

Appendix C3:

Nursing Home/Hospital Administrators- Employee Incident Information

Hospital Code: _____

Incident ID: _____

Workplace Violence Prevention Study

EMPLOYEE INCIDENT INFORMATION

Data Source: _____ Electronic Source: 01 Yes 02 No

1. Date of Incident: ____ / ____ / ____ 99 Unknown / Not specified
2. Time of Incident: _____ am / pm 99 Unknown / Not specified
3. Department Where Incident Occurred: _____ 99 Unknown / Not specified
4. Location of Incident: (check all that apply)
01 Admitting / Triage 05 Entrance / Exit / Restricted Entry 09 Seclusion / Time Out Room
02 Corridor Hallway/Stairwell 06 Lobby / Waiting Room 10 Dining Area
03 Day Room 07 Nurses Station 11 Outdoor Areas
04 Bathroom 08 Patient Room 99 Unknown / Not Specified
88 Other (Specify: _____)
5. Victim occupation: _____ 99 Unknown / Not specified
(See NHSN Occupation Codes)
6. Activity at Time of Incident: (check all that apply)
01 Escorting 07 Combative / Defiant / Unruly (further unspecified)
02 Restraining 08 Elopement
03 Approaching / Redirecting 09 Unprovoked / Came up from behind
04 Assisting co-worker 10 Monitoring / Observing
05 Medical care / Nursing duties 99 Unknown / Not Specified
06 Responding to code / Intervening / Physically confronting / Taking down
88 Other (Specify: _____)
7. Perpetrator Relationship to Victim:
01 Criminal 03 Employee (Circle one: present / past) 05 Patient Visitor
02 Patient 04 Domestic 99 Unknown / Not Specified
8. Number of Perpetrators: _____ 99 Unknown / Cannot be determined
9. Type of Violent Event: (check all that apply)
01 Physical Assault 03 Sexual Assault / Harassment
02 Verbal Assault / Threat 04 Unknown / Not Specified
88 Other (Specify: _____)

Public reporting burden of this collection of information is estimated to average 60minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0914).

10. Weapon(s) Used: (check all that apply)

- 01 Fists / Hands / Nails 05 Floor / Door / Wall 09 Food / Utensils /
 Meal tray
02 Feet 06 Body (nonspecific) 11 Words / Verbal
 Threat 03 Gun / Knife 07 Furniture 99
 Unknown / Not Specified
04 Teeth 08 Medical supply / Instrument
88 Other (Specify: _____)

11. Type of Physical Injury: (check all that apply)

- 01 Abrasion / Cut / Laceration / Scratch 05 Dislocation / Fracture
02 Bite 06 Exposure to bodily fluids
03 Bruise / Contusion / Blunt Trauma 07 No Physical Injury

04 Sprain / Strain 99 Unknown / Not Specified
88 Other: (Specify: _____)

12. Part of Body Injured: (check all that apply)

- 01 Head/Face/Neck 04 Back 07 Multiple body parts (not further specified)
02 Arm/Hand/Shoulder 05 Groin / Buttocks 08 No body part was physically hurt
03 Chest/Abdomen 06 Leg / Hip / Feet 99 Unknown / Not Specified
88 Other (Specify: _____)

13. Was the employee unable to work for at least one full day after the incident?

- 01 Yes - Number of days: _____ 02 No 99 Unknown

14. Did the employee have restricted work duty?

- 01 Yes - Number of days: _____ 02 No 99 Unknown

15. Was medical attention provided?

- 01 Yes 02 No 99 Unknown

16. Number of employees in the vicinity when the incident occurred? _____ (For each employee, describe their actions in response to the incident, if any.)

- a. _____
 b. _____
 c. _____
 d. _____
 e. _____
 f. _____

17. Recommendations, if applicable, of police advisors, employees, or consultants.

| Recommendation | Title of Person Making Recommendation |
|----------------|---------------------------------------|
| a. | |

| | |
|----|--|
| b. | |
| c. | |
| d. | |
| e. | |
| f. | |

18. Actions taken by the facility in response to the incident.

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____

19. Was law enforcement called? 001 Yes 002 No 099 Unknown

ADDITIONAL COMMENTS:

Nursing Home Code: _____

Incident ID: _____

Workplace Violence Prevention Study

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- 01 Yes - Number of days: _____
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- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____

17. Recommendations, if applicable, of police advisors, employees, or consultants.

| Recommendation | Title of Person Making Recommendation |
|----------------|---------------------------------------|
| a. | |

| | |
|----|--|
| b. | |
| c. | |
| d. | |
| e. | |
| f. | |

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- a. _____
- b. _____
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ADDITIONAL COMMENTS: