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RULE ADOPTIONS

HEALTH AND SENIOR SERVICES SENIOR SERVICES AND HEALTH SYSTEMS BRANCH HEALTH FACILITIES EVALUATION AND LICENSING DIVISION OFFICE OF CERTIFICATE OF NEED AND HEALTHCARE FACILITY LICENSURE

43 N.J.R. 2337(a)

Adopted New Rules: N.J.A.C. 8:43E-11 Adopted

Amendment: N.J.A.C. 8:43E-3.4 Violence

Prevention in Health Care Facilities

Proposed: January 3, 2011 at 43 N.J.R. 12(a). Adopted: July 16, 2011 by Christina G. Tan, M.D.,

M.P.H., Acting Commissioner,

Department of Health and Senior Services (with the approval of the Health Care Administration Board). Filed: August 3, 2011 as R.2011 d.231, **with technical changes** not requiring

additional public notice and comment (see N.J.A.C. 1:30-6.3). Authority:

N.J.S.A. 26:2H-5.23. Effective Date: September 6, 2011. Expiration Date:

August 18, 2013. **Summary** of Public Comments and Agency Responses:

The Department of Health and Senior Services (Department) received written comments from the individuals listed below on or before the close of the 60-day public comment period, which ended March 4, 2011.

1. Rick Engler, Director, New Jersey Work Environment Council, Trenton, NJ.

2. Jennifer M. Halper, Senior Staff Attorney/Legislative Coordinator, Disability Rights New Jersey, Trenton, NJ.

1. John W. Indyk, Health Care Association of New Jersey, Hamilton, NJ.

2. Scott Mueller, RN, Sayreville, NJ.

3. Michele Ochsner, Ph.D., Princeton, NJ.

4. 6. Kerry A. Stevenson, Director of Managed Care and Risk Management, Carrier Clinic, Belle Mead, NJ.

5. 7. Kerry A. Stevenson, Director of Risk Management, East Mountain Hospital, Belle Mead, NJ.

6. 8. Carolyn Torre, RN, MA, APN, Director, Regulatory Affairs, New Jersey State Nurses Association, Trenton, NJ.

9. Ann Twomey, President, Health Professionals Allied Employees, Emerson, NJ.

The numbers in parentheses after each comment below identify the respective commenters listed above.

1. COMMENT: The commenter participated in the stakeholders' meetings that included representatives of the hospital and long-term care industries. The commenter supports adoption of the new rules and amendment because they will protect patients and caregivers, and ultimately reduce health care costs. The commenter has witnessed the value of key elements of the proposed new rules, such as: worker participation in a joint worker-management committee; policies and procedures to minimize risk; worker education and training; reporting and recordkeeping requirements; and protection for workers from retaliation for exercising their rights under the law. (1)

RESPONSE: The Department appreciates the commenter's support for the proposed new rules and amendment.

2. COMMENT: The commenter is concerned that the focus of the proposed rules is on preventing injuries to health care workers and neglects to address preventing injuries to patients who may be subject to restraints. The commenter indicates that, in the scope and purpose, one of the goals of the proposed rulemaking is to maintain a safe and therapeutic environment for patients and residents. The commenter says that the rulemaking should include protection for individuals who may be subject to restraints but, as written, the proposed amendment and new rules fail to address the right of a patient to not be restrained and the right of a patient injured in a restraint to receive health treatment as a result of such injury. The commenter states that the rulemaking does not contain enough information regarding the training of staff and the use of de-escalation techniques in particular. The commenter recommends that the Department should require staff in its licensed facilities to undertake the same violence prevention and crisis management training required by staff employed in psychiatric hospitals regulated by the Division of Mental Health Services, including training in trauma-informed care. Finally, the commenter commends the Department for its proposal to establish in-house crisis response teams available on-site 24 hours a day. (2)

RESPONSE: The commenter is correct in stating that, in the notice of

proposal's scope and purpose, one of the goals is to maintain a safe and therapeutic environment for patients and residents. This wording is adapted from the "Violence Prevention and Health Care Facilities Act," which states, "[t]he Legislature finds and declares that: . . . Preventing workplace violence is essential for creating a safe and therapeutic environment for patients." (N.J.S.A. 26:2H-5.18.2 and 2F) The Act's definition of "violence" or "violent act," however, is "any physical assault, or any physical or credible verbal threat of assault or harm against a health care worker." (N.J.S.A. 26:2H-5.19) Thus, while the prevention of workplace violence contributes to the creation of a therapeutic environment for residents and patients, the intended goal of the Act and proposed rules is to prevent violence against health care workers.

