Texas Association for Home Care & Hospice
Leading ★ Advancing ★ Advocating

57th Annual Meeting

Wednesday, September 2, 2026

Crockett AB

11:15am-12:15pm

1c. Beyond the Policy: Operationalizing Workplace Violence Prevention in Home-Based Care

Presented by:

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Thank you to our Partners:

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MAC LEGACY

KanTime
How better happens.

United Healthcare Community Plan

AXXESS

Beyond the Policy:

Operationalizing Workplace Violence Prevention in Home-Based Care

1

2

3

What we'll cover.

01 Why this matters now
Joint Commission, OSHA, state legislation — and why budget follows liability.

02 SB 240 & SB 463 in practice
How Texas law maps to an actual visit, from intake to post-visit learning.

03 The numbers behind silence
What's actually happening in home and field-based care.

04 The committee that changes culture
Who, what, how — and the pitfalls that kill momentum.

05 Live scenario discussion
Four real moments. What would your team do?

06 Q&A

2026 TAHC&H ANNUAL MEETING

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Defining Workplace Violence

Any threat or act at work — including non-physical aggression — that puts a worker, patient, or visitor at risk.

OSHA & NIOSH: violence at work includes threats and verbal aggression — not just physical acts.

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Four Types of Workplace Violence

Most agencies focus on Type II. But all four show up in home and field care.

Type I

Criminal Intent

No relationship to your org. A robbery, mugging, parking-lot break-in.

Type II

Client or Patient

Most common in healthcare. Patients, family, visitors. Also called client-on-worker.

Type III

Worker-on-Worker

Lateral or horizontal violence. Bullying. Verbal/emotional abuse between staff.

Type IV

Personal Relationship

Domestic violence that follows the worker into the workplace or visit site.

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OFFICIAL DEFINITION

The Joint Commission defines WPV as:

"An act or threat occurring at the workplace that can include any of the following: **verbal, nonverbal, written**, or physical aggression; **threatening, intimidating, harassing, or humiliating words** or actions; bullying; sabotage; sexual harassment; physical assaults; or **other behaviors of concern** involving staff, licensed practitioners, patients, or visitors."

Comprehensive Accreditation Manual for Home Care (CAMHC) Glossary

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Raise your hand if...

- **Your team has experienced verbal abuse from a patient or family member.**
- **Someone on your team has felt unsafe on a visit and didn't formally report it.**
- **Your agency has had any of the four types occur — Type I, II, III, or IV.**

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Why now: compliance is the unlock

Workplace violence prevention has moved from "nice to have" to "required." Budget now follows regulation and liability.

Joint Commission
EPs effective Jan 1, 2025

Two new + one revised requirement for accredited home care.

OSHA
General Duty Clause + 2024 guidance

Employers must provide a workplace free of recognized hazards — including violence.

State legislation
17+ states active or pending

AK, CA, CT, IL, LA, MA, ME, MD, MN, NJ, NY, OR, PA, TX, VA, WA, WY

Liability & retention
Direct $$ impact

Settlements, turnover, and recruitment costs all spike when prevention is reactive.

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2025 Joint Commission Update

EFFECTIVE JANUARY 1, 2025

Two new and one revised workplace violence prevention requirements for all Joint Commission–accredited home care organizations.

EP 6	REVISED EP **Documentation**	Establish a formal process to monitor, report, investigate, and document safety-related events. Capture and track all WPV incidents.
EP 9	NEW EP **Prevention Program**	A multidisciplinary, leader-driven program with annual risk analysis, policies, incident reporting to governance, and victim/witness follow-up.
EP 29	NEW EP **Training & Education**	Role-appropriate training on prevention, recognition, response, and reporting — including de-escalation and intervention techniques.

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EP 9 – What Your Program Must Include

- **Designated leader + multidisciplinary team**
  Named accountability — not a side-of-desk task.
- **Annual analysis of WPV safety risks**
  Document the threats and gaps once per year, minimum.
- **Policies & procedures**
  Prevention, response, and reporting protocols in writing.
- **Incident reporting + trend analysis to governance**
  Numbers go up. Patterns become visible. Leaders own it.
- **Follow-up + support for victims and witnesses**
  Trauma and psychological counseling when needed.

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EP 29 – Training Requirements

Education and resources for leadership, staff, and licensed practitioners — appropriate to each role.

