

# Keeping Community Health Care Workers Safe

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## Abstract

Organizations have a responsibility to ensure the safety of staff who provide care in the community. In a survey conducted within a regional health authority in Newfoundland, health care providers reported feeling unsafe while conducting home visits. Safety initiatives were explored, and a safety program was implemented within this region to address safety concerns. The safety program includes three key components: a risk assessment screening tool, a sign-in/sign-out system, and a buddy system. This article describes the evaluation process and outcomes of these three components. The evaluation process and outcomes may be useful to other health care organizations interested in promoting workplace safety.

## Keywords

evaluation, safety programs, risk assessment screening tool, sign-in/sign-out system, buddy system, workplace violence, community health care providers

## Introduction

The Canadian Initiative on Workplace Violence (CIWV; 2000) survey of labor organizations confirmed that workplace violence is on the rise across Canada, particularly in the public sector organizations. According to the CIWV, workplace violence constitutes both physical violence and psychological violence and aggression. A report by de Leseleuc (2004) for Statistics Canada on the criminal victimization in the workplace also demonstrates that workplace violence is a concern across Canada. de Leseleuc also notes that “40% of all violent incidents in Newfoundland and Labrador (NL) occurred at the victims’ workplace” (p. 7), suggesting that the high incidence of violence in NL workplaces stemmed from the high proportion of NL respondents who worked in health care and social assistance. The survey excluded workers in residential settings, such as home care workers.

Although there have been several studies about violence against health care workers in health care institutions (Anderson, 2001; Hesketh et al., 2003; Kinross, 1992; Lundstrom, Pugliese, Bartley, Cox, & Guither, 2002; McPhaul & Lipscomb, 2004; Yassi, 2004), there has been limited research examining the nature and frequency of safety issues faced by community-based health professionals (Rippon, 2000). Sylvester and Reisner (2002) audited charts and surveyed employees before and 6 months after an educational safety session from a home care agency serving both rural and urban areas in a Midwest U.S. state. They noted that an increase in the number of referrals coincided with an increase

in safety-related problems for employees in home care. Gathering statistically reliable data regarding violence at work is difficult (French & Morgan, 1999), and underreporting of incidents is generally consistent across health care disciplines.

Several factors may influence whether or not victims decide to report their violent incident (Banerjee et al., 2008), including worker apathy and increased workload of the “paper chase,” poor communication and documentation for reporting workplace incidents, and inconsistent definitions of what constitutes workplace violence (French & Morgan, 1999; Rippon, 2000). Underreporting may also be attributed to the fact that health care workers feel it is the nature of their professional work or that they need to protect their clients (MacDonald & Sirotich, 2005).

Workplace safety advocates suggest that prevention programs should be encouraged and supported to enhance organizational performance and efficiency and to create healthy work environments resulting in increased job satisfaction (Di Martino, 2002; Eisenberg, Bowman, & Foster,

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2001; Leck, 2002). The recommended elements of a staff safety program are a risk assessment tool, a buddy system for high-risk situations, and a sign-in/sign-out system for home visits (French & Morgan, 1999; Leck, 2002; Munson, 2002) and a commitment by the employer to encourage employee involvement in his or her safety (Galloway, 2002).

To determine program effectiveness, it is critical that a comprehensive evaluation be completed. There are many ways of performing project evaluations and no one specific method is appropriate for every program (Rossi, Lipsey, & Freeman, 2004). Rossi et al. (2004) report that it may be necessary to view many programs as being multidimensional; therefore, a single measurement may not be sufficient. Diversifying the measures of a program evaluation can provide a more comprehensive review of its outcomes. A combination of qualitative and quantitative data, a mixed-method approach, enables the researcher to gather more inclusive information about the program outcomes (Trochim & Donnelly, 2007). Similarly, Leedy and Ormrod (2005) state that researchers often use a mixed-method design in evaluation approaches.

## Background

In 2008, Western Health launched a staff safety program for staff providing community-based care. Western Health is a regional health authority that provides both institutional and community-based health and social services on the west coast of Newfoundland. The safety program consisted of a Western Health Risk Assessment Screening Tool (WHRAST), sign-in/sign-out system, and a buddy system, as well as education and training sessions for staff (Lundrigan, Hutchings, Mathews, Lynch, & Goosney, 2009).

The WHRAST consisted of a series of questions related to the risk factors associated with conducting home visits (Lundrigan et al., 2009). Prior to conducting a home visit, the community worker completed the WHRAST with existing information from the referral form and the client's chart. The questions on the WHRAST were related to risk factors that had been grouped into high, moderate, or low risk. Appropriate safety protocols were identified after completion of the WHRAST. These safety protocols provided direction for staff when conducting home visits. For example, if the worker identified that there was a potentially dangerous animal at the home, the safety protocol outlined that the worker should leave the home if the client refused to restrain the animal. In addition, a safety plan was developed in consultation with the manager when a situation was identified as being high risk.

The sign-in/sign-out system was a mandatory process used to track staff conducting home visits regardless of risk. Each community worker completed a sign-out form when leaving the office for a home visit with an estimated time of return. This form was given to the appropriate administrative

support person for monitoring. This administrative support person contacted the manager or designate if the employee did not return by the scheduled time. The employee was then telephoned to ensure that he or she was safe. In addition to the WHRAST and the sign-in/sign-out system, a buddy system was established for situations assessed as being high risk. In the development of a safety plan, the manager would provide a buddy system to support the community worker entering the home. The buddy system included, but was not limited to, access to a person via phone (e.g., administrative support, coworker, or manager), joint home visit with staff member of the same program or another program, family member of client present at home visit, and/or police escort.

We conducted an evaluation to determine the impact of this program on the short-term safety of staff working in the community. This article examines the short-term impacts of the staff safety program. Specifically, we examined changes in staff's perception of safety, the incidents of unsafe events, and the strengths and weaknesses of the various components of the program. We offer strategies to help other organizations develop and implement safety initiatives.

## Evaluation Methods

Four months after the regional implementation, an evaluation was completed to determine whether the staff safety program enhanced safety of staff while conducting home visits and assess any changes in perceptions of safety. We used a mixed-methods approach in the evaluation, and we used data from surveys, focus groups, and key informant interviews and comments written on the WHRAST itself.

### Pre and Post Surveys

Staff was surveyed before and after the implementation of the safety program to gather data on changes in their perceptions of safety and the incidence of unsafe events. The preimplementation survey was conducted in August 2007 and the postimplementation survey in November 2008, 4 months after the regionwide implementation of the safety program. Using the internal mail system, survey items was distributed to all staff within the Population Health Branch who conducted home visits. To be included in the survey, staff had to provide community-based services and have been employed for at least 6 months. The mail-out package contained (a) a cover letter explaining the study, voluntary participation, implied consent, and a list of contact people; (b) a survey questionnaire; and (c) a self-addressed envelope for respondents to return their completed questionnaire. Approximately 3 weeks after the initial mail-out, a research assistant sent an e-mail reminder to all staff to encourage survey participation.

The survey gathered data on demographics (gender, age, etc.), professional practice characteristics (profession, years

in profession, number of home visits in average week, etc.), perceptions of safety, and the number and nature of unsafe incidents in the preceding 6 months including safety concerns such as verbal abuse (swearing, name calling), threats, and physical attacks. Respondents were asked to provide information on experiences of verbal abuse, threats, and/or physical attacks over the previous 6 months.

The survey data were entered into SPSS. Respondents' perceptions of safety were assessed using a 5-point Likert-type scale, where 1 = *strongly disagree* and 5 = *strongly agree*. Because the scores were not normally distributed, we collapsed the 5-point scale into three categories: 5 = *strongly agree* and 4 = *agree*, 3 = *neutral*, and 2 = *disagree* and 1 = *strongly disagree*. *t* Tests were used to identify differences in the characteristics of the sample and the number of experienced and reported incidents of workplace violence in the pre- and postimplementation surveys. Chi-square tests were used to identify differences in staff perceptions of safety in the pre- and postimplementation survey responses.