Regarding the commenter's statements about restraints, the Department wants to emphasize that, in all cases, the actual use of restraints should be determined by an appropriately-licensed health care professional. The Department also maintains that the content and level of training regarding restraints should be specifically established by the Violence Prevention Committee at each covered facility as specified at N.J.A.C. 8:43E-11.10(g)4.

Finally, the Department appreciates the commenter's support for its proposed rulemaking to establish in-house crisis response teams that would be available on-site 24 hours a day. The Department makes no change on adoption.

3. COMMENT: The commenter appreciates the opportunity to comment on the proposed amendment and new rules and for having had the opportunity to participate during the course of lengthy discussions involving the Department and stakeholders. The commenter thanks the Department for ensuring that the proposed rules adhere to the legislative intent of the Violence Prevention in Health Care Facilities Act. As a means to better facilitate compliance, the commenter appreciates the Department's willingness and efforts to incorporate clarification into the proposed rules where deemed necessary by the stakeholders. (3)

RESPONSE: The Department appreciates the commenter's support for the proposed new rules and amendment.

4. COMMENT: The commenter states that existing Department requirements for long-term care facilities require all nursing and [page=2338] professional staff to receive annual training in the use of restraints (N.J.A.C. 8:39-27.1(d)) and that only licensed nursing staff should initiate the use of restraints (N.J.A.C.

8:39 Appendix D, section B). The commenter states that with regard to a violent act, it is not practical or always possible for a physician or licensed nurse to assess the situation prior to using restraining techniques. The commenter believes that the proposed rules should provide that the use of restraining techniques need not meet the requirements of N.J.A.C. 8:39. (4)

RESPONSE: The commenter is correct in noting that the proposed new rules state that training shall be provided for "all health care workers ... regardless of risk" (N.J.A.C. 8:43E-11.10(b)) and that "training shall include ... Appropriate responses to workplace violence, including the use of restraining techniques." (N.J.A.C. 8:43E-11.10(g)4). As noted in a previous response, however, the Department maintains that, in all cases, the actual use of restraints should be determined by an appropriately-licensed health care professional. Furthermore, in the case of long-term care facilities, regarding training-session content related to the use of restraints, the Violence

Prevention Committee in each long-term care facility covered by the proposed new rules should consider the provisions of N.J.A.C. 8:39-27.1(d) and 8:39 Appendix D, which, as noted by the commenter, also address restraint use. The Department makes no change on adoption.

5. COMMENT: The commenter strongly endorses the proposed new rules and amendment that has emerged from the rulemaking process. "In the fraught and sometimes highly emotional world of healthcare, nurses and direct care workers are highly vulnerable to injuries largely caused by patients and (sometimes) their families. Patients are also vulnerable if health care workers are not skilled in recognizing situations that can escalate into violence and if facilities do not have a plan in place to deal with violent situations. The new law is based on a comprehensive plan and each of the components of the new law is critical: joint labor-management committees, reporting and record keeping, education and training, and protecting workers who exercise their rights under this rule." The data demonstrate that comprehensive health and safety programs will ultimately save facility and taxpayer money. (5)

RESPONSE: The Department appreciates the commenter's support for the proposed new rules and amendment.

6. COMMENT: The commenter represents two private psychiatric facilities that for many years have taken actions, similar to those included in the proposed new rules, to prevent violence in their facilities. The commenter believes that the proposed new rules should recognize the specific needs of private psychiatric facilities by distinguishing between "threats of violence that can breach the entrance ways of a healthcare facility from the outside" as opposed to aggressive and violent behavior that is frequently encountered and often required for the patient to meet medical necessity for admission to a psychiatric service. The commenter asks that N.J.A.C. 8:43E-11.8 be clarified to ensure that implementation of devices or deployment of extra staff be at the facility's discretion as determined by the result of the risk assessment, analysis of incident data and any other contributing data source and factors necessary to allocate funds toward these areas. The commenter believes it is unclear whether the implementation of methods to reduce risk is mandatory or that these methods are left to the facility to implement as demonstrated by need. The commenter believes that requiring a full investigation for all incidents of violence/aggression no matter how minor is not always productive and would be onerous. The commenter recommends that the study of de-identified, aggregated data is sufficient and that a detailed investigation should only occur when a violent act results in serious injury. The commenter recommends that the use of "serious" injury should be in line with that used in the Patient Safety Act. (6, 7)

