1998 edition of NFPA 25, *Standard for the Inspections, Testing, and Maintenance of Water-Based Fire Protection Systems*. This document requires quarterly testing of vane-type and pressure switch waterflow alarm devices and weekly testing of electric motor-driven pump assemblies. The waiver allows organizations to return testing frequency to the previous Joint Commission requirement of semiannual for vane-type and pressure switch type waterflow alarm devices, for an estimated savings of 50% (reduction from 4 tests per year to 2). Electric motor-driven pump assemblies may now be tested monthly rather than weekly, for an estimated 77% reduction of testing costs and time. This will reduce both the labor and testing cost burden without negatively impacting the equipment's reliability. (*See* Standard EC.02.03.05, EPs 2 and 6.)
- ***Clean waste and patient record recycling containers.*** Another CMS categorical waiver permits organizations to use 96-gallon containers for recycling clean waste—for example, paper and cans—and patient records awaiting destruction. The goal of this waiver is to reduce the number of trash containers an organization must use, thus reducing the cost burden. (*See* Standard LS.02.01.70, EP 2.)
- ***Medical gas alarms.*** An additional CMS categorical waiver permits organizations to substitute a centralized computer system for one of the medical gas master alarms required by the 1999 edition of NFPA 99-1999 *Health Care Facilities*, which is referenced in the 2000 edition of the *Life Safety Code*. The provision requires that the computer system meet the requirements outlined in section 5.1.9.4 of the 2012 edition of NFPA 99. Using a centralized computer system may result in a one-time savings, and in most cases will be a more efficient means to monitor the status of piped medical gas systems. (*See* Standard EC.02.05.01, EP 1.)

Organizations are required to:
1) Document their decision to use a categorical waiver(s).
2) Notify Joint Commission and CMS surveyors at the beginning of a survey that they have chosen to declare a categorical waiver.

Q What other topics are included?

A: Four previous *Life Safety Code* waivers, originally issued in a March 2012 S&C letter, are now addressed in the categorical waiver granted in S&C 13-58-LSC. The previous S&C waivers were only granted on a case-by-case basis. By including that S&C in the current S&C 13-58-LSC, the previously required CMS case-by-case action is nullified.

These are the four topics:

- ***Wheeled equipment*** such as lifts (with certain provisions and restrictions—*see* NFPA 101-2012 18/19.2.3.4(6)) is allowed in the egress corridor provided that at least 5 feet clearance remains and the fire plan includes management of the lift in a fire condition. Other wheeled equipment would include crash carts, transport carts (including wheelchairs), and isolation carts. Fixed seating with at least 6 feet clearance and other restrictions (see NFPA 101-2012 18/19.2.3.4(5)) is also allowed. (See Standard LS.02.01.20, EPs 12 and 13.)
- ***One alternative kitchen cooking arrangement*** (per NFPA 101-2012 18/19.3.2.5) open to the egress corridor per smoke compartment is allowed, following the requirements at 18/19.3.2.5.2. (*See* Standard LS.02.01.30, EP 25.)
- ***The installation of direct vent gas fireplaces*** in smoke compartments containing patient sleeping rooms and the installation of solid fuel-burning fireplaces in areas other than patient sleeping areas is allowed, with certain restrictions as defined in *LSC* 2012 section 18/19.5.2 *Heating, Ventilating, and Air Conditioning.* (*See* Standard LS.02.01.50, EP 1.)
- ***The installation of combustible decorations*** is allowed on walls, doors, and ceilings, with very specific restrictions as required in the 2012 *Life Safety Code* 18/19.7.5.6. (*See* Standard LS.02.01.70, EP 1.)

Q Are the waivers mandatory?

A: No. An organization must decide whether to invoke the categorical waivers or not. Because of this, The Joint Commission will ***not*** be adjusting the standards and elements of performance related to these topics. Before electing to use a waiver, an organization should fully educate itself on the waiver's requirements and make sure that the waiver's approach aligns with its operations.

Q How do I ensure compliance with the waivers?

A: For an organization to apply a categorical waiver, it must comply with all of the requirements in the *Life Safety Code* edition cited in the waiver. For example, if an organization has suite-to-suite exiting, the organization must ensure that both suites are fully compliant with the 2012 edition of the *Life Safety Code*.

Q What if an organization forgets to document the waiver decision?