### Focus Groups and Key Informant Interviews

In addition to the surveys, focus groups and key informant interviews were conducted to gather information on the strengths and weaknesses of the program's components and to gain a holistic perspective on the impact of the program on staff safety. The focus group participants were randomly selected to ensure representation from each program, profession, gender, and levels of experience. To be eligible for the focus groups, staff must have worked in one of the programs that used the "Safety Program." All managers from the Population Health Branch were invited to participate in the key informant interviews. Potential participants for the focus groups and interviews were contacted by e-mail and telephone, provided with a summary of the nature and purpose of the qualitative interviews, and requested to participate.

The focus groups were facilitated using a semistructured guide. Participants were asked to provide feedback on each component of the program. Questions regarding the program's strengths, impact, challenges, and suggestions for improvement led the focus group discussion. One member of the research team facilitated the discussion while another documented the conversation.

Members of the research team also independently read each transcript to identify key words and specific themes. Through this process of exploration, a coding and analysis template was developed (Mays & Pope, 1995). The template was then used to code all the transcripts.

We used a number of measures to increase the credibility of our qualitative data. In addition to recording discussions and keeping detailed notes, we triangulated the information obtained from the focus groups. Triangulation was achieved by cross-referencing the informal conversations with Population Health staff and managers, key informant interviews,

and comments written on the surveys and WHRAST. Also, at the end of each focus group session and key informant interview, the research team member documenting the discussion did member checking by reiterating the comments to ensure that the documentation was an accurate reflection of the conversation.

### Comments and Observations From the WHRAST

The WHRAST was duplicated and a copy forwarded to a research assistant for data entry and analysis. On the WHRAST, participants were asked to identify if the form was helpful in identifying and preventing potential risks. Also, a comment section on the tool provided qualitative data in the analysis of the tool's effectiveness. The data from the WHRAST were entered into SPSS. Descriptive statistics, frequencies, percentages, and means were run on the data. All comments from the tool were reviewed.

## Key Results

### Pre and Post Surveys

Of the 156 preimplementation surveys, 56 surveys were returned (response rate of 35.9%), and of the 157 postimplementation surveys, 64 were returned (response rate of 40.8%). Only respondents who conducted home visits were included in the analysis. Also, in the postimplementation survey, we excluded respondents from professional groups that were not represented in the preimplementation survey sample to enhance the homogeneity of the samples. A total of 42 from the preimplementation surveys and 54 from the postimplementation surveys were included in the data analysis.

There was diverse representation from all professions; however, the majority of survey respondents were either social workers or nurses who provide community services. There were no statistically significant differences between the demographic and professional characteristics of the pre- and postimplementation survey respondents (Table 1).

According to the survey results, respondents experienced a large number of verbal incidents (pre = 124, post = 141; Table 2). Despite these numbers, only half of those in the pre- and postimplementation groups indicated that they reported the incidents to their managers or on occurrence reports. Some of the respondents indicated that they felt this was "a part of their job" or "it was not serious enough." Of the respondents who reported threats of physical violence (pre = 17, post = 7), 75% (pre) and 80% (post) reported the incidents. Many of the respondents indicated that they reported these incidents to the manager or the police. All those who reported workplace violence outside of work hours reported the incident to the manager or the police. In the majority of incidents, the client or client's family was the offender.

**Table 1.** Demographic Information for Preimplementation and Postimplementation Surveys

Demographic Information	Pre	Post	<i>p</i> Value
Mean age (years)	35.33	37.66	.702
Mean years in profession	9.37	11.49	.466
Mean years in position	4.62	8.97	.096
Mean number of weekly home visits	9.00	6.71	.153

**Table 2.** Experienced and Reported Incidents of Workplace Violence

Incident	Pre	Post	<i>p</i> Value
Experienced verbal incident	124	141	.447
Reported verbal incident	26	22	.223
Experienced written incident	0	1	N/A
Reported written incident	0	1	.331
Experienced threat of physical violence	17	7	.250
Reported threat of physical violence	7	5	.478
Experienced physical assault or attack	3	3	N/A
Reported physical assault or attack	3	3	.906
Experienced work-related violence outside of work hours	2	1	N/A
Reported work-related violence outside of work hours	3	1	.284

Pre- and postimplementation survey questions assessed changes in staff perception of safety (Table 3). Two of the questions on the survey had statistically significant differences from preimplementation to postimplementation. On the preimplementation survey, 28.6% agreed that they had appropriate training and education; 56.8% agreed in the postimplementation survey. Second, a smaller proportion of respondents agreed that they entered a client's home when they felt it was not safe. In the preimplementation survey, 30% disagreed that they would enter a clients home even when they felt it was not safe, compared with 44.4% in the postimplementation survey.