RESPONSE: Although the commenter believes it is unclear whether the implementation of methods to reduce risk are mandatory or left to the facility to implement as demonstrated by need, the rules clearly specify in N.J.A.C. 8:43E-11.8(b)2 and 4 that specified prevention and control measures shall be implemented "as necessary" and "as needed."

Furthermore, the commenter believes that requiring a full investigation for all incidents of violence/aggression, no matter how minor, is not always productive and would be onerous. The "Violence Prevention in Health Care Facilities Act," however, defines "violence" or "violent act" as "any physical assault, or any physical or credible verbal threat of assault or harm against a

health care worker." In other words, according to the statute, covered facilities shall report and keep records of all violent acts. The Act does not distinguish between violent acts by patients and those that "breach the entrance ways of a health care facility from the outside."

Finally, the commenter recommends the use of "serious" injury as this term is used in the Patient Safety Act. The Patient Safety Act is an entirely separate law and the Department agreed with the consensus formed at the stakeholders' meetings to adhere to the terms and definitions set forth in the "Violence Prevention in Health Care Facilities Act." The Department believes this is consistent with legislative intent and makes no change on adoption.

7. COMMENT: The commenter was involved in the development and passage of the legislation that the proposed new rules and amendment would implement. The commenter is deeply concerned about the increasing frequency and severity of violence perpetrated against health care workers, the largest percentage of which are nurses, across all health care settings. The commenter strongly supports the proposed new rules and amendment, and is hopeful that these rules will, over time, begin to successfully contribute to a reduction in violence experienced by workers in New Jersey health care facilities. (8)

RESPONSE: The Department appreciates the commenter's support for the proposed new rules and amendment.

8. COMMENT: The commenter supports the proposed new rules and amendment. The commenter participated in an extensive and productive negotiations process while the legislation was being drafted and later during the development of the proposed new rules and amendment. The proposed new rules and amendment include elements that the health and safety literature have identified as being essential for the success of ergonomic and violence prevention programs, notably: frontline worker participation in a joint worker-management committee that oversees all aspects of the program; policies and procedures to minimize risk; periodic risk assessments; worker education and training; reporting and recordkeeping provisions; and protection from retaliation for workers exercising their rights under the law. The commenter is pleased that these long-overdue rules are poised to go into effect and looks forward to working with employers to assure that all parties benefit from these protections. (9)

RESPONSE: The Department appreciates the commenter's support for the proposed new rules and amendment.

Federal Standards Statement

At the national level, despite a 1993 petition by a multi-union coalition to the Occupational Safety and Health Administration (OSHA), the Federal government declined to issue a standard regarding violence against health care workers. Instead, the Federal government issued OSHA's 2004 "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers." (www.osha.gov/Publications/osha3148.pdf). Since then, several states have enacted legislation requiring the implementation of programs or incident reporting regarding violence in health care facilities. The adopted new rules and amendment are mandated by N.J.S.A. 26:2H-5.17 et seq. and are not subject to Federal standards or requirements. Therefore, a Federal standards analysis is not required.

Full text of adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

(**Agency Note**: The text of N.J.A.C. 8:43E-3.4 below reflects the adoption of new paragraphs (a)19 and 20, which is published elsewhere in this issue of the New Jersey Register.)

SUBCHAPTER 3. ENFORCEMENT REMEDIES

8:43E-3.4 Civil monetary penalties

(a) Pursuant to N.J.S.A. 26:2H-13 and 14, the Commissioner may assess a penalty for violation of licensure regulations in accordance with the following standards:

1.-14. (No change.)