A: If an organization neglects to document the waiver decision or forgets to tell the surveyor at the beginning of survey, the surveyor will assess compliance with the applicable requirements found in the 2000 edition of the *Life Safety Code*. Any areas of noncompliance as a result of not documenting the decision to apply the categorical waiver, or failing to declaring that decision at the beginning of survey will result in a finding.

For an organization to apply a categorical waiver, it must comply with all of the requirements in the *Life Safety Code* edition cited in the waiver.

Q Where can I get more information?

A: Joint Commission–accredited organizations that need more information should feel free to contact the Joint Commission Department of Engineering (630-792-5900).

For more information about the CMS S&C 13-58-LSC, please go to http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-58.pdf.

About this column: *The Joint Commission has identified the need to increase the field's awareness and understanding of the* Life Safety Code® *as well as other key environment of care concepts. To address this need,* Environment of Care News® *publishes the column Clarifications and Expectations, authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission. This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care but also in the vital area of emergency management. You may wish to share the ideas and strategies in this column with your organization's leadership.*

Violence Code Reload

Ft. Lauderdale hospital launches successful new violence prevention program

Health care workers endure more than long shifts, strenuous responsibilities, and hectic schedules. Statistics show that they're also particularly vulnerable to harm from aggressive outbursts by patients.

Studies indicate that anywhere from 35% to 80% of hospital staff have been physically assaulted at least once during their careers.[1] In fact, in 2011, the incidence rate for violence and other injuries for health care/social assistance workers (15 per 10,000 full-time workers) was more than triple the overall rate for all of private industry (4 per 10,000 full-time workers).[2]

Health care organizations can decrease the risk of violence by doing the following:

- Establishing policies for how health care workers should respond to aggressive behavior
- Having appropriately trained personnel
- Instituting de-escalation and violence management practices

All these important steps were at the forefront for Pat Schuldenfrei, EdD, RN, director of patient safety and clinical performance improvement for Holy Cross Hospital in Ft. Lauderdale, Florida. After seeing some nurses sustain injuries such as black eyes, bloody lips, and bites inflicted by aggressive patients, she knew it was time for significant changes.

So in late 2012, Schuldenfrei and hospital director of security Darren DeBolt created the Task Force for the Prevention of Patient Violence and outlined a violence prevention program that called for major upgrades to current response procedures.

Taking threats seriously

In the past, Holy Cross staff had often tolerated verbal abuse from patients without involving security personnel. A physically threatening individual, however, would warrant a "Code Strong" which involved staff paging security for immediate assistance. The process was not consistent, though—often, not enough security officers would arrive.

"Our nurses had little guidance on this issue and at times were afraid for their safety," says Schuldenfrei, one of up to 1,000 nurses at Holy Cross, which has 559 beds and more than 3,000 employees.[3] "The tipping point came when I was visiting a patient who was lightly restrained but potentially violent. Here was a 250-pound, big, strong guy with an older nurse's aide at the foot of his bed. I asked her, 'What if he breaks free and attacks you—what are you going to do?' She admitted that she did not know."

Schuldenfrei and DeBolt realized that the changes to be suggested would involve the expenditure of hospital resources and require the support of hospital administration. They invited Meg Scheaffel, RN, the hospital's chief nursing officer; William Korey, MD, an emergency department physician; and several other key players to join their task force. Working together, the group hammered out the blueprint for what became Holy Cross' current program, which launched in late 2012 and included revamped polices, new response protocol, additional training, and targeted communications.

Codes for help

To manage violence hazards quickly and effectively, the task force implemented a new system involving the following three levels of security codes:

- **Security Level 1—Code Assist:** This code is paged when a patient or visitor becomes verbally abusive and/or begins to act defiantly without being physically violent. In response, one uniformed security officer is immediately dispatched to the site.
- **Security Level 2—Code Strong:** This is a new and improved code that summons a team of trained first responders, including security officers, the nurse supervisor, and male hospital engineers trained to drop what they're doing and help. Typically, a Code Strong offender is both physically and verbally aggressive and presents a serious safety risk to him/herself and those nearby.
- **Security Level 3—Code Strong with Intensive Care Physician:** This code can only be called by a registered nurse (RN). It involves the same response as a Code Strong but also summons a physician, who is authorized to order the sedation sometimes required to subdue an out-of-control patient.

