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| --- | --- |
| **OMB Approved** | **Changes** |
| This question was not asked previously. | Are you currently working as a home healthcare aide in New Jersey? Yes No |
| 1a. Do you receive violence-based safety training? As a New Hire Repeated Both at New Hire and Repeated | 1a.. Do you receive violence-based safety training? As a New Hire Refresher (e.g. annual) Both at New Hire and Refresher |
| 1b. How long is the violence-based safety training? New Hire: \_\_\_\_\_\_ (minutes) Repeated: \_\_\_\_\_\_\_\_ (minutes) | 1b. How long is the violence-based safety training? New Hire: \_\_\_\_\_\_ (minutes) Refresher: \_\_\_\_\_\_\_\_ (minutes) |
| 2. Do you consistently use your employer’s violence-based safety policies and procedures?  Always Most of the Time Rarely Never | 2. Do you consistently use your employer’s violence-based safety policies and procedures?  Always Most of the Time Rarely Never My employer does not have violence-based safety policies or procedures |
| **Experienced Violent Events**  In the last year while at work, did you **experience** the following?  Please refer to the currently approved chart on page 2. | Two new columns have been added to the current chart to include the following: **“**From patient or family member” and “From coworker or boss”. Please refer to the currently approved and requested versions on pages 2- 3. |
| **Health Promotion**  Does your home healthcare agency offer wellness classes for its employees?  Smoking Cessation Yes No  Diet and Nutrition Yes No  Physical Activity Yes No  Stress Management Yes No | This information is now being captured within a chart. Please refer to the currently approved and requested versions on page 4. |
| **Age: \_\_\_\_\_\_years** | **Age:**  19 or less 20-29 30-39 40-49 50-59 60 and over |
| **Job Type (check all that apply):** Home Health Provider Hospice Care Provider | **Which employers do you work for?** Home Health Agency Assisted Living Residence  Personal Care Home Hospice  Contractor Other\_\_\_\_\_\_\_\_\_\_\_  Independent Provider  Which one of the above employers do you work for the most? \_\_\_\_\_\_\_\_\_ |
| **Employment Status** (check one):Full-time Part-Time | **Employment Status** (check one): How many hours do you usually work in a week? 40 or more 30-39 20-29 <20 |
| **Experience:** Length of time as a home health care provider: \_\_\_\_\_\_\_ years; \_\_\_\_\_\_\_month | **Experience:** Number of years as a home care provider: \_\_\_\_\_\_\_ years |

**Currently Approved**

**Experienced Violent Events**

In the last year while at work, did you **experience** the following?

|  |  |  |
| --- | --- | --- |
| Type of Violence | | Experienced at work in last year |
| Verbal Assaults  being yelled at, shouted at, or sworn at | Yes No |
| Verbal Threats Without a Weapon  threat of physical harm without a weapon; threat to damage or steal personal or workplace property | Yes No |
| Verbal Threats With a Weapon  threat of physical harm with a weapon; threat to damage or steal personal or workplace property | Yes No |
| Physical Assaults  an attack or attempted attack with or without a weapon (including hands/fists) resulting in no injury or injury at any severity level | Yes No |
| Robberies & Muggings  taking or attempting to take personal (e.g. purse) or workplace (e.g., medicine, medical supplies) property by force or threat of force | Yes No |
| Property Thefts  taking of personal or workplace property without personal threat, attack, or bodily harm (e.g. stealing medical supplies out of worker’s car) | Yes No |
| Vandalisms  damage or destruction to personal (e.g. graffiti on worker’s car) or workplace property (e.g. breaking medical supplies) | Yes No |
| Sexual Harassments  Unwanted, offensive sexual behavior or comments (verbal or non-verbal) | Yes No |
| Sexual Assaults  Attacks of unwanted sexual contact, including rape, attempted rape, grabbing or fondling | Yes No |
| Exposure to Bodily Fluids  Exposed *on purpose* to another person’s blood saliva, urine, or any other bodily fluid | Yes No |

**Requested Change**

**Experienced Violent Events**

In the last year, did you **experience** any of the following while at work?

|  |  |  |
| --- | --- | --- |
| Type of Violence **(*For patient committing the violence, this is regardless of their state of being, such as dementia or substance use.*)** | From patient or family member | From coworker or boss |
| Verbal Assaults, With or Without a Weapon  being yelled at, shouted at, or sworn at; threat of physical harm with or without a weapon; threat to damage or steal personal or workplace property | Yes No | Yes No |
| Physical Assaults  an attack or attempted attack with or without a weapon (including hands/fists) with or without an injury | Yes No | Yes No |
| Robberies & Muggings  taking or attempting to take personal (e.g. purse) or workplace (e.g., medicine, medical supplies) property by force or threat of force | Yes No | Yes No |
| Property Thefts  taking of personal or workplace property without personal threat, attack, or bodily harm (e.g. stealing medical supplies out of worker’s car) | Yes No | Yes No |
| Vandalisms  damage or destruction to personal (e.g. graffiti on worker’s car) or workplace (e.g. breaking medical supplies) property | Yes No | Yes No |
| Sexual Harassments/Assaults  unwanted, offensive sexual behavior or comments (verbal or non-verbal); attacks of unwanted sexual contact, including rape, attempted rape, grabbing or fondling | Yes No | Yes No |
| Exposure to Bodily Fluids  exposed *on purpose* to another person’s blood, saliva, urine, or any other bodily fluid | Yes No | Yes No |
| Bullying/Intimidation  Less desirable assignments | Yes No | Yes No |
| Other types of violence. Please describe: |  |  |

**Currently Approved**

**Health Promotion**

Does your home healthcare agency offer wellness classes for its employees?

Smoking Cessation Yes No

Diet and Nutrition Yes No

Physical Activity Yes No

Stress Management Yes No

**Requested Change**

**Health Promotion**

Does your home healthcare agency offer wellness classes for its employees, and if so, have you ever participated in a class?

|  |  |  |
| --- | --- | --- |
| Wellness class | Wellness classes offered  by agency? | Participated in wellness classes offered by agency? |
| Stop Smoking | Yes No Don’t Know | Yes No N/A (not a smoker) |
| Diet and Nutrition | Yes No Don’t Know | Yes No |
| Physical Activity | Yes No Don’t Know | Yes No |
| Stress Management | Yes No Don’t Know | Yes No |