1	2	3	4
Prevention	**Recognition**	**Response**	**Reporting**
What constitutes WPV. Roles and responsibilities. Including external law enforcement and security personnel.	Early-warning signs — behavioral cues, environmental risks, and patterns that precede an incident.	De-escalation. Nonphysical intervention. Physical intervention techniques. Emergency response.	How to report — and what happens after a report. Closing the loop with staff.

Translation: a documented, role-based training program — not a once-a-year poster.

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State Legislation

AK CA CT IL LA MA ME MD MN
NJ NY OR PA TX VA WA WY

17+ states with active or pending legislation

COMMON THEMES

- Mandatory risk assessments
- Written violence prevention plans
- Incident reporting and trend analysis
- Role-based training requirements

SPOTLIGHT

Texas SB 240 & SB 463

SB 240 (2023) built Chapter 331 around home health-licensed HCSSAs. SB 463 (2025) closed that gap — every HCSSA with 2+ RNs is covered now, hospice included.

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Texas SB 240: What's Required

COMPLIANCE DEADLINE: SEPTEMBER 1, 2024
Texas Health and Safety Code Chapter 331 — covering hospitals, ASCs, freestanding EDs, nursing facilities, and HCSSAs with two or more RNs.

1	PLAN **Written Plan & Policy**	Required for hospitals, ASCs, freestanding EDs, nursing facilities, and HCSSAs with 2+ RNs. Defines WPV, sets physical security and reporting procedures.
2	COMMITTEE **Prevention Committee**	At least one direct-care RN, a Texas-licensed physician if applicable, and a security employee if available. Reviews the plan and reports to governance.
3	TRAINING **Training & Reporting**	Annual training for direct care staff, a confidential reporting system, non-retaliation protections, and immediate post-incident medical care.

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Texas SB 463: Closing the Loophole

COMPLIANCE DEADLINE: SEPTEMBER 1, 2026
A 2025 fix to SB 240 that widens who's covered under Chapter 331. Newly covered agencies must comply by September 1, 2026.

1	THE GAP **The SB 240 Gap**	SB 240 originally reached only HCSSAs licensed under Chapter 142 for home health, leaving hospice-only agencies and other HCSSA types unprotected.
2	THE FIX **No More Exemption**	SB 463 redefines "facility" as any Chapter 142-licensed HCSSA with two or more RNs, dropping the home-health-only qualifier.
3	THE DEADLINE **This Week's Deadline**	Newly covered HCSSAs must comply with Chapter 331 no later than September 1, 2026, the same week as this conference.

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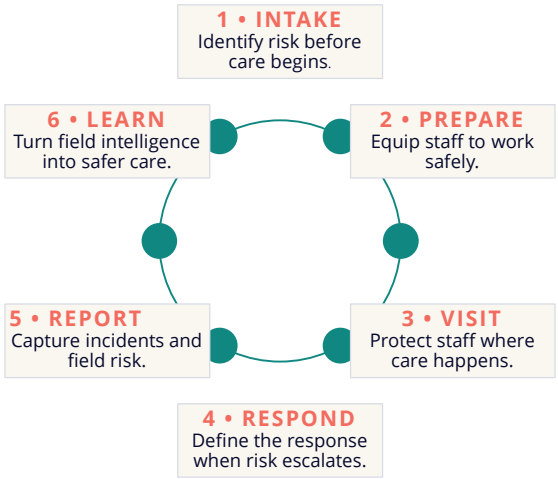
Intake to Post-Visit: A Safety Lifecycle

SB 240 requires the plan. This is how home-based care runs it, one visit at a time.



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STAGE 1 OF 6 • INTAKE

Identify Risk Before Care Begins

WHAT SB 240 REQUIRES

- The plan must "be based on the practice setting." For home-based care, that setting is the patient's home and community. (§331.004(b)(1))
- The plan must define workplace violence to **include threats and potential violence**, not only injuries already sustained. (§331.004(b)(2))

HOW AGENCIES OPERATIONALIZE THIS

- Use a pre-visit risk review: known incidents, prior threats, and household flags checked before a caregiver is assigned.
- Not named in the statute by this term, but it's how a home-based agency satisfies a plan "based on the practice setting."