15. For failure of an entity licensed in accordance with N.J.S.A. 26:2H-1 et seq. to disclose to a patient or resident, pursuant to N.J.A.C. [page=2339] 8:43E-10.7, a serious preventable adverse event that affected that patient or resident, the following:

i. (No change.)

ii. $ 5,000 for failure to disclose an event that the health care facility reported, in a timely manner, to the Department;

1. For violation of N.J.A.C. 8:43G-12A or 36.3(b)4, governing emergency care for sexual assault victims, $ 5,000 per violation, which may be assessed for each day noncompliance is found;

2. For violations of the requirements of N.J.A.C. 8:43E-11 that result in injury to a health care worker, $ 5,000 per violation, which may be assessed for each day noncompliance is found; *[and]*

3. For violations of the requirements of N.J.A.C. 8:43E-11 not resulting in injury as set forth in (a)17 above, $ 2,500 per violation, which may be assessed for each day noncompliance is found*[.]****;***

19.-20. (No change.)

(b)-(c) (No change.)

SUBCHAPTER 11. VIOLENCE PREVENTION IN HEALTH CARE FACILITIES

8:43E-11.1 Scope and purpose

(a) The provisions of this subchapter apply to general hospitals, special hospitals, county and private psychiatric hospitals and nursing homes licensed by the Department of Health and Senior Services pursuant to P.L. 1971, c. 136
(N.J.S.A. 26:2H-1 et seq.).

(b) The purpose of this subchapter is to establish violence prevention programs in each of the covered health care facilities in order to protect health care

workers from violence; to minimize insurance claims, lost productivity, disruptions to operations, legal expenses and property damage; to maintain a safe and therapeutic environment for patients and residents; and to retain health care professionals.

8:43E-11.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Covered health care facility" or "facility" means a general hospital, special hospital, county or private psychiatric hospital or nursing home licensed by the Department of Health and Senior Services pursuant to P.L. 1971, c. 136 (N.J.S.A. 26:2H-1 et seq.).

"Credible verbal threat of assault or harm" means a knowing and willful statement that is corroborated by independent evidence, which would cause a reasonable person to believe that he or she is under imminent threat of death or serious bodily injury, and which actually causes a person to believe that he or she is under imminent threat of death or serious bodily injury.

"De-identified" means information that does not specifically identify the individual or individuals involved, either by name or other pre-assigned identification number, and that makes a reasonable effort to prevent the individual or individuals involved from being identified from such information.

"Direct patient or resident contact" means hands-on or face-to-face contact with patients or residents.

"Health care worker" means an individual who is directly employed by a covered health care facility.

"Incident investigation" means an in-depth analysis of a violent act that is designed to identify both direct and underlying causes of the act, in order to develop corrective actions that could reduce the potential for similar violent acts in the future.

"In-house crisis response team" means a crisis response team on-site at a facility 24 hours-a-day, seven days a week, or immediately available from an outside contractor.

"Job task analysis" means an evaluation conducted by the facility in collaboration with and for each health care worker to determine job or task-specific hazards or risk factors that may contribute to a health care worker's vulnerability to a violent act.

"OSHA" means the Occupational Safety and Health Administration of the United States Department of Labor.

"Violence," "violent act" or "incident" means any physical assault or any physical or credible verbal threat of assault or harm that is committed against a health care worker.

"Zero-tolerance policy" means a policy stating that a violent act will not be tolerated and that, in every case, management will ensure reporting, response

and follow-up as specified in this subchapter.

8:43E-11.3 Establishment of a violence prevention program

(a) Except as provided in N.J.A.C. 8:43E-11.6, by *[(three months after effective date of these rules)]* ***December 6, 2011***, a covered health care facility shall establish a violence prevention program that complies with the requirements of this subchapter for the purpose of protecting health care workers.
(b) A covered facility shall allow health care workers including, but not limited to, union representatives, supervisors and managers, to participate in the establishment and evaluation of the violence prevention program through means developed by the violence prevention committee.

8:43E-11.4 Violence prevention committee

(a) A covered health care facility shall establish a violence prevention committee, which shall meet at least quarterly, or more frequently as needed.

(b) The violence prevention committee shall include a representative of facility administration who shall be responsible for overseeing all aspects of the program.

(c) The violence prevention committee shall select a chairperson from among its members.

(d) The violence prevention committee shall be comprised of members as follows:

1. At least 50 percent of the committee members shall be health care workers who engage in direct patient contact or otherwise have contact with patients or residents;

2. The remaining committee members shall have experience, expertise or responsibility relevant to violence prevention; and

3. In a facility or health care system where health care workers are represented by one or more collective bargaining agents, the administration of the facility or system shall consult with the applicable collective bargaining agents regarding the selection of the health care worker committee members.

