CALL TO ACTION:

Protecting Home Care Employees from Workplace Violence

HOMECARE & HOSPICE
National Association for Home Care & Hospice

JOHNS HOPKINS
MEDICINE

Home care employees can be defined as individuals who contribute toward providing healthcare in the home (e.g., nurses, physicians, therapists, personal care providers and delivery professionals). The desire of patients to receive care in the home, coupled with the increasing amount of care that can be provided in the home, has made home care one of the fastest-growing sectors in the healthcare industry.[1] However, with this shift from facility-based to home-based care, the risks for workplace violence and other safety concerns for home care workers are expected to increase. People who provide care services in the home face a combination of occupational health and safety challenges that are not traditionally experienced by health care providers in other short-term care settings.[3] On average, 65% of home care workers have reported experiencing some form of workplace violence.[2]

Although awareness is increasing on the issue of employee safety in the healthcare industry, current research does not include significant information specific to care in the home. Recognizing the importance of this issue for the well-being of their employees and the long-term success of care in the home, a group of home care leaders who are also members of the National Association for Home Care & Hospice (NAHC) met to discuss the core elements of an employee safety plan for organizations with home care professionals.

The NAHC Task Force (Task Force) includes representatives from a diverse group of home care organizations across the U.S. who have a unified mission and goal to improve employee safety for those working in the home and community, with a focus on physical harm (e.g., weapons, aggressive animals) and harassment. Harassment is unsolicited behavior that can cause emotional distress and is based on race, color, religion, sex (including sexual orientation, gender identity or pregnancy), national origin, older age (beginning at age 40), disability or genetic information (including family medical history).[9] Types of harassment include but are not limited to domestic violence, verbal abuse, workplace violence or harassment, sexual harassment, discrimination, racism, cyber stalking and bullying. It is important to acknowledge that other forms of harm exist and to appropriately define them in an inclusive and nonjudgmental manner that aligns with the organization's diversity, equity and inclusion frameworks.

The Task Force identified five pillars of safety that were used to create recommendations they felt organizations should consider when developing an employee safety plan, which ultimately lead to the accountability matrix in Table 1. Those pillars include: organizational leadership, policy and structure; education, training and engagement; prevention, mitigation and support; data reporting, collection, measurement and analysis; and community integration and advocacy. The recommendations are meant to serve as a starting point, and should be tailored and based on the needs of an organization. The Task Force members do not claim to be experts on the safety of employees in the home, nor is this resource guide intended to be the ultimate tool for employee safety in the home. Rather, the Task Force hopes that this free online guide will evolve with the input of many, spur discussion regarding a national problem and serve as a starting point for sharing best practices nationally. The Task Force understands the need to create, collect and share tools necessary for home care organizations to implement and manage an employee safety program. This resource guide is the first step in understanding current resources and creating a call to action that fits the needs of home care workers.

Although there are varying roles and responsibilities among each level of personnel, everyone should be actively involved in workplace safety. Stakeholders should participate by engaging in meaningful discussions and providing valuable feedback — creating an open and transparent environment that fuels the organizational safety culture.

Table 1 on pg. 6 outlines an accountability matrix with recommendations for organizations to consider building into their employee safety culture and plan. The accountability matrix includes organizational leadership, managers who oversee staff, staff who provide care and services in the home, partners to the organization such as safety experts (e.g., safety teams, law enforcement) and support services (e.g., personal well-being teams). The recommendations are categorized into six topics:

1. Leading through a culture and structure that promotes the safety of the employee
2. Communicating about safety risks and mitigation strategies
3. Supporting the employee in their everyday work and after a safety event
4. Assessing trends and risks in employee safety
5. Educating about identified risks in trends in employee safety
6. Acting based on risks and trends in employee safety

The development and implementation of a safety plan is initially established by organizational leadership, based on the diversity and inclusion of the voices of all home care workers. However, a key leader or leaders must be accountable and responsible for maintaining and continuously improving the plan by setting the tone for the culture of safety. The formation of a safety committee that includes engaged leadership, staff and partners is crucial to implementing an effective safety plan.[6] A safety committee allows organizations to have strategic oversight of all components of the plan, identify actions and create an open forum to discuss safety-related information.

