Emerging Health Care Concern: Preventing Workplace Violence

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Workplace Violence:
A Growing Concern

Workplace Violence

▸ A violent act (or acts) including physical assaults or *threats* of assaults directed towards a person at work or while on duty
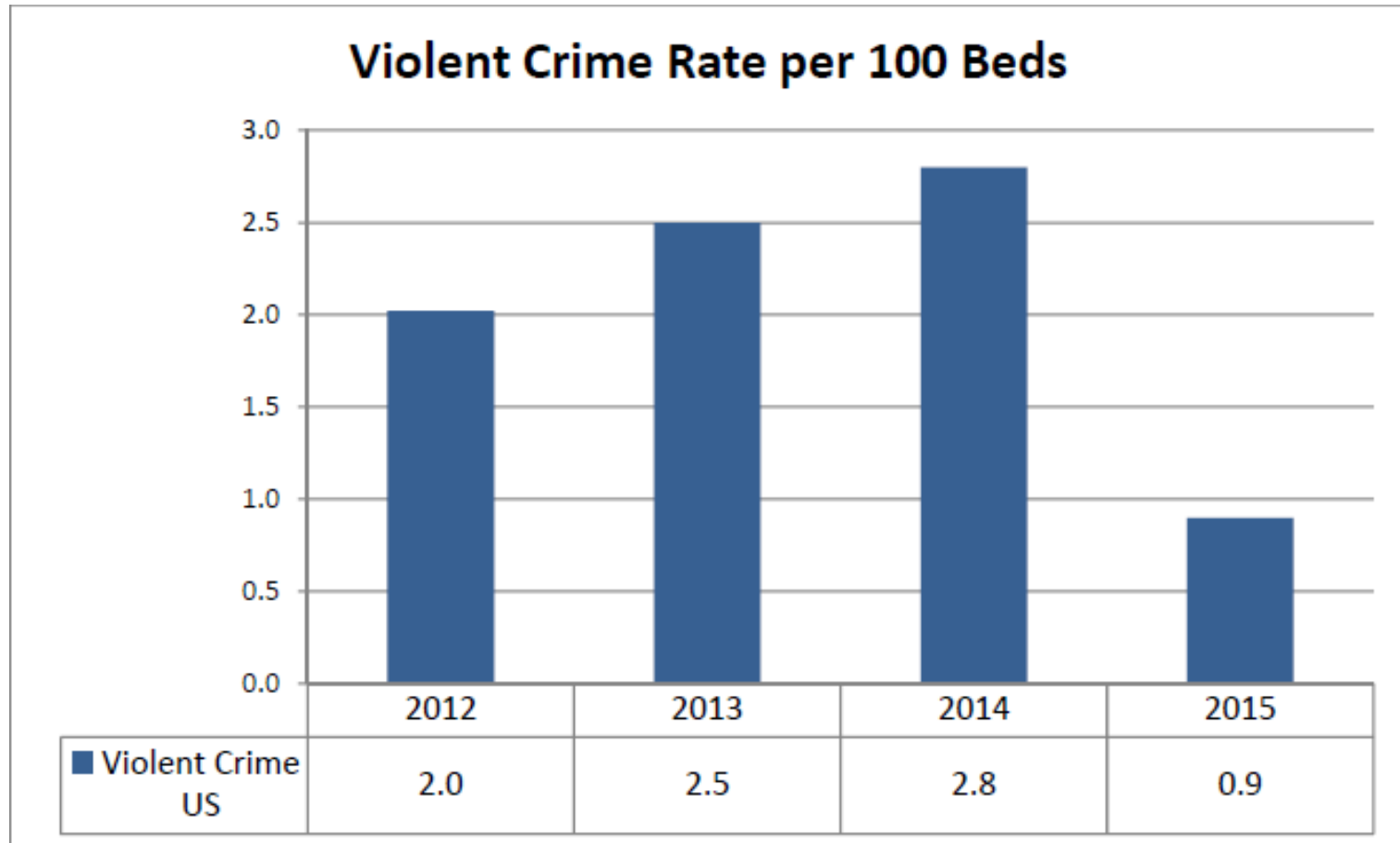
CDC/NIOSH, 2002

Patient Safety Events

▸ Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a patient, <u>staff member, licensed independent practitioner, visitor, or vendor</u> while on site at the hospital

CAMH, 2016

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Survey: Rate of Violent Crime Increasing in U.S. Hospitals

Violent Crime Rate per 100 Beds

|	2012	2013	2014	2015
Violent Crime US	2.0	2.5	2.8	0.9

2016 Healthcare Crime Survey produced by the International Healthcare Security and Safety Foundation (IHSSF) and reflects health care crime trends for 2012, 2013, 2014, and 2015.

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Workplace Violence Against Health Care Workers in the US

Types of Workplace Violence

Type	Description	Example
I	Perpetrator has no association with the workplace or employees	Person with criminal intent commits armed robbery
II	Perpetrator is a customer or patient of the workplace or employees	Intoxicated patient punches nursing assistant
III	Perpetrator is a current or former employee of the workplace	Recently fired employee assaults former supervisor
IV	Perpetrator has a personal relationship with employees, none with the organization	Ex-husband assaults ex-wife at her place of work