(e) The violence prevention committee shall be responsible for tasks including, at a minimum, the following:

1. Completion of an annual violence risk assessment to analyze risk factors for workplace violence and to identify patterns of violence;

2. Development of a written violence prevention plan that shall be submitted to facility administration.

i. The written violence prevention plan shall outline policies, procedures and responsibilities and shall be updated annually;

1. Provision of recommendations to the facility regarding methods to reduce identified risks based on findings of the violence risk assessment;
2. Review of the design and layout of all existing, new and renovated covered health care facilities to ensure safe, secure work areas and to prevent entrapment of workers;
3. Identification of information in the violence prevention plan that might pose a threat to security if

made public;

4. Development, annual review, evaluation and revision of violence prevention training content and methods as required by N.J.A.C. 8:43E-11.10;
5. Development of strategies for encouraging the reporting of all incidents of workplace violence and procedures for reporting such incidents; and
6. Review of de-identified, aggregated data that has been compiled from incident investigation reports by the appropriate department designated by the facility, in order to identify trends and, if needed, to make recommendations to prevent similar incidents.

i. The violence prevention committee shall have access to data prior to de-identification and aggregation, as determined necessary by the committee and in keeping with procedures established by the committee.

8:43E-11.5 System-level programs and committees

(a) When a health care system owns or operates more than one covered health care facility, the violence prevention program and committee may be operated at the system level, provided that:

1. Committee membership shall include at least one health care worker from each facility that provides direct care to patients or residents;

[page=2340] 2. The committee shall develop a violence prevention plan for each covered health care facility; and

3. Data related to violence prevention shall remain distinctly identifiable for each covered health care facility.

8:43E-11.6 Written violence prevention plan

(a) By *[(six months after the effective date of these rules)]* ***March 6, 2012***, the violence prevention committee shall develop and maintain a detailed, written violence prevention plan that identifies workplace risks and provides specific methods to address them.

(b) The plan shall, at a minimum, describe the following:

1. The establishment of a violence prevention committee;

2. Violence prevention policies;

3. The recordkeeping process;

4. Incident reporting, investigation and evaluation methods;

5. Follow-up medical and psychological care, which may include support groups, family crisis intervention and professional referrals; and

6. How employees shall access a covered facility's post-incident response system.

(c) The plan shall require an annual comprehensive violence risk assessment for the covered health care facility that meets the requirements of N.J.A.C. 8:43E-11.7.

(d) The plan shall identify methods to reduce identified risks including, at a minimum: facility modifications; changes to equipment, job design, staffing and security; and revision of violence prevention training content as specified in N.J.A.C. 8:43E-11.10.

(e) The plan shall include the following:

1. Copies of any agreements, if applicable, with law enforcement agencies and prosecutors, that contain contacts and a consistent set of remedial actions for specific events;

2. Dates on which the workplace violence prevention plan shall be reviewed; and

3. A copy of the written incident reporting procedure required by N.J.A.C. 8:43E-11.11.

8:43E-11.7 Completion of a violence risk assessment

(a) The violence prevention committee or a subcommittee with facility representation (in the case of a system-level committee) shall conduct an annual violence risk assessment, for each covered facility, that shall consider OSHA's 2004 Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers (OSHA 3148-2004), which are incorporated herein by reference, as amended and supplemented, and available at www.OSHA.gov.

1. The facility shall conduct a job task analysis in collaboration with and for each health care worker that shall be used by the violence prevention committee to identify improved security procedures and controls based on potential risk factors for violent incidents.

i. Such risk factors shall include, as applicable, working with unstable or volatile persons (for example, those under the influence of drugs or alcohol, in acute psychiatric distress, having a history of violence and/or having criminal backgrounds); prevalence of weapons on site among patients, family and visitors; the increasing presence of gang members; overcrowding and long waits for service that lead to client frustration, especially in emergency and clinical areas; isolated and/or solo work with patients and/or residents during examinations or treatment; lack of staff training; and the impact of staffing, including security personnel.

