MSHRM MICHIGAN SOCIETY OF HEALTHCARE RISK MANAGEMENT

Can We FINALLY Get Serious About Violence in Healthcare?

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Conflict of Interest Disclosure

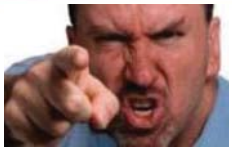
Monica Cooke does not have any real or apparent conflict(s) of interests or vested interest(s) that may have a direct bearing on the subject matter of the continuing education activity.

Objectives

This presentation will enable participants to:

- List multiple reasons for the persistent tolerance of aggression in our health care settings.
- Describe OSHA's general duty clause and methods of abatement for workplace violence in healthcare.
- Discuss the components of a workplace violence prevention program.

Sound familiar?



"You know, we joke around about it's not a good day if you haven't been verbally abused, spit on, or someone's taken a swing at you."

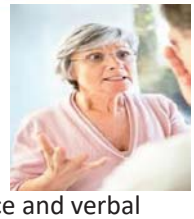
"You gotta put people in their place when they yell at you"

"It's just part of the job…you have to be tough"

Workplace Violence (WPV): Organizations Speak Out

- The Joint Commission
- Emergency Nurses Association
- National Nurses United
- American Nurses Association
- American Association of Critical Care Nurses
- International Council of Nurses
- American Medical Association
- American Hospital Association
- American Organization of Nurse Executives

ENA 2011 Nurses Study



- The overall frequency of physical violence and verbal abuse during a seven-day period for full time ED Nurses was 54.5%
- Experienced physical violence: 12.1% and verbal abuse only- 42.5%
- The majority of the victims did not file an event report

OSHA Data

- In 2013: healthcare and social workers experienced 7.8 cases of serious WPV injuries per 10,000 FTEs
- Other large sectors such as construction, retail, and manufacturing: fewer than 2.0 per 10,000 FTEs
- 2016 GAO published analysis: In 2013, inpatient healthcare workers: WPV injuries required time off rate 5 times higher than private sector workers

Why Does Patient to Staff WPV Persist?

- A weak/nonexistent policy
- Inadequate employee acquisition, supervision, and retention practices
- Inadequate training on violence prevention
- No clearly defined rules of conduct
- A nonexistent/weak mechanism for reporting
- Failure to take immediate action

Violence Reporting Statistics

- Data on patient aggression is deceiving
- Healthcare is historically weak in aggression data collection
- In some settings the data are nonexistent
- We generally only see data related to staff/patient injury
- Data that does not involve injury may be deemed to low to merit attention and resources

Underreporting Reasons

- Absence of policies
- “Part of the job”
- Poor performance
- Empathy for patient/family member
- Lack of evidence of physical injury
- Shame/fear/threat of further violence
- Lack of supervisor support/fear of reprisal
- Cumbersome reporting mechanisms

State Laws

- Passed laws that require HC employers to conduct periodic security and safety assessments
- Require the development and implementation of assault prevention and protection programs
- Require training on a regular and ongoing basis
- Enacted legislation to strengthen or increase penalties for acts of WPV against staff

Costs of Action vs. Inaction

- Action Costs: Include proactive steps to prevent WPV
- Inaction Costs: Widespread financial & human resource cost
  - Workers' compensation claims
  - Litigation for unsafe work environment
  - Increased turnover/absenteeism
  - Property Damage
  - Need for increased Security
  - Overtime or hiring temps
  - Effects on recruitment/retention
- 60:1 ratio of cost in terms of aftermath vs. prevention
- Some estimate inaction at **100 times more costly**

Risk Factors for Violence

- **Alcohol/Drugs/Psych**
- High levels of stress
- Inappropriate staff attitudes
- Long waits for service
- Lack of training
- Limits on drink/food consumption
- Lack of TX options
- Difference in language/culture
- Access to guns
- Lack of staff
- Poor environmental design
- Unrestricted movement
- Poorly lit areas
- Inadequate security

Patient Experience vs. Staff Safety

"We live in a world where the patient has more rights than the staff and that is beat into us every day"

Impact of Aggression/Violence

- Loss of self esteem and confidence
- Loss of trust of professional abilities/expertise
- Job dissatisfaction
- Elevated stress levels (PTSD)
- Feelings of anger, fear, depression, guilt
- Trauma
- Death

OSHA

General Duty Clause

- *OSH ACT of 1970 Section (5)(a)(1): The employer did not furnish employment and a place of employment which was free from recognized hazards that were causing or likely to cause death or serious physical harm to employees in that employees are exposed to the hazard of workplace violence.*

OSHA Citations

California

- State Hospital: $57,000
- State Hospital: $38,555

Maine

- Hospital: $6,300

New York

- Residential Substance Abuse Rehab: $28,000

CASE

- Involves a Corporate entity that has several behavioral health facilities
- One facility specializes in inpatient treatment of severe autistic children/adolescents
- Other inpatient facilities treat adults and/or adolescents
- Believed that they were in keeping with the standards related to workplace violence

OSHA ABATEMENT RECOMMENDATIONS

BASED ON

ACTUAL ORGANIZATIONAL CITATION CASE

Develop a WPVP Policy

- Clearly define WV hazards: physical and verbal
- Policy should include: WPV will not be tolerated and all incidents will be investigated
- Clear description: How to respond to patients making threats, aggression, and assault including when to call police
- Clear statement that employees will not experience retaliation for reporting threats or violence or for calling police
- Information: how and where to seek emotional support and mental health care including after hours
- Annual review of WPVPP and update as necessary. Solicit employee input into the review

Additional Abatement Measures

- Ensure WPVPP is conveyed to employees and patients/clients
- Perform a workplace hazard assessment
- Establish WPV Safety Committee – with front line staff
- Provide a reliable/readily available means of communication
- Establish policy to maintain the effectiveness of communication device, inform employees, and enforce policy

Additional Abatement Measures

- Determine appropriate training for staff and time frame for refreshers
- System of flagging patients with history of violence
- Evaluate the need and appropriateness of devices that can protect employees during a crisis (arm guards, blocking pads)
- Ensure appropriate staffing
- Make changes to patient's treatment plan promptly

Abatement Measure: Incident Reporting

- Encourage employees to promptly report all incidents and near misses
- System for staff to report WPV events anonymously
- System to provide affected employees feedback about their WPV concerns/suggestions
- Review and analyze all crisis intervention events with staff to determine root causes, actions that worked and necessary improvements

Major Focus in the Case…

- 29 CFR 1910.132(a): Protective equipment not used when necessary whenever hazards are capable of causing injury and impairment were encountered
- Mandatory use of available and reliable personal alarms/communication systems
- Nursing station design

BH Nurses Station: Enclosed?

- Only prevent WPV if no one LEAVES THEM!
- Cuts off a patient's access to nurses
- Creates a theme of power via the glass barrier, with patients feeling powerless to the divide (Andes & Shattell, 2006)
- Forces the patient to tap on the glass, wave, essentially beg for attention
- Inflames patients feelings of not being cared about (feel like objects) (Forchuk & Reynolds, 2001).
- Studies: No increase in aggression toward staff was found. More research is needed

Additional Strategies for WPVP

Culture of Zero Tolerance

- Aggressive/violent behavior is not tolerated (including lateral/vertical/horizontal violence)
- No weapon signs at ED and Main entrance
- Posted notification to the community of the Culture of Zero Tolerance
- Involvement of law enforcement
- Possible termination of patient relationship

Debrief All Aggression

Culture of Debriefing

- Routine
- Constructive
- Non-blaming
- Encourage discussion of the event
- Documentation

Barriers to Debriefing

- Culture: aggression is "part of the job"
- Little understanding of how immediate defect review can provide valuable learning
- Lack of time
- Lack of administrative support

Establish a Rapid Response Team

- Proactive approach to risk mitigation
- Person(s) that can be immediately accessed should a patient, visitor, staff person BEGIN to escalate
- Could be a multidisciplinary team of trained personnel
- Debrief after all responses

Ensure Staff Competencies

- Train ALL staff in predicting/identifying aggression and de-escalation techniques
- Competencies for Sitters

Non-violent crisis intervention for:

- Security
- ED Staff
- ICU Staff
- Administrative/Nursing Supervisors
- All staff involved in Crisis Intervention

WPVP Program Evaluation

- Survey employees
- Evaluate safety/security measures
- Review reports/minutes on safety/security
- Analyze trends relative to “baseline” rates
- Set QI goals to lower the frequency and severity of workplace violence
- Evaluate work practice changes for effectiveness
- Request law enforcement/consultation for additional recommendations for safety

Post Event Support

- Provide comfort and peer support

- Expression of understanding
- Debriefing with staff involved
- Referrals for staff to appropriate resources
- Post incident response and evaluation

Summary

- Most workplace violence is preventable
- Institute a strong, comprehensive violence prevention program focused on zero tolerance
- Mandate reporting
- Collect data and set improvement goals

TOOL BOX

- Staff Debriefing worksheet
- Learning From Defects – Johns Hopkins
- ENA ED Workplace Violence Staff Assessment

RESOURCES

- OSHA Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers *http://www.dangerousbehaviour.com/DisturbingNews/Guidelines%20for%20PreventingViolence%20HSS.htm*
- *CDC/IOSH, Violence Occupational Hazards in Healthcare, https://www.cdc.gov/niosh/docs*
- ASHRM Workplace Violence Toolkit, *http://www.ashrm.org/resources/workplace_violence/index.dhtml*
- PA Patient Safety Advisory: Violence Prevention Training for ED Staff: http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2012/Mar;9(1)/Pages/01.aspx
- Crisis De-Escalation Training for Staff and Consumers in Inpatient and Other Service Delivery Settings, National Research and Training Center(NRTC) *http://www.psych.uic.edu/UICNRTC/dep-training.htm*
- Emergency Nursing Association Workplace Violence Toolkit, *http://www.ena.org/IENR/ViolenceToolkit/Documents/OSHA%20analysis.htm*

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Questions?

THE END

Thank you for your participation!
Proceed with Confidence!

Questions/comments can be forwarded to:
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