2015 Type 2 Aggravated Assault and Type 2 Assault Rate per 100 Beds in U.S. Hospitals
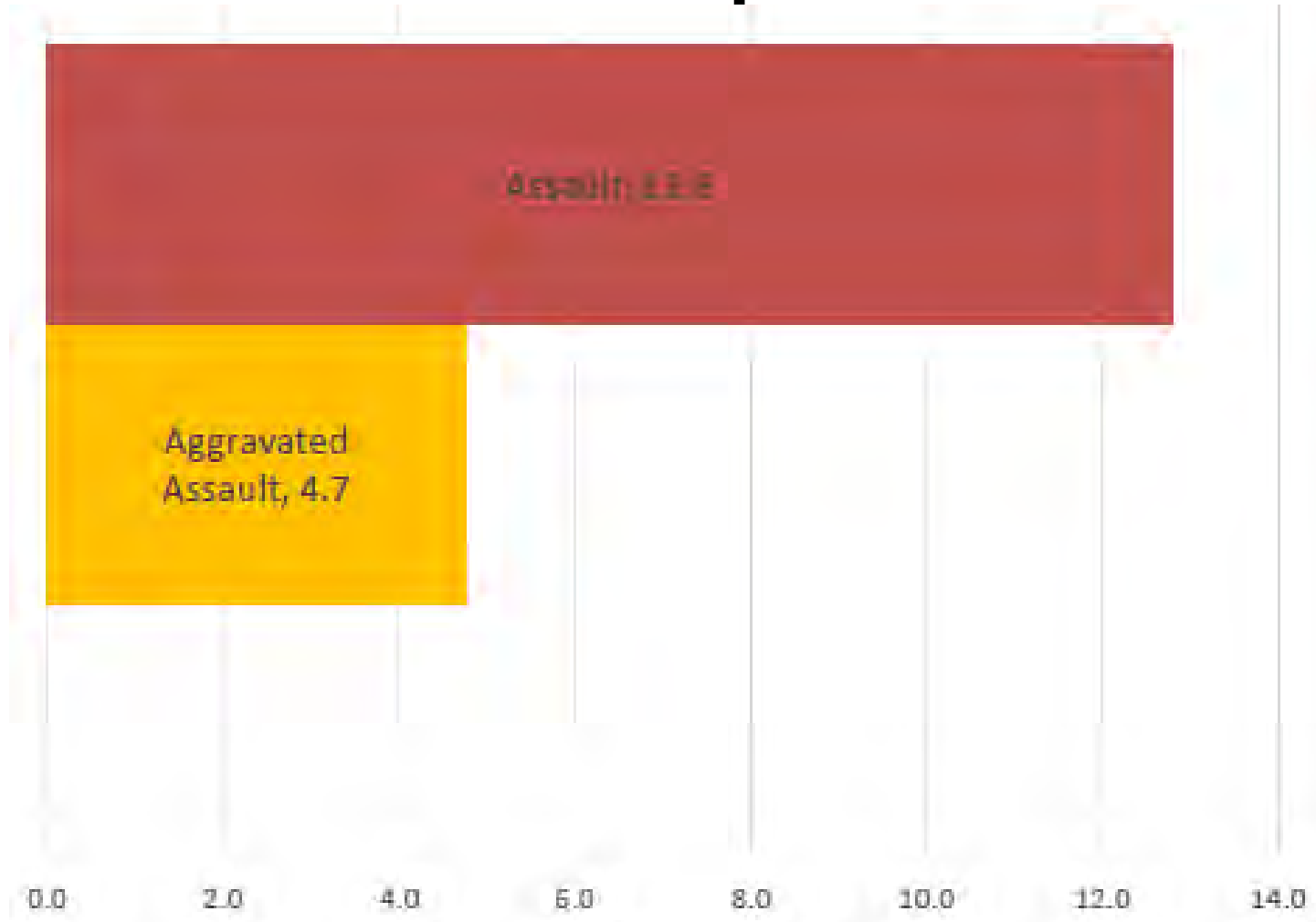
Workplace Violence Statistics and Nurses

- 5,910 incidents occurred in hospitals (15.6 per 10,000)
- 8,990 incidents in nursing or residential care facilities (37.1 per 10,000)
- 1,790 incidents (3.7 per 10,000) in ambulatory care centers and offices
- In 2012, a total of 2,160 episodes of workplace violence were reported against registered nurses
- 780 episodes against licensed practical/vocational nurses were reported

US Department of Labor, US Bureau of Labor Statistics. Table R12. Number of nonfatal occupational injuries and illnesses involving days away from work by occupation and selected events or exposures leading to illness or injury, private sector, 2012. http://www.bls.gov/news.release/osh2.nr0.htm Accessed February 23, 2015

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Workplace Violence Statistics and Nurses (continued)

- **80%** of nurses do not feel safe in their workplace (Peek-Asa, et al, 2009)

- **82%** of ED nurses had been physically assaulted at work in one year (May and Grubbs, 2002)

- **25%** of psychiatric nurses experienced disabling injures from patient assaults (Quanbeck, 2006)

- Between **35-80%** of hospital staff have been physically assaulted at least once during their careers (Clements, et al, 2005)

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US Department of Labor, US Bureau of Labor Statistics. Table R12. Number of nonfatal occupational injuries and illnesses involving days away from work by occupation and selected events or exposures leading to illness or injury, private sector, 2012. http://www.bls.gov/news.release/osh2.nr0.htm Accessed February 23, 2015

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Workplace Violence Against Health Care Workers in the US

States with Enhanced Penalties for Violence against Health Care Workers

Source: Phillips JP. Workplace Violence against Health Care Workers in the United States. *N Engl J Med* 2016;374:1661-9.