2. The covered facility shall require at least two members of the violence prevention committee, at least one of whom is a direct care staff member, to conduct walk through surveys of all worksite areas at least annually and as needed to identify existing or potential physical environment risk factors for workplace violence.

i. Such possible risk factors shall include, at a minimum, the facility's physical layout; access restrictions; crime rate in surrounding areas; non-working alarm systems, communication devices, surveillance cameras and/or mirrors; and poor lighting and visibility in the facility and in parking areas.

3. The covered facility shall require the violence prevention committee to analyze trends in violent incidents through the collection and review of de-identified data provided by the appropriate department within the facility pursuant to N.J.A.C. 8:43E-11.4(e)8.

8:43E-11.8 Implementation of methods to reduce identified risks

(a) The covered facility shall implement prevention and control measures to counteract the risk factors identified by the violence risk assessment required by N.J.A.C. 8:43E-11.7.

(b) The prevention and control measures shall include, at a minimum, the following:

1. Lighting indoors and in parking lots;
2. The installation, as necessary, and maintenance of items including, alarm systems, closed circuit TVs, metal detection systems, cell phones, personal alarm devices, codes, drop phones, panic alarms and audio surveillance systems;
3. Assigning and training appropriate personnel to respond to each alarm system in use at a facility;
4. The training and posting of security personnel in emergency departments, psychiatric wards and in other locations, as needed; and
5. Controlled access, as needed, to staff offices and employee work areas, especially secluded work areas.

8:43E-11.9 Copies of the violence prevention plan

(a) A covered facility shall make a copy of the violence prevention plan available upon request, to the Office of Certificate of Need and Health Care Facility Licensure in the Department of Health and Senior Services.

(b) A covered facility shall make a copy of the violence prevention plan available within two business days of the request, to any health care worker or collective bargaining agent who represents health care workers at the facility.

(c) If a language other than English is the exclusive language spoken by at least 10 percent of a covered health care facility's health care workers, the facility shall translate the workplace violence prevention plan into that language and make it available to those workers.
(d) In the event that the violence prevention committee determines, in accordance with N.J.A.C. 8:43E-11.4(e)5, that the plan contains information that would pose a threat to security if made public, the facility shall exclude any such information before providing copies to workers or collective bargaining agents.

8:43E-11.10 Violence prevention training

(a) The violence prevention committee of a covered health care facility shall designate a coordinator or team to arrange for violence prevention training.

(b) Within three months after a violence prevention plan has been developed, a covered facility shall conduct initial violence prevention training and annual training, thereafter, for all health care workers, including supervisors, managers and security staff, regardless of their level of risk.

(c) Training shall be at least two hours in duration and shall be held during paid work time.

(d) The training methods shall include, but not be limited to, at least two of the following: handouts, presentations, discussion, role playing and DVD or computer-based training activities.

(e) A covered facility shall provide interim training for individuals designated in (b) above who begin work between annual training sessions.

(f) The training shall be conducted in easily understandable terminology.

1. If a language other than English is the exclusive language spoken by at least 10 percent of a covered facility's health care workers, the training also shall be conducted in that language and handouts shall be made available in that language.

(g) The content of the training shall include, at a minimum, the following:

1. Requirements of the workplace violence administrative rules in this subchapter;

2. A review of the facility's relevant policies;

3. Techniques to de-escalate and minimize violent behavior;

4. Appropriate responses to workplace violence, including the use of restraining techniques;

5. Reporting requirements and procedures;

6. Location and operation of safety devices;

7. Resources for coping with violence;

[page=2341] 8. A summary and analysis of the facility's risk factors identified in the violence risk assessment and preventive actions taken in response to the risk factors identified; and

9. Information on multicultural diversity to increase staff sensitivity to racial and ethnic issues and differences.

8:43E-11.11 Incident response, investigation and reporting

(a) A covered facility shall respond to violent acts, conduct incident investigations and prepare incident investigation reports in keeping with procedures specified by the violence prevention committee.

1. The procedures shall be in writing, easily understood by all employees and take into account issues of confidentiality, as determined by the violence prevention committee.

(b) A health care worker in a covered facility who is present during an incident of violence, or who is the first on the scene after such an incident occurs, shall act according to procedures established by the violence prevention committee.

1. Law enforcement officials shall be summoned, if necessary and in keeping with specified procedures, in order to assist victims, assess and secure the incident area, ensure the safety of everyone involved, protect evidence and reduce distractions during the incident response process.