Trio of training levels

For violence prevention to be effective, staff need to be carefully educated about how to identify and respond to hostile threats. Consequently, the task force also developed the following three-tiered training program:

- **Tier 1 training:** This requires every hospital employee to complete a one-hour online class that covers the general

A Tale of Two Patients

The positive impact that Holy Cross's violence prevention program has made can be demonstrated by two similar incidents—one that occurred prior to the program rollout (in 2012), and one after (in 2013).

Before the rollout: A homeless alcoholic is admitted to the medical surgical unit. He acts belligerently—throwing punches, thrashing about, and screaming. The nurse calls a Code Strong, which summons two security guards who are unsure if they are allowed to physically restrain the patient. The patient screams for 30 minutes while the nurse calls his physician for orders.

After the rollout: A different homeless alcoholic is admitted to the medical surgical unit. Recognizing impending delirium tremens based on the new assessment tool she uses, the nurse immediately requests an alcohol detoxification protocol from the attending physician. However, the patient grows increasingly aggressive—flailing about and being verbally abusive. The nurse calls a Code Strong with Intensive Care Physician, and five well-trained staff, including security officers, a nurse supervisor, and hospital engineers, arrive to restrain the patient. Moments later, the intensive care physician authorizes additional medication, and the situation is quietly resolved within 15 minutes.

topic of workplace violence prevention.

- **Tier 2 training:** This obligates all clinical staff to complete two hours of live classroom continuing education, which addresses topics like violence awareness and prevention, de-escalation techniques, and personal safety best practices. These techniques include effective blocking of punches and kicks; freeing oneself from grabs, choke holds, hair pulls, and bites; and maintaining a safe personal space buffer of 3 to 6 feet from a patient if a caregiver feels threatened.
- **Tier 3 training:** ED staff, nurse supervisors, security personnel, and engineers are mandated to complete tier 3, which consists of eight hours of nonviolent crisis intervention training. In addition to the techniques covered in tier 2, attendees learn more advanced techniques to protect themselves and patients—including team intervention for control and restraint. They also learn what it takes to be a member of the code response team, which involves collaborating with two to five other members to safely control and restrain an out-of-control individual. In addition, they practice giving and taking commands, ensuring that the environment is safe (dispersing crowds, moving furniture, opening doors), communicating with the potentially violent individual, and providing a safe environment during a crisis.

All hospital classes employ the methodology of nonviolent crisis intervention training, DeBolt says.

Other safety steps

Holy Cross didn't stop there. It took more steps to help prevent violence.

Incorporating violence drills. The hospital also began incorporating violence-themed situations in its security drills. For instance, in June the organization hosted an "active shooter" scenario in which a vest-clad security officer, portraying an out-of-control gunman on the loose in the hospital, attempted to hunt down employees spread across different floors and hallways. Any worker spotted by the gunman was considered a casualty.

"That drill was a great success, even though it was the first time we'd ever conducted a scenario of that kind," says DeBolt, who adds that other crisis intervention drills are practiced throughout the year so that staff learn how and when to call a Code Strong versus a Code Assist. "This was the first of many 'active shooter' drills that we will be practicing. The objective was to teach staff basic principles to apply during a real-life event. As we move forward, we will incorporate how we will best protect patients, visitors, and others in the facility."

Providing panic buttons. To better protect those who may be assigned close observation of dangerous patients, the hospital equipped nurse's aides with panic buttons that, when activated, emit a 130-decibel screeching distress siren.

Sharing best practices. Holy Cross created a series of helpful signs, posters, and checklists that reinforce violence prevention policies and procedures. Schuldenfrei and several peers are also preparing to share these best practices in a forthcoming nursing journal article and will present a poster outlining their model at an upcoming nursing conference.

Meeting high standards

Holy Cross's violence prevention program was carefully designed to incorporate and address several Joint Commission Standards, including the following: Environment of Care Standards EC.01.01.01, "the hospital plans activities to minimize risks in the environment of care," and EC.02.01.01, "the hospital manages safety and security risks"; plus Emergency Management Standard EM.02.02.05, "as part of its emergency operations plan, the hospital prepares for how it will manage security and safety during an emergency."