Successful implementation of a workplace safety plan depends heavily on effective communication to avoid misunderstandings and ensure alignment on objectives. Effective safety communication involves four key components: It should be interactive, informative, positive and productive.[6] In order to build trust with employees, the safety committee must create an open forum and safe space for discussion. Two-way communication systems allow employees to voice their feedback and concerns to leadership and management. Communication can occur in a variety of different forums, with both formal and informal approaches allowing full coverage of relevant topics and opportunities for everyone's voice to be heard. Staff can engage patients and caregivers in cultivating a safe workplace environment through communication and by setting appropriate expectations.

Support resources are vital to reduce risk and provide practical and emotional support to those who have had a traumatic experience. Each organization should proactively identify and organize support resources so they are readily available in the case of an event. Recognizing signs of potential trauma can help leaders and staff mitigate negative health behaviors and ensure help is available to those in need. Outside of organizational support, community partnerships also can be engaged to provide further support and resources based on their expertise.

Being aware of surroundings and perceived threats, not only in the home but also within the community (e.g., mass transit, commercial buildings, etc.), is important to understanding potential risks and assessing the situation appropriately. Pre-screening risk assessment tools should be developed based on the home care environment and external community. Risk assessments should include but not be limited to weapons, verbal and physical assault, and animals. Risk assessment data is needed to develop evidence-based strategies to reduce risk and provide the appropriate forum to discuss findings and trends that inform actionable next steps.[4] Workplace violence is one of the largest threats in the healthcare industry; however, workplace violence is notoriously underreported. This results in an underestimation of the true extent of the problem, which limits resources and lessens the ability to create a call to action.[11] Collecting both qualitative and quantitative data on worker safety is crucial to establish a baseline and evaluate effectiveness of the employee safety program, as a reduction in occurrences does not equate to improved safety.

De-escalation is the most recommended prevention technique to reduce violence or threats in the healthcare setting.[7] In healthcare, de-escalation refers to a range of interwoven staff-delivered components including communication, self-regulation, assessment, actions and safety maintenance.[7] De-escalation aims to reduce patient aggression/agitation regardless of the reason and improve staff-patient relationships. Studies have shown that providing de-escalation training to healthcare workers can significantly contribute to a reduction in lost workdays, complaints and overall expenditure while improving staff retention.[10] Providing staff with the tools needed to control escalated situations can limit negative impacts of aggression and violence while also giving staff the confidence and knowledge base to identify and handle these situations. After an event occurs, quickly debriefing within the appropriate forum with relevant staff can aid in identifying trends and prevent future instances based on lessons learned.

Due to the lack of environmental control home care employees have in the home, prevention techniques can be prioritized to keep employees safe and to diffuse situations. An effective safety decision aims to reduce or eliminate the risk of workplace violence toward the home care employee, and may result in modifications to the visit (e.g., visiting in pairs, using escort services, rescheduling the visit to a safer time of day, shortening the visit, abandoning the visit, declining to make the visit or discharging the client).[8] Leaders and managers should empower staff to trust their judgment and immediately exit an unsafe situation.[8] Once outside the situation and in a safe space, the employee should escalate the situation to their manager without fear of retaliation.

In addition to prevention techniques, training and education can help staff members navigate best practices and protocols that are unique to each organization and their experiences. As home care staff are mobile, with dynamic schedules (i.e., going from home to home providing care), education should be available in easily digestible formats for the sake of better retention and uptake. Outside of the home, stakeholders should share information about known risks in the community.

Although each organization has processes and protocols in place for employee safety, it is crucial to be adaptive on a case-by-case basis, acknowledging the uniqueness of each situation and taking action based on trends, lessons learned and best practices. Action is dependent on organizational factors, and should be evaluated based on the appropriateness of the situation while simultaneously providing support in the interim. Resource allocation and availability should be embedded into the safety plan to ensure proper management that is fluid, changing based on need. Technological innovations can be leveraged as part of a home care employee's "toolkit," such as a panic button or similar device that yields a quick emergency response. Organizations must conduct a risk-benefit analysis to determine feasibility of implementing such devices, but the most important factor is ensuring the devices work as intended.

Table 1. Accountability Matrix

	Executive Leadership	Managers	Staff	Partners
LEAD				
Identify a leader or leaders to be ultimately responsible for the employee safety plan, and ensure safety is part of organizational culture	X	X		
A committee of executives, managers, staff and partners (e.g., a member of a public-safety unit) should oversee all aspects of the employee safety plan and actions coming from the plan	X	X	X	X
COMMUNICATE				
Establish and maintain a two-way communication system in which people can speak without fear	X	X		
Communicate in formal and informal places about workplace safety and health and security issues, including situations that did not result in harm but could if they happen again	X	X	X	X
Raise awareness about how the community can support home care workers	X	X	X	X
Speak up and report events	X	X	X	X
SUPPORT				
Identify and develop a collection of support resources (e.g., safety checklists)		X		X
Recognize signs of potential trauma among staff		X	X	
Make available the appropriate staff support, paying special attention to needs after an employee safety event	X	X		
Engage with the local community and partner organizations to provide support and resources to staff pre- and post-event	X	X		X
ASSESS				
Develop and use a pre-screening risk assessment tool		X	X	X
Use safety event reporting to support actions and decisions	X	X		
Debrief quickly after an event to understand "lessons learned"	X	X	X	X
Understand and communicate about planned (e.g., parades) and unplanned (e.g., demonstrations) events that could affect travel or care, avoiding high-traffic areas or other risks	X	X	X	X
EDUCATE				
Promptly share lessons learned from events and trends	X	X		
Create employee training and update it regularly based on lessons learned; consider multiple types of training (e.g., de-escalation and self-defense) to protect the employee from harm		X	X	X
Share information about known risks in the community and home setting		X	X	X
ACT				
Utilize known trends and reports to take appropriate action (e.g., changes to how services are provided and changes to communication)	X			
Immediately exit situations that seem unsafe, no matter the circumstances		X	X	
Evaluate tools that are meant to promote employee safety, and make them available to staff as appropriate (e.g., panic devices)		X	X	X

As the U.S. population continues to grow and the demand for home care services increases, it is important to strengthen, modernize and streamline efforts to create a safe workplace environment for home- and community-based workers, given their unpredictable, nontraditional settings of providing care. Many of the security protections offered in healthcare facilities such as hospitals and clinics are not available in the home or community, causing employees to rely on their own resources — or, in some instances, leave the home and community workforce altogether. The negative effects of experiencing violence or harassment can lead to harmful impacts on the delivery and quality of care, resulting in low productivity, job dissatisfaction and overall poor health outcomes among workers.[3] Supporting the mental health and well-being of home care workers is important to build a culture of safety and trust in the workplace, which can increase retention, decrease burnout and ultimately lead to improved outcomes.[5]

This resource guide is meant to provide a starting point of minimum standards for an employee safety plan that home care agencies can implement. However, more discussion is needed from a broader audience — the experiences of home care workers can further refine and strengthen workplace safety guidelines. The issue of workplace violence specific to home care workers is not new, and has been a persistent problem within the U.S. and worldwide for decades.[12] Even so, proposed measures of home care safety are still being developed, and there is limited evidence-based literature to support standardization.

While the Task Force believes it is important for every organization to have an employee safety plan, change will only happen if aligned action is taken at a national level. The NAHC Task Force discussed what needs to happen over the next three years to create substantial change, and determined:

- Much like action taken regarding medication errors and their impact on patients, a national organization must collect and report trends on the safety of the home care worker. The task force believes this data collection and sharing will lead to the development and spread of best practices and data-driven informed decisions.
- Professional organizations such as NAHC must lead the national discussion by dedicating more time, money and people to understand and mitigate the safety challenges home care employees face in the home.
- Funding must be made available to provide for the tools and resources identified through both national trends and collaborative learning achieved through professional organizations intended to keep home care workers safe.

References

1. Home Health and Personal Care Aides. (2021). U.S. Bureau of Labor Statistics. https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm
2. Felice, S.T., Goodwin, S.G., Oliveri, A., Socias-Morales, C., Castillo, D., & Olawoyin, R. (2021). Home Health care Workers: A Growing and Diverse Workforce at High Risk for Workplace Violence. Centers for Disease Control and Prevention. https://blogs.cdc.gov/niosh-science-blog/2021/09/02/hhc-violence
3. Stevenson, L., McRae, C., & Mughal, W. (2008). Moving to a Culture of Safety in Community Home Health Care. Journal of Health Services Research & Policy, 13 Suppl 1, 20–24. https://doi.org/10.1258/jhsrp.2007.007016
4. Gershon, R. et al., (2008). Home Health Care Patients and Safety Hazards in the Home: Preliminary Findings. Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 1: Assessment). Agency for Health care Research and Quality. https://www.ncbi.nlm.nih.gov/books/NBK43619
5. Morris, G. (2022). How to Support Nurses and Raise Nurse Retention Rates. NurseJournal. https://nursejournal.org/articles/how-to-support-nurses-considering-resigning
6. Gross, N., Peek-Asa, C., Nocera, M., & Casteel, C. (Jan. 31, 2013). Workplace Violence Prevention Policies in Home Health and Hospice Care Agencies. OJIN: The Online Journal of Issues in Nursing Vol. 18, No. 1, Manuscript 1. https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-18-2013/No1-Jan-2013/Workplace-Violence-Prevention-Policies-in-Home-Health-and-Hospice-Care-Agencies.html
7. Hallett, N., & Dickens, G. L. (2017). De-escalation of Aggressive Behaviour in Healthcare Settings: Concept Analysis. International Journal of Nursing Studies, 75, 10–20. https://doi.org/10.1016/j.ijnurstu.2017.07.003
8. McPhaul, K., Lipscomb, J., & Johnson, J. (2010). Assessing Risk for Violence on Home Health Visits. Home Healthcare Now, 28(5), 278-289. https://journals.lww.com/homehealthcarenurseonline/Fulltext/2010/05000/Assessing_Risk_for_Violence_on_Home_Health_Visits.5.aspx
9. Harassment. (N.d.). U.S. Equal Employment Opportunity Commission. https://www.eeoc.gov/harassment
10. Leach, B., Gloinson, E.R., Sutherland, A., & Whitmore, M. (2019). Reviewing the Evidence Base for De-escalation Training: A Rapid Evidence Assessment. RAND Corporation. https://www.rand.org/pubs/research_reports/RR3148.html

References (continued)

11. Arnetz, J. E., Hamblin, L., Ager, J., Luborsky, M., Upfal, M. J., Russell, J., & Essenmacher, L. (2015). Underreporting of Workplace Violence: Comparison of Self-Report and Actual Documentation of Hospital Incidents. Workplace health & safety, 63(5), 200–210. https://doi.org/10.1177/2165079915574684

12. Byon, H.D., Sagherian, K., Kim, Y., Lipscomb, J., Crandall, M., & Steege, L. (2021). Nurses' Experience With Type II Workplace Violence and Underreporting During the COVID-19 Pandemic. Workplace Health & Safety. 70(9):412-420. https://journals.sagepub.com/doi/10.1177/21650799211031233

Contributors – Safety Task Force Members

Rama Abou-Seif
Project Manager
Johns Hopkins Care at Home
Baltimore, MD

Matthew Broadwater, Pharm.D., B.C.P.S.
PGY2 Health-System Pharmacy Administration and Leadership Resident
The Johns Hopkins Hospital
Baltimore, MD