(c) The incident investigation required by (a) above shall focus on fact-finding, prevention and corrective action rather than on assessing blame and/or fault finding.

(d) The incident investigation required by (a) above shall gather the following facts:

1. Date, time and location of the incident;

2. Identity, job title and job task of the victim;

3. Identity, if known, of the person who committed the violent act;

4. Description of the violent act, including whether a weapon was used;

5. Description of physical injuries, if any;

6. Number of employees in the vicinity when the incident occurred, if known, and their actions in response to the incident, if any;

7. Recommendations, if applicable, of police advisors, employees or consultants; and

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

(e) A covered facility shall prepare a written incident investigation report for each violent act.

1. A covered facility shall provide written incident investigation reports, that have been de-identified as required by N.J.A.C. 8:43E-11.4(e)8, to the designated administrative representative and to the violence prevention committee according to established procedures.

i. The violence prevention committee shall decide if and when the de-identified data shall be aggregated.

2. The victim's identity shall not be included in the incident report if such

identity would not be entered on NJOSH 300 (N.J.A.C. 12:110-5.1) and the OSHA Log of Work-Related Injuries and Illnesses (OSHA 300 Log) required by 29 CFR Part 1904;

(f) After reviewing the de-identified incident reports, the covered facility, in collaboration with the violence prevention committee, shall encourage appropriate follow-up, consider changes in procedures and add elements to training as needed.

8:43E-11.12 Recordkeeping

(a) A covered facility shall keep a record of all violent acts that occur in the facility to help select the appropriate controls to prevent the recurrence of workplace violence and to determine required training.

(b) A covered facility shall maintain, for at least five years after the reported act, all incident investigation reports required by N.J.A.C. 8:43E-11.11(a) and any record of a violent act contained in any of the following documents:

1. NJOSH 300, copies of which can be found at http://lwd.dol.state.nj.us/labor/forms_pdfs/Isse/NJOSH300.pdf;
2. The OSHA Log of Work-Related Injuries and Illnesses (OSHA Form 300, which can be found at http://osha.gov/recordkeeping/RKforms.html) required by 29 CFR Part 1904;
3. Staff termination records;
4. Union grievances and complaints;
5. Workers' compensation records;
6. Insurance records;
7. Medical records;
8. Police reports;
9. Accident investigation reports;
10. Minutes of safety meetings;
11. Training records; and
12. Employee questionnaires.

(c) A covered facility shall provide the Department of Health and Senior Services with immediate access to the records required to be maintained by this section and to any de-identified and/or aggregated data.

1. An employee and/or his or her authorized representatives shall have access to the employee's identifiable records and to de-identified and/or aggregated data within two business days.

(d) In accordance with N.J.S.A. 26:2H-5.20, the records created and maintained pursuant to this section shall not be considered public or government records under P.L. 1963, c. 73 (N.J.S.A. 47:1A-1 et seq.) or P.L. 2001, c. 404 (N.J.S.A. 47:1A-5 et seq.).

8:43E-11.13 Post-incident response

(a) The covered facility shall ensure that prompt and appropriate medical care is provided to health care workers injured during an incident.

(b) The covered facility shall establish a post-incident response system.

1. The covered facility shall provide, at a minimum, an in-house crisis response team for employee-victims and their co-workers, and individual and group crisis counseling, which may include support groups, family crisis intervention and professional referrals as indicated in the violence prevention plan.

(c) The covered facility shall ensure that provisions for medical confidentiality and protection from discrimination shall be included in facility policies and procedures to prevent victims from suffering further loss.

8:43E-11.14 Prohibition of retaliatory action

(a) As used in this section, "retaliatory action" means the discharge, suspension or demotion of an employee, or other adverse employment action taken against an employee in the terms and conditions of employment, in accordance with section 2 of P.L. 1986, c. 105 (N.J.S.A. 34:19-2).

(b) A covered facility shall not take any retaliatory action against any health care worker for reporting violent incidents.

8:43E-11.15 Enforcement and penalties

A covered facility licensed pursuant to N.J.S.A. 26:2H-1 et seq. that is in violation of the provisions of this subchapter shall be subject to enforcement actions and penalties specified in N.J.A.C. 8:43E-3.