Occupational Traumatic Injuries Among Workers in Health Care Facilities
United States, 2012-2014

Comparison of OSHA-recordable injury incidence rates per 10,000 worker-months by occupation groups among 112 U.S. health care facilities. Jan. 1, 2012 – Sept. 30, 2014
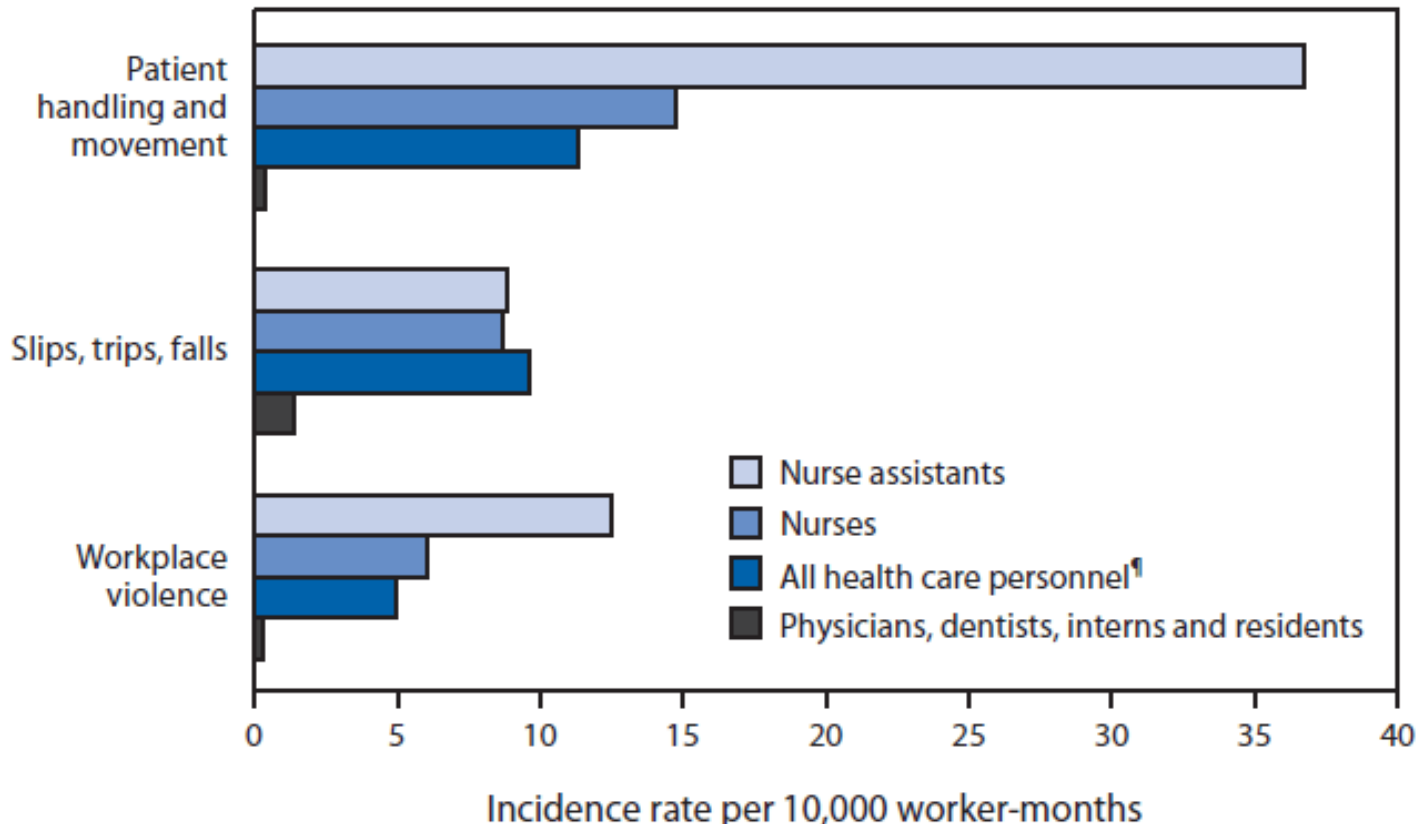
Incidence rate per 10,000 worker-months

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Gomaa AE, et al. Occupational Traumatic Injuries Among Workers in Health Care Facilities – United States, 2012-2014. CDC Weekly. April 24, 2015, 64(15);405-410.

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# Occupational Traumatic Injuries Among Workers in Health Care Facilities
United States, 2012-2014

Comparison of OSHA-recordable injury incidence rates per 10,000 worker-months by 112 U.S. health care facilities. Jan. 1, 2012 – Sept. 30, 2014

Gomaa AE, et al. Occupational Traumatic Injuries Among Workers in Health Care Facilities – United States, 2012-2014. CDC *Weekly*. April 24, 2015, 64(15);405-410.

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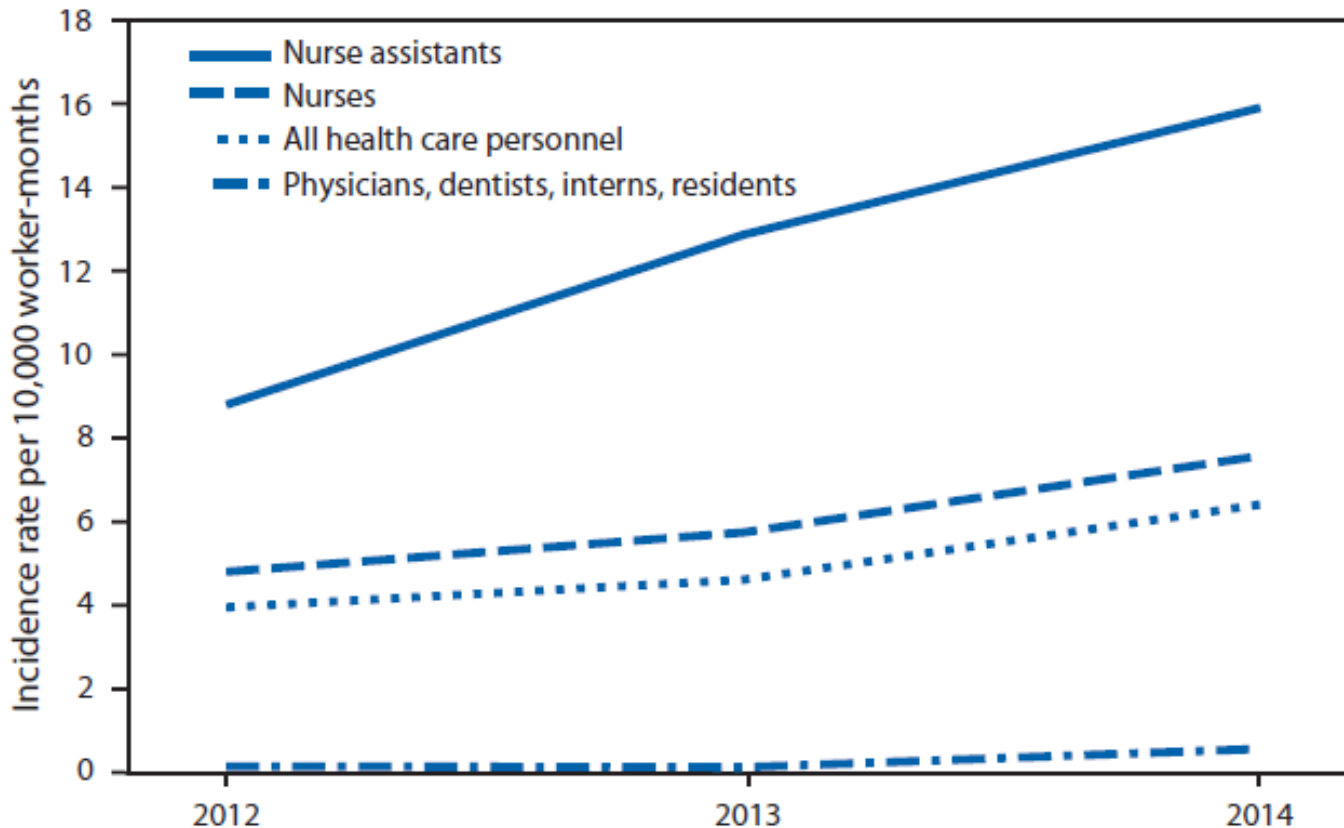
Workplace Violence Against Health Care Workers in the US

Rates of Workplace Violence with Injury Requiring Missed Workdays
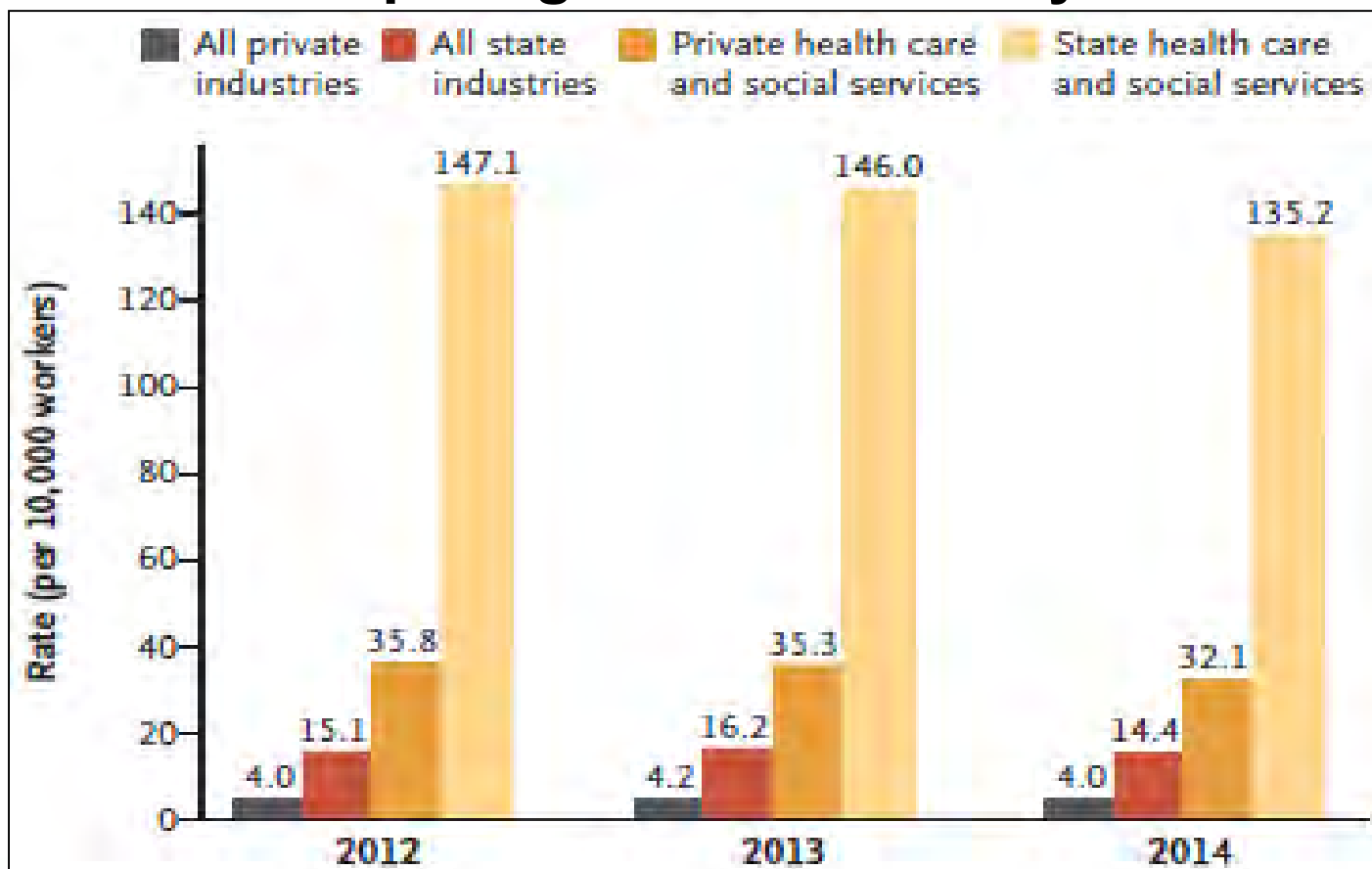
Source: Phillips JP. Workplace Violence against Health Care Workers in the United States. *N Engl J Med* 2016;374:1661-9.

Abstract

Introduction

Workplace violence against nurses is a serious problem. Nurses from a US urban/community hospital system employing more than 5,000 nurses researched the incidence of workplace violence against nurses perpetrated by patients or visitors in their hospital system.

Methods

Survey research and retrospective database review methods were used. Nurse participants (all system-employed nurse types) completed a 34-item validated survey in electronic format. Retrospective database review provided annual nurse workplace violence injury treatment and indemnity charges. Institutional review board approval was received.

Results

Survey research participants (N = 762) were primarily white female registered nurses, aged 26 to 64 years, with more than 10 years of experience. Over the past year, 76.0% experienced violence (verbal abuse by patients, 54.2%; physical abuse by patients, 29.9%; verbal abuse by visitors, 32.9%; and physical by visitors, 3.5%), such as shouting or yelling (60.0% by patients and 35.8% by visitors), swearing or cursing (53.5% by patients and 24.9% by visitors), grabbing (37.8% by patients and 1.1% by visitors), and scratching or kicking (27.4% by patients and 0.8% by visitors). Emergency nurses (12.1%) experienced a significantly greater number of incidents ($P < .001$). Nurses noted more than 50 verbal (24.3%) and physical (7.3%) patient/visitor violence incidents over their careers. Most serious career violence incidents (n = 595, 78.1%) were physical (63.7%) (60.8% by patients and 2.9% by visitors), verbal (25.4%) (18.3% by patients and 7.1% by visitors), and threatened physical assault (10.9%) (6.9% by patients and 4.0% by visitors). Perpetrators were primarily white male patients, aged 26 to 35 years, who were confused or influenced by alcohol or drugs. Per database review, annual workplace violence charges for the 2.1% of nurses reporting injuries were $94,156 ($78,924 for treatment and $15,232 for indemnity).

Speroni KG et al. Incidence and Cost of Nurse Workplace Violence Perpetrated by Hospital Patients or Patient Visitors. *Journal of Emergency Nursing*, Volume 40, Issue 3, 218-228.

Joint Commission Sentinel Events Database Violence-Related Events, 2010 to 2015

Homicides – 57 incidents

- 25 patients victimized by other patient
- 23 patients victimized by relative or significant other
- 9 patients victimized by staff member and other

Assaults – 59 incidents

- 43 patients victimized by other patient
- 11 patients victimized by staff
- 5 patients victimized by other

Rapes – 146 incidents

- 96 patients victimized by other patient
- 40 patients victimized by staff
- 10 patients victimized by relative, significant other, and other

Other Violence - <5

- <5 patients victimized by other patient
- <5 patients victimized by relative or significant other

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Medical Center Shooting

The Medical Center campus covers a large tract of land

The hospital-owned Ambulatory Center (AC) sits across the street from the medical center and is connected by a pedestrian bridge

BREAKING NEWS

MEDICAL CENTER SHOOTING

Medical Center Shooting

(continued)

▸ The AC consists of three stories with the third floor leased to private physician practices

▸ On the day of the shooting, a patient, accompanied by his case worker, went to the third floor of the AC for an appointment

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Medical Center Shooting
(continued)

▶ During the visit with the psychiatrist, the patient became loud and argumentative

▶ The patient fatally shot the case worker and injured the psychiatrist

▶ The psychiatrist returned fire and injured the patient

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Pertinent Questions

- Was a thorough facilities risk assessment, including ambulatory center, performed?

- Were there prior incidents of violence by this patient?

- What was security's response to the shooting?

- Was the psychiatrist permitted to carry a gun on medical center premises?

- Could anything have been done differently to anticipate and prevent the tragedy?

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Managing the Media: Prepare in Advance

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Science of Violent Behavior

Recent discoveries have been made about the invisible workings of the brain in the fields of social psychology, neurology, and epidemiology that have shed some light on how violent behaviors are formed.

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What does science tell us about the causes of violent behavior?

1. Most behaviors – including violent behavior – are actually acquired or learned.

2. Most of this learning is not intentional or classroom-based; rather, they are learned. Behaviors come from modeling, observing, imitating or copying. (This is sometimes call "social learning.")

3. Most of this social learning is unconscious – meaning behaviors are picked up without our awareness of it.

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What does science tell us about the causes of violent behavior?

4. **Exposure to violence increases one's risk of becoming violent**, transmitting from one person to another in the same manner as a contagious disease.

5. Neurological events mediate this contagion and there are additional physiological effects from both witnessing and experiencing trauma that accelerate the contagion.

6. Social norms, scripts, and perceived social expectations further exacerbate this contagion by encouraging violent behavior to spread.

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Risk Factors for Violence in Health Care

- The prevalence of handguns and other weapons among patients, their families, or friends

- The increasing use of hospitals by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals

- The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care

Source: OSHA's Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, 2004

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Risk Factors for Violence in Health Care (continued)

- The availability of drugs or money at hospitals, clinics, and pharmacies, making them likely robbery targets

- Factors such as the unrestricted movement of the public in clinics and hospitals and long waits in emergency or clinic areas

- The increasing presence of gang members, drug or alcohol abusers, trauma patients, or distraught family members

Source: OSHA's Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, 2004

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Risk Factors for Violence in Health Care (continued)

▸ Low staffing levels during times of increased activity such as mealtimes, visiting times, and when staff are transporting patients

▸ Isolated work with patients during examinations or treatment

▸ Solo work, often in remote locations with no backup or way to get assistance, such as communication devices or alarm systems

Source: OSHA's Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, 2004

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Risk Factors for Violence in Health Care (continued)

▸ Lack of staff training in recognizing and managing escalating hostile and assaultive behavior

▸ Poorly lit parking areas

Source: OSHA's Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers, 2004

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Relationship to Standards

- Standards related to <u>security</u> <u>and</u> <u>violence</u> <u>prevention</u> are reflected in chapters:
  - Environment of Care
  - Emergency Management
  - Leadership
  - Patient Rights

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Relationship to Standards (continued)

▧ Standards that support a <u>safe environment</u> <u>and</u> <u>culture</u> are reflected in chapters:

- – Human Resources
- – Leadership
- – Provision of Care
- – Performance Improvement

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STANDARDS RELATED TO SECURITY AND VIOLENCE PREVENTION

■ Standards ■ Elements of Peformance
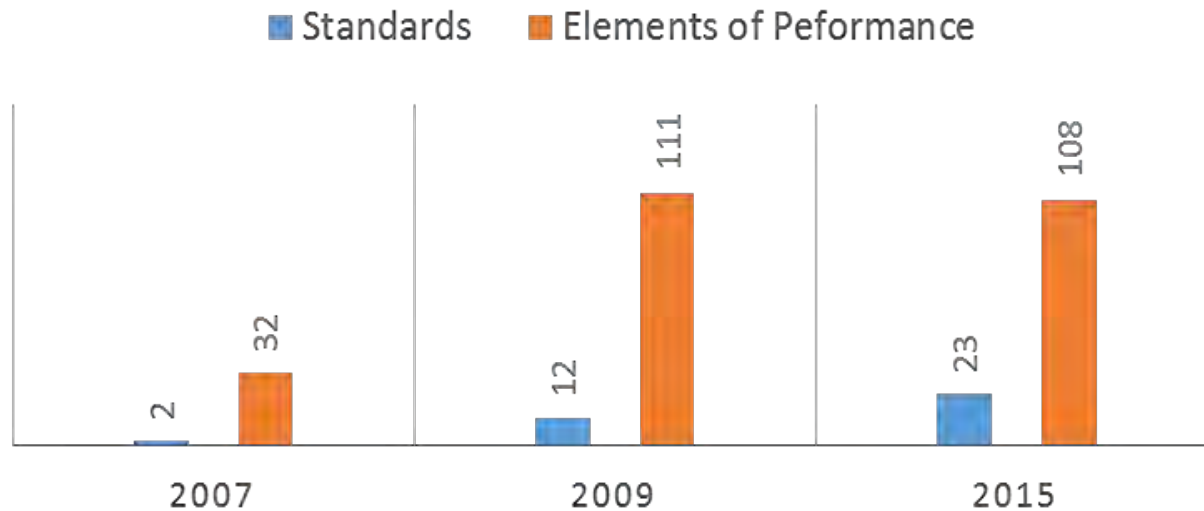
Includes all accreditation programs

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Restraining Violent Patients

- Standard PC.01.02.13 that applies to patients receiving treatment for emotional and behavioral disorders states that the patient receives an assessment that would include "maladaptive or other behaviors that create a risk to patients or others."

- PC.03.05.03 states: For hospitals that use Joint Commission accreditation for deemed status purposes: The use of restraint and seclusion is in accordance with a written modification to the patient's plan of care.

Balancing Staff Safety and Patient Rights

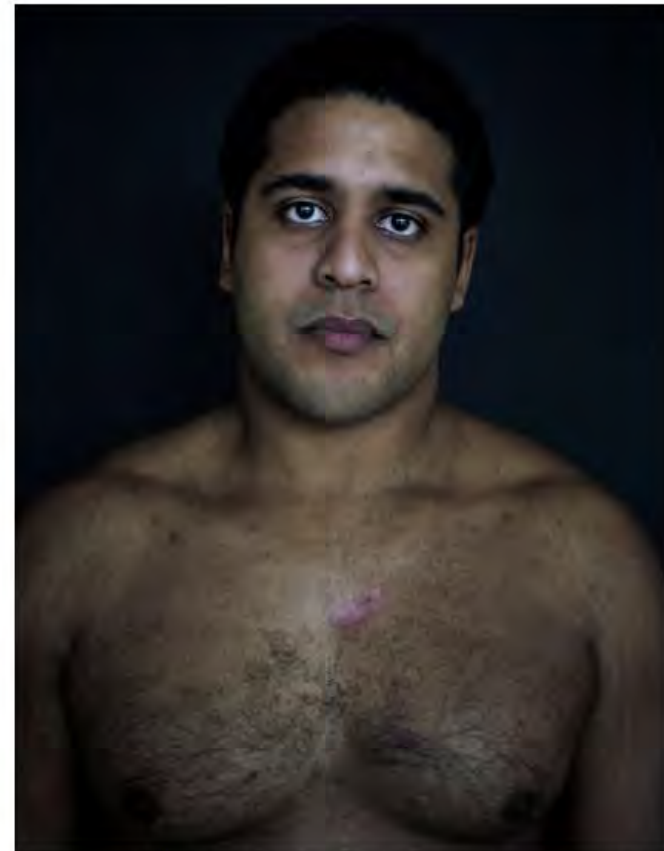**Patient Rights & Restraint-Free Environment**

Staff Safety (and Other)

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When the Hospital Fires the Bullet

More and more hospital guards across the country carry weapons. For Alan Pean, seeking help for mental distress, that resulted in a gunshot to the chest.

By ELISABETH ROSENTHAL   FEB. 12, 2016

In the center of Alan Pean's chest is the scar left by a hospital security officer's bullet last August. Chad Batka for The New York Times

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CMS Position On Weapons

There is no standard regarding tazers. CMS CoP 482.13 (e) states: CMS does not consider **the use of weapons** in the application of restraint or seclusion as a safe, appropriate health care intervention. For the purposes of this regulation, the term "weapon" includes, but is not limited to, pepper spray, mace, nightsticks, tazers, cattle prods, stun guns, and pistols. Security staff may carry weapons as allowed by hospital policy, and State and Federal law. <u>However, the use of weapons by security staff is considered a law enforcement action, not a health care intervention.</u> <u>CMS does not support the use of weapons by any hospital staff as a means of subduing a patient in order to place that patient in restraint or seclusion.</u>

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Sentinel Event Alert 56: Detecting and treating suicide ideation in all settings

February 24, 2016

Download This File

The rate of suicide is increasing in America. Now the 10th leading cause of death, suicide claims more lives than traffic accidents and more than twice as many as homicides. At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death, usually for reasons unrelated to suicide or mental health.

Additional Resources:

- Infographic
- Joint Commission requirements relevant to suicide

Application of Lessons Learned

Quick Safety - Issue Four, July 2014
July 28, 2014

Preparing for active shooter situations

*Quick*Safety

Quick Safety - Issue Five, August 2014
August 28, 2014

Preventing violent and criminal events

Safety

Sentinel Event Alert, Issue 45: Preventing violence in the health care setting

June 3, 2010

Download This File

Once considered safe havens, health care institutions today are confronting steadily increasing rates of crime, including violent crimes such as assault, rape and homicide. As criminal activity spills over from the streets onto the campuses and through the doors, providing for the safety and security of all patients, visitors and staff within the walls of a health care institution, as well as on the grounds, requires increasing vigilant attention and action by safety and security personnel as well as all health care staff and providers.

fety & quality issues

Joint Commission Suggested Actions to Prevent Assault, Rape, and Homicide in Health Care Settings

- Work with the security department to audit the risk of violence

- Identify strengths and weaknesses and make improvements to the facility's violence-prevention program

- Take extra security precautions (points of access)

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Joint Commission Suggested Actions to Prevent Assault, Rape, and Homicide in Health Care Settings
(continued)

▸ Work with the HR department to make sure it thoroughly prescreens job applicants and establishes and follows procedures for conducting background checks of prospective employees and staff

– For clinical staff, the HR department also verifies the clinician's record with appropriate boards of registration and practitioner data banks

Source: *Sentinel Event Alert*, June 3, 2010

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Joint Commission Suggested Actions to Prevent Assault, Rape, and Homicide in Health Care Settings

(continued)

- Confirm that the HR department ensures that procedures for disciplining and firing employees minimize the chance of provoking a violent reaction

- Require appropriate staff members to undergo training in responding to patients' family members who are agitated and potentially violent

Source: *Sentinel Event Alert*, June 3, 2010

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Joint Commission Suggested Actions to Prevent Assault, Rape, and Homicide in Health Care Settings

(continued)

▸ Ensure that procedures for responding to incidents of workplace violence (e.g., notifying department managers or security, activating codes) are in place that employees received instruction on these procedures

▸ Encourage employees and other staff to report incident of violent activity and any perceived threats of violence

Source: *Sentinel Event Alert*, June 3, 2010

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Joint Commission Suggested Actions to Prevent Assault, Rape, and Homicide in Health Care Settings
(continued)

▶ Educate supervisors that all reports of suspicious behavior or threats by another employee must be treated seriously and thoroughly investigated

– Train supervisors to recognize when an employee or patient may be experiencing behaviors related to domestic violence issues

Source: *Sentinel Event Alert*, June 3, 2010

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Joint Commission Suggested Actions to Prevent Assault, Rape, and Homicide in Health Care Settings

(continued)

- Ensure that counseling programs for employees who become victims of workplace crime or violence are in place

- Report the crime to appropriate law enforcement officers

- Recommend counseling and other support to patients and visitors who may be affected by the violent act

- Review the event and make changes to prevent future occurrences

Source: *Sentinel Event Alert*, June 3, 2010

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AONE-ENA Mitigating Violence in the Workplace

Guiding Principles

1. Recognition that violence can and does happen anywhere

2. Healthy work environments promote positive patient outcomes

3. All aspects of violence (patient, family and lateral) must be addressed

4. A multidisciplinary team, including patients and families, is required to address workplace violence

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AONE-ENA Mitigating Violence in the Workplace (continued)

5. Everyone in the organization is accountable for upholding foundational behavior standards, regardless of position or discipline

6. When members of the health care team identify an issue that contributes to violence in the workplace, they have an obligation to address it

7. Intention, commitment and collaboration of nurses with other health care professionals at all levels are needed to create a culture shift

8. Addressing workplace violence may increase the effectiveness of nursing practice and patient care

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AONE-ENA Mitigating Violence in the Workplace (continued)

▶ **Five Priority Focus Areas**

1. **Foundational behaviors to make this framework work:**

   - Respectful communication, including active listening

   - Mutual respect demonstrated by all (i.e., members of the multidisciplinary team, patients, visitors and administrators)

   - Honesty, trust and beneficence

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Source: AONE-ENA White Paper, April 2015. Accessed May 2015.
http://www.aone.org/resources/PDFs/Mitigating_Violence_GP_final.pdf

AONE-ENA Mitigating Violence in the Workplace (continued)

Five Priority Focus Areas

2. **Essential elements of a zero-tolerance framework:**

   - Top-down approach supported and observed by an organization's board and C-Suite

   - Enacted policy defining what actions will not be tolerated, as well as specific consequences for infractions to the policy

   - Policy is clearly understood and equally observed by every person in the organization (i.e., leadership, multidisciplinary team, staff, patients and families)

   - Lateral violence is prohibited, regardless of role or position of authority (i.e., the standard of behavior is the same for doctors, nurses, staff and administration)

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Source: AONE-ENA White Paper, April 2015. Accessed May 2015.
http://www.aone.org/resources/PDFs/Mitigating_Violence_GP_final.pdf

AONE-ENA Mitigating Violence in the Workplace (continued)

▸ Five Priority Focus Areas

3. **Essential elements to ensuring ownership and accountability:**

   - Personal accountability, meaning everyone in the organization is responsible for reporting and responding to incidence of violence
   - Zero-tolerance policy is developed with input from staff at every level in the organization, thus ensuring staff co-own the process and expectations
   - Universal standards of behavior are clearly defined and every person in the organization (including patients and families) is held equally accountable
   - Incidents of violence are reported immediately to persons of authority, through the chain of command, to ensure immediate enforcement of the zero-tolerance policy

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AONE-ENA Mitigating Violence in the Workplace (continued)

Five Priority Focus Areas

4. **Essential elements of training and education on workplace violence**

   - Organizational and personal readiness to learn
   - Readily available, evidence-based and organizationally-supported tools and interventions
   - Skilled/experience facilitators who understand the audience and specific issues
   - Training on early recognition and de-escalation of potential violence in both individuals and environments
   - Health care specific case studies with simulations to demonstrate actions in situations of violence

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Source: AONE-ENA White Paper, April 2015. Accessed May 2015.
http://www.aone.org/resources/PDFs/Mitigating_Violence_GP_final.pdf

AONE-ENA Mitigating Violence in the Workplace (continued)

▶ Five Priority Focus Areas

5. **Outcome metrics of the program's success**

   - Top ranked staff and patient safety scores

   - Incidence of harm from violent behavior decreases

   - Entire organization (staff) reports feeling "very safe" on the staff engagement survey

   - Patients and families report feeling safe in the health care setting

   - Staff feels comfortable reporting incidents and involving persons of authority

   - The organization reflects the following culture change indicators: employers are engaged, employees are satisfied, and HCAHPS scores increase

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Systems Improvements and Follow-Up Actions

- Develop an Organizational Safety Policy
- Improve staff reporting of potential safety risks
- Complete a Safety Risk Assessment
- Enhance Video Surveillance
- Implement Mental Health First Aid Training
- Implement Crisis Emergency Response Team Training Program
- Implement CDC/NIOSH Violence Prevention and Colleague Safety Program

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Tips for Creating a Safe and Caring Hospital

- Encourage and promote courteous interactions
- Pay attention to behavioral warning signs
- Consider objects that could be used as weapons
- Practice and promote a team approach
- Assess your environment
- Trust your instincts
- Educate staff about relevant response protocol

Source: Crisis Prevention Institute, Inc.

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When Interacting With An Agitated Person . . .

▸ If possible, before interacting with the agitated person, call for help so that help is on the way

▸ Place yourself (always keep yourself) between the person and the exit

CPI's Top 10 De-Escalation Tips

1. **Be Empathic and Nonjudgmental**

   Keep in mind that whatever the person is going through, it may be the most important thing in their life at the moment.

2. **Respect Personal Space**

   If you must enter someone's personal space to provide care, explain your actions to the person feels less confused and frightened.

3. **Use Nonthreatening Nonverbals**

   Keeping your tone and body language neutral will go a long way toward defusing a situation.

4. **Avoid Overreacting**

   Positive thoughts like "I can handle this" and "I know what to do" will help you maintain your own rationality and calm the person down.

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CPI's Top 10 De-Escalation Tips

5. Focus On Feelings

Watch and listen carefully for the person's real message.

6. Ignore Challenging Questions

Ignore the challenge, but not the person. Bring their focus back to how you can work together to solve the problem.

7. Set Limits

A person who's upset may not be able to focus on everything you say. Be clear, speak simply, and offer the positive choice first.

8. Choose Wisely What You Insist Upon

If you can offer a person options and flexibility, you may be able to avoid unnecessary altercations.

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CPI's Top 10 De-Escalation Tips

9. **Allow Silence For Reflection**

Believe it or not, silence can be a powerful communication tool.

10. **Allow Time For Decisions**

A person's stress rises when they feel rushed. Allowing time bring calm.

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Summary

- Improve understanding of violence in health care settings
  - No universal strategy exists to prevent violence
  - Risk factors vary from facility to facility
- Review of current standards and tools
- Consider new alliances (police, crisis centers, FBI)
- Disseminating prevention strategies and toolkits
- Collaborate with other stakeholders (providers and community resources)

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