"Abiding by Joint Commission standards is essential for an accredited hospital like ours," says DeBolt. "Instituting this violence prevention program shows that we're being proactive and trying to provide a safe environment to patients, visitors, and staff."

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Violence Code Reload
(continued from page 7)

Reading between the numbers

Before implementing its new violence prevention program, Holy Cross set a goal of reducing Code Strong incidents by 25% in 2013. Despite a rise in Code Strongs after the program started—113 in the first seven months of 2013 versus 152 total violent events recorded in 2012—Holy Cross's program has proved to be a success, says DeBolt. The spike was expected, as nurses have been more likely to call for help and report aggression since the program rollout.

"We expect Code Strong events to decease significantly over time as we're more aware of the dangers and aggressive actions in our midst," says DeBolt, who is hopeful that nurses will effectively use de-escalation techniques and Code Assists to prevent Code Strongs from occurring.

Code Strong incidents actually dropped recently from an average of 20 per month between January and May to an average of 6 during June and July. Code Assists (33 between March and July) have also decreased in recent months.

"Nurses today tell us how pleased they are that a visible effort is being made for their safety, and the level of trust and collegiality between nursing and security is definitely better," Schuldenfrei says.

Lessons learned

The violence prevention program is a work in progress but one that continues to provide valuable learning opportunities to hospital staff.

Learning from the data. "We've learned quite a bit because we follow up on every Code Strong event. A nurse from our team will revisit a patient's chart and his caregiver within 24 hours of the incident to determine why it happened and what could have been done differently to prevent or improve the situation," says Schuldenfrei.

The data collected have helped determine the triggers of violence. Among all Code Strongs that occurred between January and July 2013, 42% were related to alcohol/drugs, 15% were related to delirium, 12% were triggered by dementia, 7% by mental illness, and 4% by hypoxia. Many who become hostile are homeless, psychotic, and/or elderly.

Learning to recognize and react. Most importantly, the program has taught vulnerable employees how to recognize and react appropriately to a volatile situation.

"Nurses have learned that the Code Assist is a valuable tool to set boundaries with persons who are verbally assaultive. The interaction with a uniformed security person sets limits. It is often enough to change behavior," says Schuldenfrei. *See* the sidebar on page 7, "A Tale of Two Patients," for a before-and-after case study of program results.

Involving security in policies and procedures. DeBolt says the hospital has benefitted by having security personnel help shape policies and procedures.

"We used to be just first responders for a Code Strong call. Now we sit on the violence prevention advisory committee and help teach the training classes," says DeBolt.

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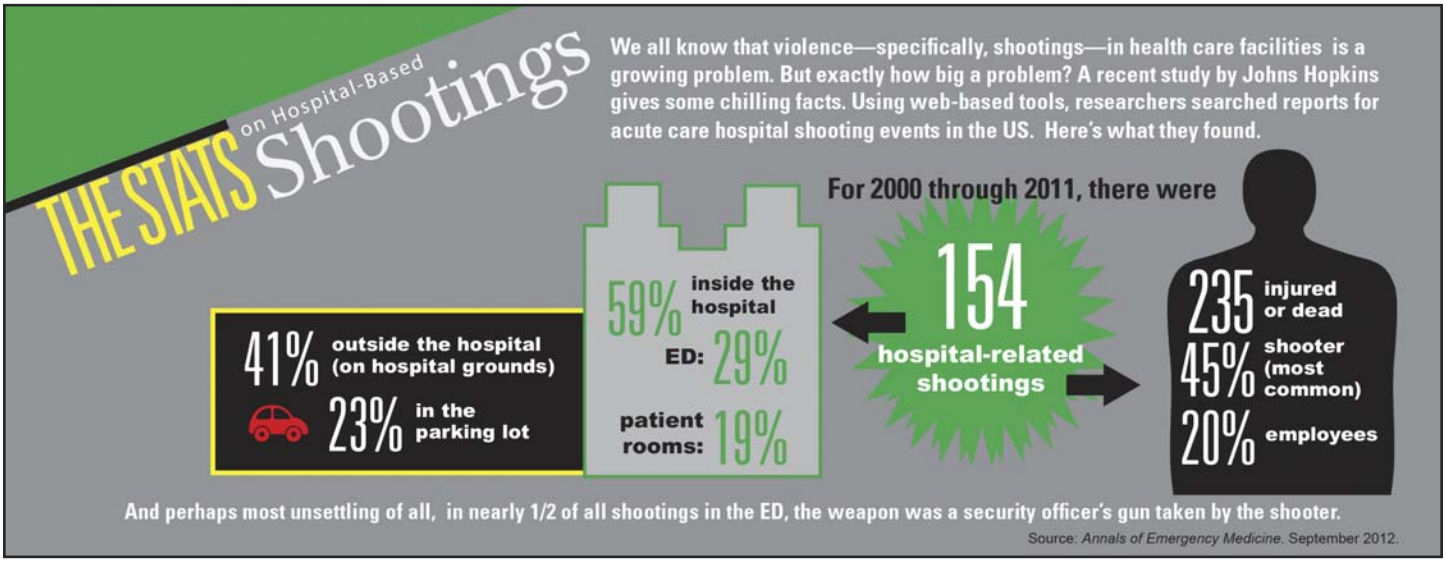