Other important safety issues were identified in the pre- and postimplementation surveys. Slightly more than 69% of preimplementation survey respondents and 72.7% of postimplementation survey respondents indicated that there is often no cell phone service in areas that they work. Nearly 67% of respondents in the preimplementation survey and 72.7% of postimplementation survey respondents indicated that they were not always informed about a client's history of aggression or abusive behavior. In addition, 90.5% of preimplementation survey respondents and 95.5% of postimplementation survey respondents reported that there should

be a formal communication process for identifying potentially violent clients.

### Focus Groups

In general, focus group participants felt positive about the sign-in/sign-out system. The theme of appreciation emerged about having a designated person to follow-up with them if they did not arrive when expected. Participants felt a sense of safety and security with the knowledge that someone knew their whereabouts. For example, one participant stated that "It is hard to predict what you will face . . . so we need a system in place to ensure that someone knows where we are." Although many participants felt positively about this system, a few participants voiced a theme of mistrust. For example, some indicated that they thought it was a means for management to audit their whereabouts. One participant suggested that she had a "feeling that it was a way of keeping track of you . . . where you were going." Another stated, "I was filling out the sheet . . . but out beyond 4:30—no one to check up on you." The third theme that arose with the actual process of signing-in and signing-out was one of "needed human resources." Participants felt that in areas with good clerical and management support, the sign-in/sign-out system worked very well, but in areas with a lack of support, challenges were encountered. Participants revealed that in some areas clerical support is only half time and therefore no one knew where staff were when the clerical support went home. As one participant voiced, "Not having full-time clerical support is an issue . . . I would e-mail someone at the hospital but I don't know if they got my e-mail or if they would follow-up." Another stated that "working after hours is also a problem. Managers are not always available after hours. Particularly, at the end of the day it is difficult to reach managers."

One of main themes that resonated about the risk assessment screening tool was a heightened awareness of safety. One participant with many years of experience stated that you "become hardened to risk if you work 30 plus years. However, the risk assessment has increased my awareness of safety." Another participant stated that "it allowed me to take time to stop and think, and made me more aware of safety. I felt more justified to ask if someone else could go with me for safety sake." Yet another expressed that "It has actually made me a little bit nervous, which is not a bad thing."

Although the WHRAST brought safety awareness to the forefront, another theme that emerged from the data was the "lack of knowing." Many participants expressed that while filling out the risk assessment form there were too many unknowns or "don't know" answers to the assessment questions: "there are a lot of don't knows on the risk assessment so it didn't help me." There was some discussion about not knowing information because of the ethics of sharing client information between health care providers. As one participant reported, "We are not supposed to share information about a client with others, but we have taken it to the

**Table 3.** Staff Perception of Workplace Safety

Question	Disagree, n (%)	Neutral, n (%)	Agree, n (%)	p Value
I feel unsafe carrying medications while conducting home visits.				
Pre	11 (50)	4 (18.2)	7 (31.8)	.925
Post	8 (53.3)	2 (13.3)	5 (33.3)	
I feel unsafe driving with clients in my vehicle.				
Pre	5 (17.9)	11 (39.3)	12 (42.9)	.532
Post	4 (15.4)	7 (26.9)	15 (57.7)	
I feel unsafe conducting home visits when I know there is inadequate backup.				
Pre	6 (14.3)	8 (19.0)	28 (66.7)	.435
Post	7 (16.3)	4 (9.3)	32 (74.4)	
The use of cell phones has made me feel safer when conducting home visits.				
Pre	4 (10.8)	7 (18.9)	26 (70.3)	.183
Post	11 (25.0)	10 (22.7)	23 (52.3)	
There is often no cell phone service in places where I work.				
Pre	7 (17.9)	5 (12.8)	27 (69.2)	.158
Post	11 (25.0)	1 (2.3)	32 (72.7)	
I have had appropriate training and education on violence prevention.				
Pre	20 (47.6)	5 (11.9)	17 (40.5)	.410
Post	15 (34.1)	8 (18.2)	21 (47.7)	
I have had appropriate training and education on crisis prevention.				
Pre	19 (45.2)	11 (26.2)	12 (28.6)	.028
Post	13 (29.5)	6 (13.6)	25 (56.8)	
I am competent in diffusing potentially violent situations.				
Pre	11 (26.2)	16 (38.1)	15 (35.7)	.504
Post	8 (17.8)	16 (35.6)	21 (46.7)	
I have safety concerns related to working alone when conducting home visits.				
Pre	8 (19.0)	10 (23.8)	24 (57.1)	.873
Post	7 (15.6)	10 (22.2)	28 (62.2)	
I am aware of policy related to violence in the workplace.				
Pre	14 (33.3)	8 (19.0)	20 (47.6)	.078
Post	9 (20.0)	4 (8.9)	32 (71.1)	
I am aware of protocols related to violent incidents.				
Pre	16 (38.1)	10 (23.8)	16 (38.1)	.117
Post	12 (26.7)	6 (13.3)	27 (60.0)	
I feel Western Health should do more to enhance staff safety while working in the community.				
Pre	1 (2.4)	6 (14.3)	35 (83.3)	.457
Post	2 (4.7)	10 (23.3)	31 (72.1)	
I feel unsafe when working in homes that are isolated from other buildings or structures.				
Pre	6 (15.0)	5 (12.5)	29 (72.5)	.438
Post	7 (16.3)	2 (4.7)	34 (79.1)	
I often enter a client's home even when I feel it's unsafe.				
Pre	12 (30.0)	11 (27.5)	17 (42.5)	.012
Post	20 (44.4)	2 (4.4)	23 (51.1)	
I always inform a designated person of my location.				
Pre	8 (19.0)	1 (2.4)	33 (78.6)	.275
Post	4 (8.9)	3 (6.7)	38 (84.4)	
I feel comfortable in reporting my concerns about risks to my manager.				
Pre	3 (7.1)	4 (9.5)	35 (83.3)	.281
Post	2 (4.4)	1 (2.2)	42 (93.3)	
My manager or designate is available to discuss my safety concerns prior to making a home visit.				
Pre	13 (32.5)	4 (10.0)	23 (57.5)	.074
Post	13 (28.9)	0 (0.0)	32 (71.1)	

(continued)

**Table 3. (continued)**

Question	Disagree, <i>n</i> (%)	Neutral, <i>n</i> (%)	Agree, <i>n</i> (%)	<i>p</i> Value
I always complete/review a client history prior to conducting a home visit.				
Pre	13 (31.7)	5 (12.2)	23 (56.1)	.898
Post	16 (35.6)	6 (13.3)	23 (51.1)	
I feel competent in identifying risks.				
Pre	2 (4.8)	5 (11.9)	35 (83.3)	.894
Post	2 (4.4)	4 (8.9)	39 (86.7)	
The potential for violence when conducting home visits is minimal.				
Pre	20 (47.6)	8 (19.0)	14 (33.3)	.586
Post	23 (51.1)	5 (11.1)	16 (35.6)	
I feel anxious when conducting home visits.				
Pre	20 (47.6)	11 (26.2)	11 (26.2)	.179
Post	24 (53.3)	16 (35.6)	5 (11.1)	
I fear for my personal safety when conducting home visits.				
Pre	19 (45.2)	12 (28.6)	11 (26.2)	.504
Post	26 (57.8)	10 (22.2)	9 (20.0)	
My colleagues fear for their personal safety when conducting home visits.				
Pre	8 (19.5)	14 (34.1)	19 (46.3)	.650
Post	12 (26.7)	16 (35.6)	17 (37.8)	
I have the option of refusing to do a scheduled home visit if I feel it is unsafe for me.				
Pre	6 (14.6)	5 (12.2)	30 (73.2)	.389
Post	12 (26.7)	5 (11.1)	28 (62.2)	
I am always informed about a client's history of aggression or abusive behavior.				
Pre	28 (66.7)	10 (23.8)	4 (9.5)	.801
Post	32 (72.7)	8 (18.2)	4 (9.1)	
I feel that there should be a formal communication process for identifying potentially violent clients.				
Pre	1 (2.4)	3 (7.1)	38 (90.5)	.508
Post	0 (0.0)	2 (4.5)	42 (95.5)	
I feel work-related violence is increasing.				
Pre	5 (11.9)	15 (35.7)	22 (52.4)	.499
Post	6 (13.3)	21 (46.7)	18 (40.0)	
When my colleagues experience workplace violence, I am personally affected.				
Pre	0 (0.0)	8 (20.0)	32 (80.0)	.573
Post	1 (2.3)	7 (15.9)	36 (81.8)	
Overall, I am concerned about violence on the job.				
Pre	4 (9.5)	13 (31.0)	25 (59.5)	.154
Post	10 (22.2)	8 (17.8)	27 (60.0)	

extreme . . . there has to be a balance between client confidentiality and staff safety.”

An apathy theme emerged from the analysis of comments made about the buddy system component of the staff safety program. There was general agreement that although the concept of a buddy system was very good, it did not work well in practice for various reasons. For example, group members knew that the buddy system was available; however, some participants felt that “there were inconsistencies with managers about the buddy system. A protocol to guide managers about when a buddy system is needed should be developed.” Another participant said that

when a buddy is requested because you don't know what you are facing, it is up to the discretion of the manager and some are very reluctant to send two workers, while other managers willingly send someone. More stringent criteria for managers are needed to help them make a decision.

Others felt staff shortages posed challenges for some programs and made it difficult for the buddy system to work. One participant said, “I am in a smaller office so there is no buddy to go unless the situation was severe but I wouldn't hesitate to call police.” Another said, “in our area we can

take a buddy if we feel it is needed.” Much of the information obtained from the focus groups was consistent with the findings from the key informant interviews.

### **Key Informant Interviews**

Managers felt that this program heightened their own awareness of safety concerns for the staff they supervised. Also, the program formalized the process of reducing risk. They also felt that the program heightened safety awareness among frontline staff. One manager commented that

staff are learning to ask questions and not put themselves at risk. Even experienced staff who sometimes go out without asking a lot of questions are now taking a second look and realizing that there may be risk to them.

The sign-in/sign-out system was also considered to be a positive aspect of the program. One manager stated that “it was long overdue . . . had to track people down a few times . . . and realized what would have happened before.” Consistent with the frontline staff feedback, managers also expressed concern about the sign-in/sign-out system after hours when no administrative support was available. As one manager stated,

For me as a manager, I’m out of the office more than I’m in . . . so, I wasn’t clear on what I was supposed to do . . . what do you do in the case where the admin support go home at 4:30 and I don’t get back to the office until 5:00.

Managers also commented on the buddy system. Although a number of managers suggested that more than one worker would be sent on a visit if necessary, others noted that more than one worker was not always available.

### **Comments From the WHRAST**

Consistent with focus group findings, there were a high percentage of those who responded “don’t know” on many of the questions about potential risks on the risk assessment screening tool. For example, 41.3% did not know if there was a history of drug or alcohol abuse in the home; nearly 49% did not know if there were dangerous animals on the property, and more than 40% of the respondents reported that they did not know if there was a potential for violence or aggression in the home. Nearly 70% of the respondents reported that they had a written safety plan established. One third (33.8%) indicated that the WHRAST was helpful in identifying and preventing potential risks.

In written comments on the WHRAST, one of the staff commented that the form allowed workers to reflect on and assess potential risks and/or other safety factors. Several other

staff indicated that the form was not helpful given that there were many unknowns; however, there was no indication from their comments that an incident occurred while on a visit.