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STAGE 2 OF 6 • PREPARE

Give Staff What They Need to Work Safely

WHAT SB 240 REQUIRES

- The plan must "provide at least annually workplace violence prevention training or education" for direct care staff. (§331.004(b))
- The plan must "address physical security and safety." (§331.004(b))
- Agencies must "solicit information from health care providers and employees" when building and running the plan. (§331.004(b))

HOW AGENCIES OPERATIONALIZE THIS

- Pair annual training with real field input, not a once-a-year video.
- The staff walking into homes alone are the best source on what "physical security" actually requires there.

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STAGE 3 OF 6 • VISIT

Protect Staff Where Care Actually Happens

WHAT SB 240 REQUIRES

- The plan must address "violent incidents or potentially violent incidents," not only completed violence. (§331.004(b))
- Workplace violence includes "an act or threat of physical force" likely to cause injury or psychological trauma. (§331.004(b)(2))

HOW AGENCIES OPERATIONALIZE THIS

- Field staff work alone, often out of sight of a supervisor.
- Give them a fast, practical way to recognize a risk signal and escalate it in the moment, not after the visit ends.

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STAGE 4 OF 6 • RESPOND

Have a Defined Response When Risk Escalates

WHAT SB 240 REQUIRES

- The plan must "prescribe a system for responding to and investigating" violent or potentially violent incidents. (§331.004(b)(4))
- Facilities must "offer immediate post-incident services," including any necessary acute medical treatment. (§331.005(a))
- Employees can't be discouraged from contacting or filing a report with law enforcement. (§331.005(b))

HOW AGENCIES OPERATIONALIZE THIS

- Detection, escalation, response, and investigation should run as one connected process...
- Not four separate ones that only meet on paper, after the fact, in a binder.

20

STAGE 5 OF 6 • REPORT

Capture Incidents, Threats & Field Risk

WHAT SB 240 REQUIRES

- Staff must be able to "report incidents of workplace violence through the facility's existing occurrence reporting systems." (§331.004(b)(7))
- The policy must encourage staff to give the committee confidential information on workplace violence. (§331.003(b))
- Retaliation against a good-faith report is prohibited. (§331.005(c))

HOW AGENCIES OPERATIONALIZE THIS

- Give field staff a low-friction way to report what they encountered, even when nothing "happened."
- **Near misses are the data most programs never capture, and the earliest warning sign you'll get.**

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STAGE 6 OF 6 • LEARN

Turn Field Intelligence Into Safer Future Care

WHAT SB 240 REQUIRES

- The committee must "review and evaluate the workplace violence prevention plan" at least annually and report results to the governing body. (§331.004(d))
- Multi-facility systems must keep violence-prevention data "distinctly identifiable for each facility." (§331.002(d)(2))
- Agencies must adjust patient care assignments "to the extent practicable" when a patient has intentionally abused or threatened a caregiver. (§331.004(b)(8))

HOW AGENCIES OPERATIONALIZE THIS

- That last requirement only works if the history is captured and visible at the next intake, not held in one caregiver's memory.

22

23

96.1%

Verbal abuse is the norm.

of healthcare professionals have experienced verbal abuse or intimidation in the workplace.

If only 4% of your team isn't experiencing it, you don't have a fringe issue. You have a baseline.

MDLINX, 2023

24

61%

Home-based care is the front line.

of home health workers report physical assaults from patients — making home-based care one of the highest-risk settings in all of healthcare.

Yet most prevention investment still flows to hospital settings.

NIOSH / OJIN RESEARCH

25

79.2%

Turnover is the symptom.

annual turnover rate across home care. Workers exposed to violence are among the top drivers of departure.

Replacing one caregiver costs $3,500–$5,000+. Do the math on five departures per year per office.

HOME HEALTH CARE NEWS, 2024

26

47%

Half of incidents go unreported.

Only 47% of nurses report incidents to their employers — most often because they perceive that leadership won't act.

The other 53% is your blind spot. Every unreported event is a warning sign that never reached the people who could prevent the next one.

HENNEPIN HEALTHCARE SURVEY, 2022

27

20%

Even survivors lose focus.

drop in productivity for workers exposed to violence. Fear, anxiety, and distraction reduce focus and efficiency — especially in independent home-based work.

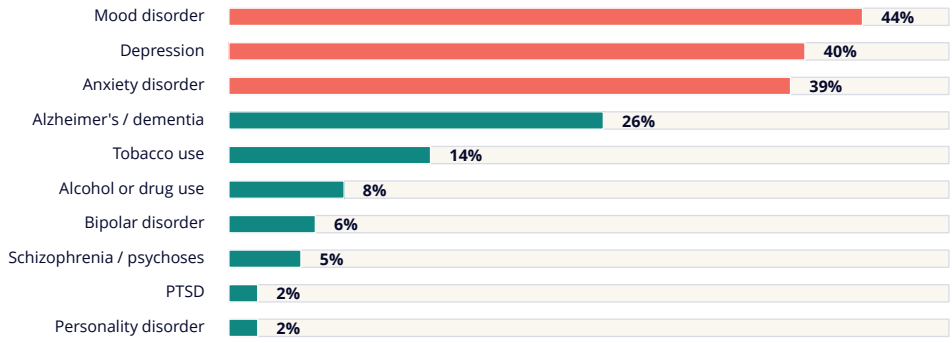
20% means delayed visits, incomplete documentation, and slower clinical decision-making.

INDUSTRY RESEARCH

28

PAC patients have behavioral health needs.

Post-acute care is now de facto behavioral health care. Most caregivers are trained for the body — not the brain.



Source: Medicare, 2023

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Why staff don't report — The Case for a Committee

"It's part of the job."

Normalization — when the perception is that violence is built into the role.

No clear policy or training

If staff have never been shown how to respond, they won't.

Reporting is complicated

Multiple forms, multiple systems, no follow-up. Why bother.

Fear of looking weak or careless

Caregivers worry it'll reflect on their performance.

Belief patients can't be held accountable

"He has dementia" / "She didn't mean it" gets used to dismiss real risk.

No response when they DO report

Silence from leadership trains the team to stop trying.

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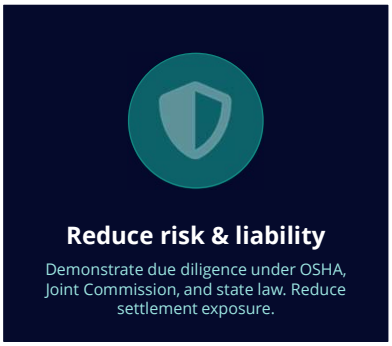
Why Safety Committees Matter



Reduce risk & liability

Demonstrate due diligence under OSHA, Joint Commission, and state law. Reduce settlement exposure.

Promote a culture of safety

Reporting becomes a contribution, not a complaint. Silence breaks.

Support recruitment & retention

Staff stay where they feel protected. "We have a committee" is a recruiting line.

A committee isn't a meeting. It's a compliance engine, a culture shift, and a retention lever — at once.

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Building Your Committee

- Include staff from clinical, HR, field, and operations
- Define roles clearly
- Establish regular meeting cadence

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Building Your Committee

Multidisciplinary or it doesn't work. The biggest pitfall: a committee of administrators, no field staff.

Chair / Facilitator — ESSENTIAL

Guides meetings, owns accountability, reports to governance.

Data Lead

Brings incident trends, near-misses, and reports to every meeting.

Field Staff Rep(s) — ESSENTIAL

Real-world frontline insight — the room's most important voice.

Training Liaison

Drives education rollout and policy translation to staff.

HR / Compliance

Aligns with employee policy, accommodations, and reporting structure.

Operations / Ops Mgr.

Owns process changes — scheduling, dispatch, intake controls.

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Key Functions of a Safety Committee

01

Risk Assessment

Proactively identify and evaluate safety risks. Use existing data: incident reports, HR logs, field staff feedback.

02

Policy Development

Create a zero-tolerance policy. Write the response protocol. Put it in the patient handbook.

03

Incident Response

When something happens: who acts, who's notified, who follows up, who supports the worker.

04

Education & Communication

Annual training, just-in-time training, and a feedback loop that closes.

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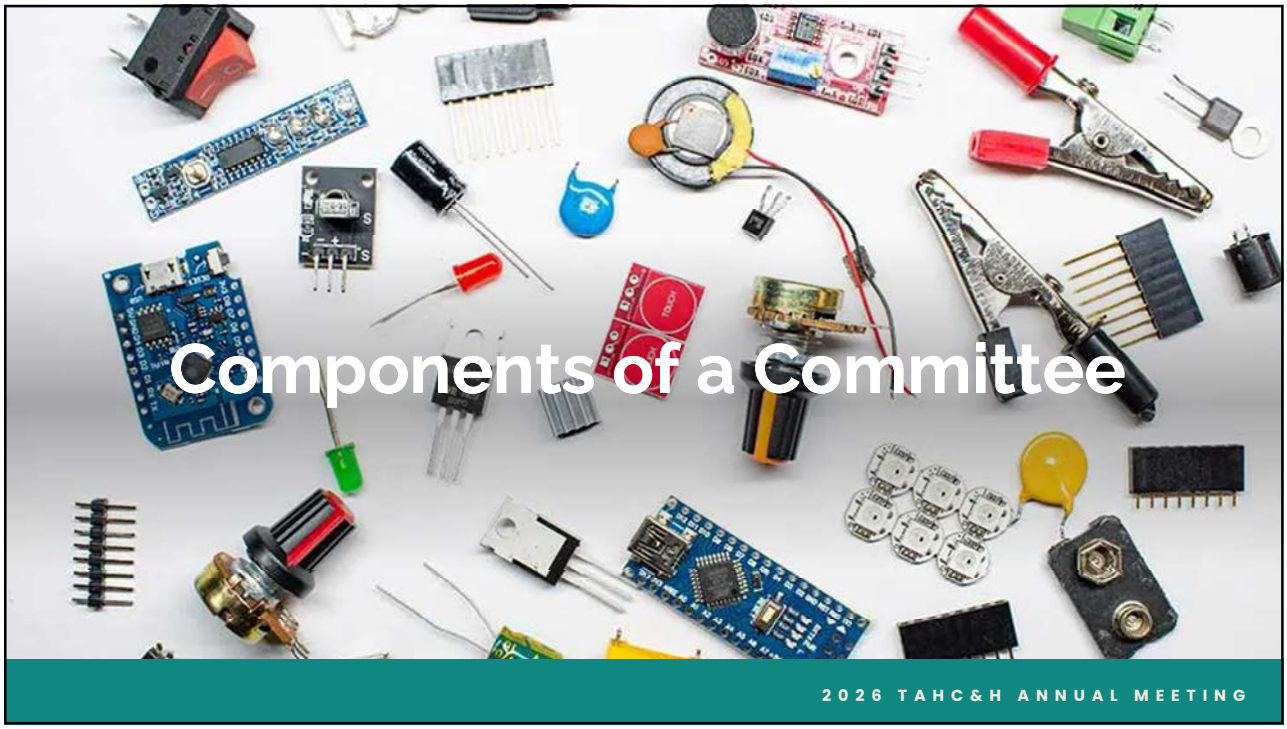

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Conducting Risk Assessments

Before you can fix risk, you have to see it. The data already exists — most agencies just don't aggregate it.

1. **Review incidents (and near-misses)**

   Spot trends: time of day, geography, patient profiles, types of threats. The near-miss is your leading indicator.

2. **Use OSHA & NIOSH tools**

   Don't reinvent. Hazard assessment templates, the OSHA WPV checklist, and NIOSH home care toolkit are free.

3. **Map high-risk zones and roles**

   Specific addresses, specific routes, specific shift windows, specific role types. Know where exposure concentrates.

4. **Listen to caregivers**

   Psychological safety is OSHA-recognized data. Field staff see the early warning signs first.

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Policy Development

Your policy sets the tone. Make it clear, make it specific, make it visible.

STATEMENT	PROTOCOL	FOLLOW-UP
Zero tolerance	**Response steps**	**Care + closure**
• Verbal, physical, and behavioral aggression are not tolerated • Applies to staff, patients, family, and visitors • Stated in patient handbook and onboarding	• How to report — immediate and after-the-fact • When to notify leadership and law enforcement • When discharge for cause is on the table	• Trauma and psychological support for victims/witnesses • Documented follow-up with the reporter • Trend reporting back to the committee

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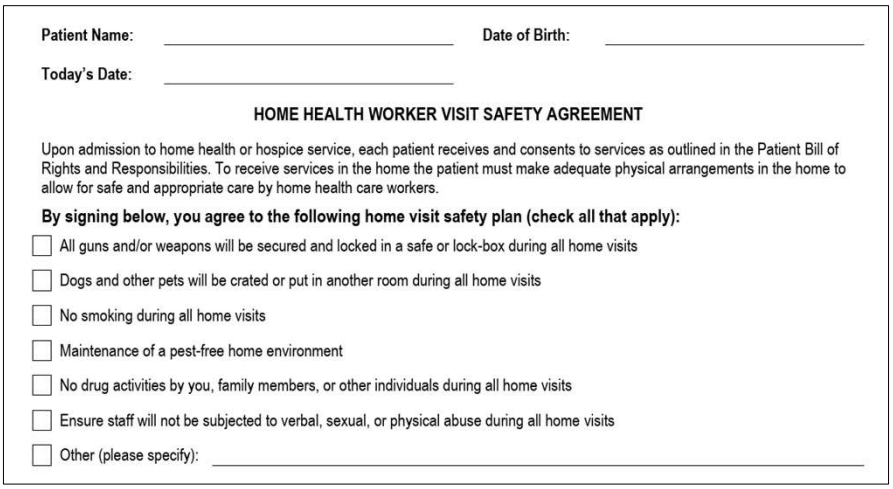
Worker Safety Client User Agreement



Patient Name: _____ Date of Birth: _____

Today's Date: _____

HOME HEALTH WORKER VISIT SAFETY AGREEMENT

Upon admission to home health or hospice service, each patient receives and consents to services as outlined in the Patient Bill of Rights and Responsibilities. To receive services in the home the patient must make adequate physical arrangements in the home to allow for safe and appropriate care by home health care workers.

By signing below, you agree to the following home visit safety plan (check all that apply):

- ☐ All guns and/or weapons will be secured and locked in a safe or lock-box during all home visits
- ☐ Dogs and other pets will be crated or put in another room during all home visits
- ☐ No smoking during all home visits
- ☐ Maintenance of a pest-free home environment
- ☐ No drug activities by you, family members, or other individuals during all home visits
- ☐ Ensure staff will not be subjected to verbal, sexual, or physical abuse during all home visits
- ☐ Other (please specify): _____

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Worker Safety Client User Agreement

Home health care staff have identified the following worker safety concern/s:

- ☐ Unsecured guns and/or weapons
- ☐ Dogs or other pets
- ☐ Second-hand smoke
- ☐ Pest infestation
- ☐ Actual or suspected drug activities, substance/alcohol abuse
- ☐ Actual or threat of abuse, verbal or physical
- ☐ Other (please specify): _____
- ☐ **No worker safety concerns were identified at this time.**
  **note: a new home health safety worker agreement may be required if new risks are identified during the episode of home care services.*

Due to the above risk/s, patient/responsible party agrees to the following safety plan for all home visits (specify):

_____

_____

Additional safety measures required are:

- ☐ Co-visits by security personnel are required during all home visits
- ☐ Family member/caregiver present during all home visits
- ☐ Specific family members or individuals will not be present during all home visits

I understand that failure to abide by the above safety plan will result in immediate termination from home health care services.

Patient/Responsible Party Signature **Date** **Clinician Signature** **Date**

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Why This Works

- **Sets expectations early**
  Households know the rules before the first visit.
- **Empowers caregivers**
  Staff have something to point to when behavior crosses a line.
- **Documents your due diligence**
  Critical for compliance and legal posture.
- **Enables clean discharge**
  When the agreement is broken, the path forward is clear.

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Build Controls & Prevention Strategies

The best safety plan is the one your team can access in real time — wherever they are.

Mobile safety tools

GPS-enabled apps and devices. Real-time emergency dispatch. Lifeline for staff working alone.

Check-in / check-out protocols

Pre-visit briefings. Post-visit confirmation. Missed check-in triggers a response.

Environmental controls

Lighting in stairwells, parking. Clear exits. Threat signage and documented household notes.

Pre-visit screening

Risk flags at intake. Address risk profile. Behavioral history. Pet/weapon notes.

Buddy / pair visits

For high-risk addresses, two-clinician scheduling — even if it costs the visit window.

Escalation tree

Clear path: staff → supervisor → 911. Everyone on the team knows it cold.

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Training & Education

ORIENTATION

Set the standard from day one.

JUST-IN-TIME

Address risks as they emerge.

ANNUAL

Refresh, update, document.

WHAT THE TRAINING MUST COVER

- What constitutes WPV — including verbal, written, and behavioral
- De-escalation and nonphysical intervention skills
- Emergency response procedures
- Roles & responsibilities of leadership, staff, security, and law enforcement
- Physical intervention techniques (where appropriate to role)
- How and when to report — and what happens after

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Fostering a Culture of Safety

Leadership visibility

Culture starts at the top. Leaders show up at committee meetings, ride along with staff, and open trainings.

Transparent reporting

Where incidents go after they're reported — and what the org did about them — is visible to staff.

Celebrate reporting

Recognize the person who flagged the near-miss. Reporting is a contribution, not a complaint.

In a strong safety culture, reporting is seen as a contribution — not a complaint.

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Metrics & Accountability

Near-miss tracking

Stop celebrating "zero incidents." Start asking about risks and near-misses. Those are the leading indicators.

Staff safety surveys

Regular pulse on perceived safety, by role and region. Anonymous. Compared over time.

Monthly incident review

Committee reviews the prior month — patterns, gaps, and one corrective action.

Governance reporting

Findings and committee activity reported up to leadership / board on a fixed cadence.

What gets measured gets managed. What gets shared gets improved.

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Common Pitfalls

You don't need perfection. You do need progress your team can see and feel.

No field staff voice

A committee of administrators is a meeting. Not a committee.

Reports get ignored

Silence after a report trains your team to stop trying.

No follow-through

Action items without owners or due dates die. Every meeting needs both.

Caregiver bias dismissed

When staff feedback gets labeled as "opinion," you miss the leading indicators.

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Pattern 1: The Committee Becomes an Incident Review Club

Every meeting turns into a case review. Something happened, the committee hears about it, members discuss what went wrong. Useful. But not prevention.

Prevention requires looking forward: at patterns, at near misses, at intake signals, at trends. When 100% of airtime goes to reviewing what already happened, nothing changes about what's coming.

The Data Point:

Organizations spending more than 70% of meeting time on post-incident review see no measurable reduction in WPV rates over 12 months.

The fix: Balance the agenda. Target 30% on incident review, 70% on risk prevention and proactive analysis.

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Caregiver Insight Is Not Biased

WHAT THE EVIDENCE SAYS

- Asking about safety isn't judging communities — it's supporting your staff.
- Psychological safety is valid data, recognized by OSHA and Joint Commission.
- Ignoring staff input means missing early warning signs.
- Caregiver insight prevents harm — it doesn't assign blame.

REAL STORIES

Parking-lot flag ignored → Car break-in

Staff flagged a parking lot as unsafe. The flag wasn't acted on. A break-in happened the following week.

Subtle behavior → Pattern of harassment

A clinician noted "weird vibes" from a household member. Three reports later, a clear harassment pattern emerged.

Safety committees help sort signal from noise — they don't assign blame.