On Course to Curb Workplace Violence

Free new NIOSH online class offers valuable tips and CE credits

Nurses, clinicians, and other medical staff shouldn't have to fear for their safety. And yet, research shows that providing health care can be hazardous to the caregiver's health. On average, over the past decade in statistics covering all industries, US health care workers (HCWs) sustained two-thirds of all nonfatal workplace violence injuries requiring days away from work.[1] And from 1997 to 2009, there were 130 workplace homicides in the health care and social assistance industries within the private sector.[2]

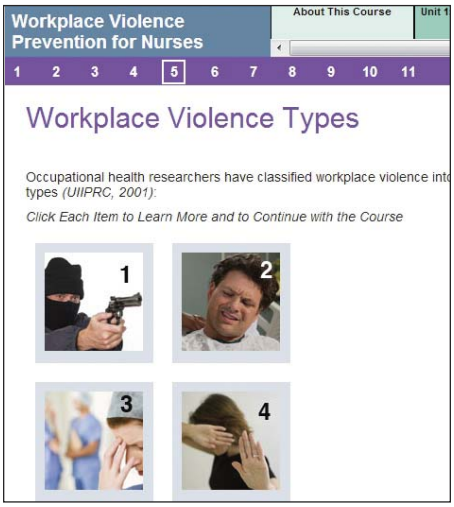
The concern over violence is so prevalent that The Joint Commission has issued two *Sentinel Event Alerts* related to the topic:

- Issue 40, "Behaviors that undermine a culture of safety"[3] (2008)
- Issue 45, "Preventing violence in the health care setting"[4] (2010)

Recognizing the increasing risks of aggression in health care environments, the National Institute for Occupational Safety and Health (NIOSH) has created a new online course entitled "Workplace Violence Prevention for Nurses" (available at http://www.cdc.gov/niosh/topics/violence/training_nurses.html). This free electronic class module meets an important need: helping HCWs identify and avoid hostility on the job.

Four years in the making

Daniel Hartley, EdD, NIOSH workplace violence prevention coordinator, Division of Safety Research, Morgantown, West Virginia, conceived of the course in 2009, with the help of Marilyn Ridenour, BSN, MBS, MPH, CPH, NIOSH nurse epidemiologist.



The NIOSH course is embedded with user-friendly, interactive graphic elements that can be clicked on for more content.

"NIOSH has been researching workplace violence for approximately 30 years. Over the past 10 years, we have participated in several discussions with health care professionals, and one recurring theme that we noted was that many go their entire career without receiving training in workplace violence prevention," says Hartley.

Although other classes on this topic exist, Ridenour feels that the NIOSH course is unique.

"It's the only known online instructional of its kind that is gratis and offers free CE units to those who qualify," says Ridenour. "Additionally, the class covers the subject more thoroughly, having been developed by several of the leading experts in the field of workplace violence prevention for health care workers."

To develop and design the digital materials, NIOSH partnered with a Cambridge, Massachusetts–based provider of courses, programs, and e-learning materials for the health care industry—and its chief operating officer John Craine and project manager LeeAnn Hoff, who served as lead author of NIOSH course content. In creating the curriculum, NIOSH also enlisted 30 academic researchers as well as numerous representatives from the Centers for Disease Control and Prevention, Veteran's Health Administration, American Nurses Association, and other groups.