### **Discussion and Conclusion**

The intent of this program evaluation was to identify whether, in the short term, the staff safety program enhanced the safety of staff working in the community. Although we found few statistical significant differences between pre- and post-implementation survey responses, the results were promising. The pre- and postimplementation survey results demonstrated a positive shift in changes of perceptions of safety, including a heightened awareness of safety. Participants in the study indicated that the staff safety program was a positive approach to enhancing safety of staff despite their voiced concern regarding the unknown responses when completing the risk assessment screening tool.

Despite the implementation of the staff safety program, a large number of staff experienced incidents of verbal violence. This may be because of the increased awareness of staff of safety issues and better understanding of what constitutes workplace violence. Workplace violence, except in its severest forms, remains underreported, particularly for this group of health care providers (Banerjee et al., 2008; French & Morgan, 1999; Hesketh et al., 2003; McPhaul & Lipscomb, 2004). Many of the respondents indicated that they did not report incidents of verbal abuse because they felt it was the nature of their jobs. For example, one respondent indicated that she did not report an incident of verbal abuse because it came from a child. These findings suggest that zero tolerance policies may not be suitable for some staff given the type and source of violence they encounter. More practical policies that encourage safety plans sensitive to the type and nature of the risk are needed to protect community-based workers.

Our study also found that sufficient information on safety-related issues may not be recorded on client intake or referral. For example, staff indicated that there was a high number of “don’t know” responses on the risk assessment screening tool and recognized that “not knowing” may compromise their safety. This recognition may have created a greater awareness of potential safety risks. Several respondents indicated that the form was not helpful in identifying and predicting potential risks given the many unknowns. This protocol may have helped minimize risk by heightening their awareness of potential safety concerns. If the health care provider did not know about the potential for violence or aggression in the home, he/she was required to carry a cell phone, consult with staff who knew the family, or consult with the manager. This lack of knowing provides further evidence to support the need for an alert system and/or increased information on referral intake. Occupational Safety and Health Service, New Zealand (2004) concurs that a significant

measure to reduce risk for workers is accurate, complete client information from referral agencies. Our study highlights the importance of gathering this information during the referral process. It also illustrates the need to balance the needs of client privacy with the need to promote staff safety.

There was agreement throughout the region in the focus groups and with key informant interviews that the sign-in/sign-out system worked well. Although in some areas a lack of resources to fully implement this system was reported, the majority felt safer with the establishment of the process of signing-in and signing-out. This finding is supported in the literature, and some studies suggest implementing policy regarding a formal tracking system (Canadian Centre for Occupational Health and Safety, 2007; Henry & Henry, 1997). Our study also noted the suspicion that the sign-in/sign-out system could be seen as a means of tracking employee behavior and its potential for misuse. These findings emphasize the need to educate staff about the purpose of the system. They also illustrate how an employer can commit to employee involvement in their safety (Galloway, 2002) by ensuring that safety procedures are not misused by managers.

The buddy system was defined in terms of having access to support by phone, joint home visit with staff member of the same program or another program, family member of client present at home visit, or police escort. However, some of the staff and managers continued to feel that a buddy system was having a joint home visit with another staff member. This perception may have contributed to the emerging theme of apathy given that there was sometimes a lack of human resources for two people to conduct home visits. The focus groups and key informant interviews indicated that shortage of staff in some areas resulted in the inability to fully implement this system.

Our study is limited by its small sample size, which may explain why we found few significant differences between pre- and postimplementation survey responses. However, the mixed-methods approach and triangulation between data sources strengthen the validity of our findings. Our evaluation focused on implementation and short-term outcomes. Future evaluations should examine the long-term outcomes of the program.

The Staff Safety Program was successfully implemented with employees who conduct home visits within the Population Health Branch. The Safety Program could be modified to meet the unique needs of other health organizations to foster the achievement of healthy, safe work environments. The intent of this project was to enhance the safety of staff working in the community. This program heightened awareness of potential safety issues for staff. Although not all risks can be eliminated, they can be minimized through the implementation of safety programs. Feedback from staff, managers, and directors indicated that a safety program is necessary to support the safety of staff who provide

home-based services. The results of this evaluation showed that a staff safety program is fundamental to ensuring an optimal level of safety.

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