Form Approved

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HEALTHCARE FACILITY WORKPLACE VIOLENCE PREVENTION PROGRAMS

Home Healthcare Aide Survey

Are you currently working as a home healthcare aide in New Jersey? Yes No If Yes, please complete the survey and return it in the envelope provided.

If No, stop and return the survey in the envelope provided.

**Violence-Based Safety Programs in Health Care**

1. Did you receive training about violence-based safety in your workplace?

 Yes. Go to question 1a-e.

 No. Go to question 2.

 Unknown. Go to question 2.

**IF YES:**

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) Refresher: \_\_\_\_\_\_\_\_\_\_\_\_ (minutes)

1c. Which of the following components are included in the violence-based safety training either at new hire or as a refresher?

|  |  |
| --- | --- |
| Review of the agency’s violence-based safety policies |  Yes No Unknown |
| Identification of predicting factors for violence |  Yes No Unknown |
| Verbal methods to stop aggressive behavior |  Yes No Unknown |
| Physical methods to stop or avoid aggressive behavior |  Yes No Unknown |
| Obtaining a history on a patient with violent behavior |  Yes No Unknown |
| Techniques for restraining violent patients |  Yes No Unknown |
| Self-defense if preventive action does not work |  Yes No Unknown |
| Requirements and procedures for reporting violence |  Yes No Unknown |
| Location and operation of safety devices |  Yes No Unknown |
| Resources for employee victims of violence |  Yes No Unknown |
| Other (please describe):  |  |

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1d..What, if anything, do you feel should be changed about the training? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1e. How good would you say your violence-based safety training program is:

 Excellent Very Good Adequate Not very good

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, 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 Weaponbeing 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 Assaultsan attack or attempted attack with or without a weapon (including hands/fists) with or without an injury | Yes No | Yes No |
| Robberies & Muggingstaking 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 Theftstaking 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 |
| Vandalismsdamage 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/Assaultsunwanted, 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 Fluidsexposed *on purpose* to another person’s blood, saliva, urine, or any other bodily fluid | Yes No | Yes No |
| Bullying/IntimidationLess desirable assignments | Yes No | Yes No |
| Other types of violence. Please describe: |  |  |

**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 |

Does your home healthcare agency offer exercise facilities for its employees?

Yes No Don’t Know

**Driving**

Has your employer ever given you any information about safe driving on the job? This may include training, safety talks, videos, or information about traffic laws or company policies.

Yes No Don’t Know

In the past 12 months, have you been involved in a motor vehicle accident while on the job? *Please include only accidents that took place during your work day (for example, while driving to visit a patient or crossing the street to attend a work meeting).* ***Do not include*** *accidents that took place while you were commuting from your home to your agency’s work site and vice versa.* (Check all that apply.)

Yes- My vehicle was involved in an accident with another vehicle.

Yes- Only my vehicle was involved (e.g., hit a tree).

Yes- I was struck as a pedestrian by a motor vehicle (e.g., crossing the street to visit a patient.

 No

 **IF YES to any of the above:** What was the result of the accident (check all that apply)?

 There was no damage to any vehicle involved, and no injuries.

There was damage to one or more vehicles or to nearby property, but no one was

injured.

I was injured, but I did not need medical treatment.

I was injured severely enough to need medical treatment or to miss work for more than

4 hours.

**Background**

**Age:**  19 or less 20-29 30-39 40-49 50-59 60 and over

**Sex:**  Male Female

**Race / Ethnicity** (check all that apply):

* White or Caucasian
* Black or African American
* Asian
* Native Hawaiian / Pacific Islander
* Native American Indian or Alaskan
* Hispanic / Latino

**Education** (check highest level completed):

* Less than High School Diploma
* High School Diploma / GED
* Some college, including Associate Degree
* Bachelor’s Degree (Field of study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* Some graduate work or advanced degree; (Field of study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Agency:** Is your home healthcare agency part of a hospital? Yes No

**Employment Status** (check one):

How many hours do you usually work in a week? 40 or more 30-39 20-29 <20

**Experience:**

Number of years as a home care provider: \_\_\_\_\_\_\_ years

**Which employers do you work for?** (check all that apply)

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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Safety at Work:**

On a scale from 1-10 with “1” being *never feel safe* and “10” being *always feel safe*, how safe do you generally feel when making home visits? (Please circle one number)

 1 2 3 4 5 6 7 8 9 10

Never feel safe Always feel safe