Andrea L. Devoti
Executive Vice President
National Association for Home Care and Hospice
Washington, DC

Melinda Jarjura, R.N., B.S.N.
Regional Director, Homecare Operations
Trinity Health of New England At Home
Farmington, CT

Mary Myers, M.S., R.N.
President and Chief Executive Officer
Johns Hopkins Care at Home
Baltimore, MD

Steven Pamer, P.T., M.P.A., G.C.S.
Administrator
Director, Rehabilitation Services
Cleveland Clinic Home Care
Independence, OH

Tom Threlkeld
Director of Communications
National Association for Home Care and Hospice
Washington, DC

Lori Bonderson, M.S.
Director, Quality and Compliance
Avera@Home
Sioux Falls, SD

Ali Byro
Director, Administrative Services
Johns Hopkins Care at Home
Baltimore, MD

Tonya Gray, M.S.H.A., C.P.A.
Director, Home Health Care & Home Services
UW Health
Rockford, IL

Shannon Mintz, R.N., M.B.A., C.O.S.-C.
VP, Home Health and Regulatory Affairs
Association for Home and Hospice Care of North Carolina
Raleigh, NC

Brittany Nada, A.S.P.
Safety Manager
Amedisys Inc.
Baton Rouge, LA

Nathan Thompson, R.Ph., M.B.A., M.P.H.
Chief Administrative Officer/VP of Administrative Services
Johns Hopkins Care at Home
Baltimore, MD

Mark Winchester
Director of Marketing
National Association for Home Care and Hospice
Washington, DC

The National Association for Home Care & Hospice and Johns Hopkins Care at Home acknowledge and thank the following reviewers of the resource guide:

Linda A. Arthur, Comprehensive Nursing Services, Inc.

Eugene Banks, Gulfside Healthcare Services

Candace Bowman, Brightspring Health Services

Maria Capretta, Cleveland Clinic

John Castleman, Visiting Nurse Association Health Group Hospice

Clover Crowder, Horizon Home Care and Hospice

Alicia Dyment, Granite VNA

Lucy Emechete, MB Homecare

Amy Genthe, MSPT, Porter Hills Homecare

Michelle Hummel, Tower Health at Home

Abigail Johnson, RN, HomeCentris Home Health

Manjeet Kaur, Option Care Health Amedisys

Barbara Knott, UNC Health

Elizabeth Lee, Augusta Health

Amy Magee, Cleveland Clinic Connected Care

Kelly Oechslin, WellSpan VNA Home Care

Kathy Quan, TheNursingSite.com

Bob Roth, Cypress HomeCare Solutions

Bill Sczepanski, Team Select Home Care

Karen Smith, Concordia Visiting Nurses

Wendi Tingley, Indiana Association for Home & Hospice Care

Bob Banerjee, Shanti Hospice LLC

Sandra Bennis, WellSpan Home Care

Janine Brunjes, University of New Mexico Hospitals

Lissette Carcano, Valley Health System

Jenna Cotterman, Bridge Home Health and Hospice

Sheila Davis, Always Best Care Senior Services

William H. Edwards, LifeCare Home Health Family

Sarah Frank, Trinity Health At Home

Jennifer Gold, Cincinnati Children's Hospital Medical Center

Keri Jaeger, Mount Evans Home Health Care and Hospice

Stephanie Johnston, Transcend Strategy Group

Melanie Keller, RN, BSN, MHA, Meritan, Inc

Andrew Koski, Home Care Association of New York State

Terri Lindsey, Bon Secours Home Health

Vince Moffitt, Basin Health Companies

Connie Oliphant, North Kansas City Hospital Home Health

Beth Redfield, ChristianaCare HomeHealth

Linda Scott, Scott's Solutions

Kate Sicotte, Androscoggin Home Healthcare & Hospice

Danielle Thai, UW Health Care Direct

Dorathea Velasco