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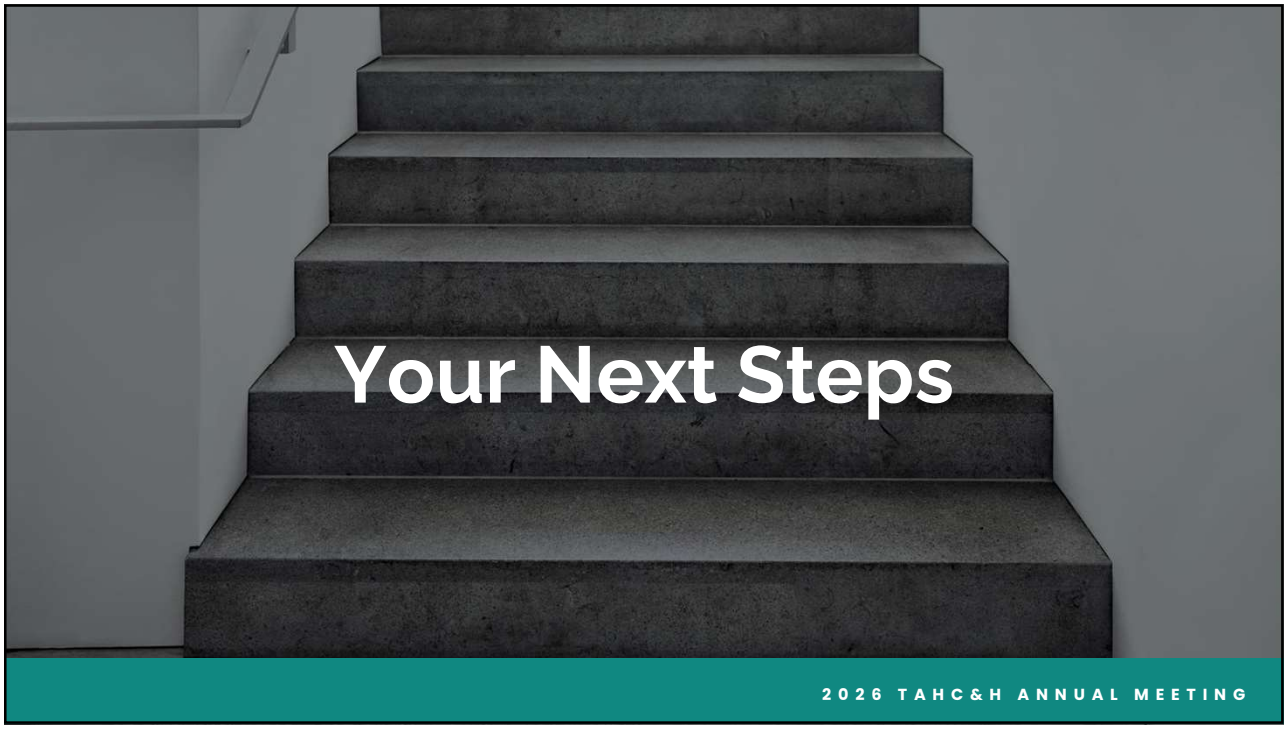

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Your Next Steps

- Commit to one change in the next month
- Bring up proactive safety at your next team meeting
- Start (or take another look at) a risk audit

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A 30/60/90-Day Roadmap

Days 1–30	Days 30–60	Days 60–90
Identify your safety champion	Build your committee structure	Launch first staff training
Conduct a baseline risk audit	Hold your first committee meeting	Establish near-miss reporting system
Review existing incident reports — or document the absence of them	Draft or review your zero-tolerance policy	Report findings and committee activity to leadership

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Resources

- osha.gov/workplace-violence
  - OSHA Guidelines
- CDC.gov/niosh/healthcare
  - NIOSH WPV Toolkit
  - Training modules

WPV Committee Kit Templates

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THANK YOU!

Be Proactive. Not Reactive.

Jonas Fortenberry, VP of Business Development, POM Safe | Jonas@pomsafe.com

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Appendix

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Scenario 1: The Creepy Greeting

A nurse enters a senior high-rise and a man in the lobby says, "Hey beautiful, coming to see me today?" She feels uncomfortable but walks past and completes her visit.

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Scenario 2: The Angry Son

During a home visit, a patient's adult son becomes agitated when asked to leave the room during medication administration. He raises his voice, slams a door, but doesn't touch anyone.

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Scenario 3: The Isolated Address

A clinician is scheduled to visit a patient in a rural area with poor cell reception. She texts a coworker before heading in, just in case. Nothing happens—but she felt uneasy.

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Scenario 4: The Patient with a Past

A caregiver discovers through word of mouth that a new patient has a past history of violence, but it wasn't flagged in the intake notes. The visit goes fine, but he's hesitant to return.

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References

- Workplace Violence Prevention Strategies and Research Needs
- OSHA Workplace Violence Fact Sheet
- 2025 Joint Commission Updates on WPV Prevention in Home Care Settings
- H.R. 2531- Workplace Violence Prevention for Health Care and Social Service Workers Act
- Unsafe Haven: The rise of violence against physicians in the workplace
- Hennepin Healthcare Survey, 2022
- Engaged, energized, and effective safety committees | Oregon OSHA
- Call To Action: Protecting Home Care Employees from Workplace Violence | NACH
- Workplace Violence Prevention Course for Nurses | CDC
- OSHA Workplace Violence
- Texas SB 240 (88th Legislature, 2023) Bill Analysis — Health & Safety Code Ch. 331
- Texas SB 463 (89th Legislature, 2025) Bill Analysis — Closing the HCSSA Coverage Gap

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