Learning about violence—From A to Z

Separated into 13 units that each take approximately 15 minutes to complete, the course includes lesson text, videos portraying workplace violence events, testimonials from practicing nurses, eye-catching graphics, brief quizzes after each unit, and a comprehensive exam at the course conclusion.

The main goal of the course is to increase violence awareness among nurses and other HCWs. Attendees can expect to learn definitions, classifications, and risk factors for workplace violence; consequences for the employee and employer; post-event responses; and how workplace violence has affected other HCWs. The course also teaches proactive prevention strategies, such as recognizing the warning signs that precede most violent incidents and identifying methods to increase one's own safety by being attuned to personal behaviors of a potential aggressor.

Hartley says the video case studies, featuring professional actors who depict different troublesome scenarios based on real-life events, are particularly beneficial. These scenarios include a patient's family member who becomes aggressive

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with a nurse, a home health care patient threatening homicide, and a cognitively impaired patient who injures an HCW.

"One of the best videos is a scenario involving a psychiatric patient," says Hartley. "He has just acted out violently and is presenting some indications that he may become violent again. The patient is escorted by security to a psychiatric nurse, who speaks compassionately with him. She realizes he's stopped taking his medication. She discusses some options with him, and they determine that it's best for him to get back on his medications and stay in the facility for overnight observation."

Recorded interviews with real HCWs are also riveting. For example, one video spotlights several nurses who discuss the disturbing assaults they survived. A nurse describes an injury she sustained that permanently affected her grip, and another recounts her inability to sleep at night because of the psychological trauma her attack caused.

Graduating to the head of the class

Jane Lipscomb, RN, PhD, FAAN, professor at the University of Maryland, Baltimore, notes that the NIOSH course is far more comprehensive and educational than comparable paid classes available to hospitals and their staff. Consequently, she strongly encourages HCWs to complete the class and health care organizations to introduce it into their violence prevention programs.

"A lot of comparable commercial curricula usually focus on only three domains—early intervention, escalation of potentially violent patients, and self-defense," says Lipscomb, who was one of the expert consultants NIOSH recruited to review and revise the course materials created. "What's often missing is the way in which that training fits into the organization's overall workplace violence prevention program and how essential it is for organizations to collaborate with frontline workers to ensure that both patients and staff are safe."

Unlike many others, "this class reinforces the importance of getting commitment from top management and involvement from employees, conducting comprehensive risk assessments, and encouraging reporting of incidents and continuous quality improvement," Lipscomb says.

The NIOSH course "is worth health care professionals' time and effort because, aside from not costing anything, the techniques it teaches could not only increase your feeling of safety and satisfaction on the job but could also save your life," says Ridenour.

Lipscomb agrees, adding that completing the NIOSH course could make the difference between having a long, healthy career in the health care profession and leaving the profession prematurely out of fear or because of a work-related injury.

Test Your Workplace Violence Knowledge

Take this quiz, pulled from materials in the new NIOSH workplace violence course, to see how sharp you are on the subject.

1. Approximately 82% of emergency department nurses: (a) do not feel safe in the workplace; (b) have been physically assaulted at least once during their career; (c) were physically assaulted at work in one year.
2. The most common type of workplace violence in health care settings is classified as: (a) Type 1—criminal intent; (b) Type 2—patient/client/visitor; (c) Type 3—worker on worker; (d) Type 4—personal.
3. True or false: The Occupational Safety and Health Administration uses the General Duty Clause of the Occupational Safety and Health Act of 1970 as its enforcement authority regarding workplace violence.
4. An acutely distressed person is essentially out-of-control on which of the following levels: (a) cognitive, behavioral, and emotional; (b) behavioral, emotional, and biophysical; (c) biophysical, behavioral, and cognitive.

Source: Workplace Violence Prevention for Nurses. CDC Course No. WB1865 - NIOSH Pub. No. 2013-155

Answers: 1 (c); 2 (b); 3 (true); 4 (a).

Extra credit incentives

"The course is aimed at prevention of violence in health care, but many of the underlying principles apply to any industry," Hartley says. He points out that anyone with Internet access can take the class, even workers in non-health care professions.

Attendees can also earn continuing education (CE) units for licensing requirements by completing the course and posttest. The Centers for Disease Control and Prevention awards 2.6 hours of CE credits to nurses, and the International Association for Continuing Education and Training awards 0.3 CE credits to any health care professional, or 2.5 category I CE credits to health education specialists.

The electronic course has no completion deadline, and bookmarking technology allows users to return at any time to the exact point they left off.

Future of the class

The NIOSH course was launched online in August. "The early feedback we've been getting from visitors and attendees

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so far via e-mail, Facebook, and our blog has been overwhelmingly positive and complimentary," Hartley says. For a taste of the content and to test your own knowledge, take the sample quiz on page 10.

The NIOSH team plans to update the course content periodically and is currently working on adding occupation-specific units to it—to be rolled out in 2015—that will address workplace violence issues in emergency departments, psychiatric departments, and long term care facilities. Completing each extra unit will likely earn one additional hour of CE credits for the attendee.

"We also have future plans to address emergency first responders, home health providers, and social services workers," adds Hartley.

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Test your STANDARDS IQ

The Answers

Here are the answers to the questions on page 2. How did you do?

1. **C, The name and manufacturer of the fire extinguishers used in the building.** While you may choose to include details about the equipment used to contain a fire, such as the name and manufacturer, it is not necessary. A fire response plan is your organization's emergency plan for fire safety. It describes the actions your staff and licensed independent practitioners will take when responding to a fire, outlining their roles and responsibilities at and away from the fire's point of origin. The fire plan must address both facilitywide and area-specific incidents, and it must detail how to sound the fire alarms, contain any smoke and fire, operate any fire equipment, and evacuate the area, if necessary.

   STANDARDS REFERENCE: EC.02.03.01, EP 10

2. **True.** The Joint Commission requires long term care organizations, critical access hospitals, and hospitals to consider the role of both internal security personnel and community security agencies—police, sheriff, National Guard—during an emergency and work with outside agencies to ensure the safest environment for patients and staff. Your organization's relationship with community security agencies may be quite different during an emergency than during normal business operations. Organizations should think about how the relationship will change and address it within the Emergency Operations Plan.

   For instance, you may want to review what law enforcement agents should do with their weapons when they enter your facility during an emergency. Will you allow agents to bring their weapons into the facility at all? Require agents to check weapons at the door? Limit where agents with weapons can go? If an organization does not allow law enforcement to bring weapons into the facility during normal business operations but would like to alter this policy for emergency situations, the organization should make law enforcement aware of this change in policy before the onset of an emergency.

   STANDARDS REFERENCE: EM.02.02.05, EP 2

3. **D, Every six years.** The Joint Commission requires organizations to maintain any fire safety equipment and features present in their facilities, including fire and smoke dampers. If a hospital has fire and smoke dampers in place, it must test them every six years. During this test, organizations should make sure the dampers fully close to adequately prevent the spread of smoke and fire. The completion dates of the test must be documented. For additional guidance, *see* NFPA 80, *Standard for Fire Doors and Other Opening Protectives*, 2007 edition (Section 19.4.1.1) and NFPA 105: *Standard for Smoke Door Assemblies and Other Opening Protectives*, 2007 edition (Section 6.5.2).

   STANDARDS REFERENCE: EC.02.03.05, EP 18

4. **False.** The Emergency Management (EM) standards require organizations—including critical access hospitals—to inventory their supplies for use in an emergency *every* year. This ensures that the organization is ready to continue and sustain the delivery of care, treatment, and services in the event of an emergency. Note that the findings of this review must be documented. A solid understanding of the scope and availability of your organization's resources and assets is essential at any time but is perhaps most important during an emergency, when there is no time to address shortfalls.

   STANDARDS REFERENCE: EM.03.01.01, EP 3

5. **C, Two years.** Performance and function testing are critical activities in a laboratory. The Joint Commission requires laboratories to conduct daily, weekly, monthly, quarterly, or semiannual performance tests on all instruments and equipment used in the laboratory. The time frame will vary, depending on the nature of the instrument or equipment. The results of these tests must be documented and retained for at least two years. This provides a detailed equipment performance history that can be used to evaluate future testing and use.

   STANDARDS REFERENCE: EC.02.04.03, EP 11

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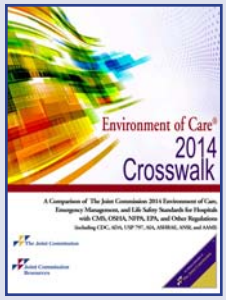

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