

Workplace Violence Initiatives
Engagement, de-escalation, & regulatory compliance

Thursday, August 15, 2024

CHARTIS

The webinar will start at the top of the hour.

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Navigating the Zoom interface

Handouts:
Check the chat function for copies of the slides for note taking and any other handouts.

Questions and comments:
Please participate in the discussion by asking question through the Q&A function during the webinar.
There will also be a survey you will receive immediately after the webinar that will give you an opportunity to ask additional questions or make comments.
Any questions not answered during the webinar will be addressed in a follow-up email or posting.

Handouts are linked in the "chat" function

1 Chat 2 Q&A

Please ask questions by clicking on "Q&A"

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MONTHLY INSIGHTS

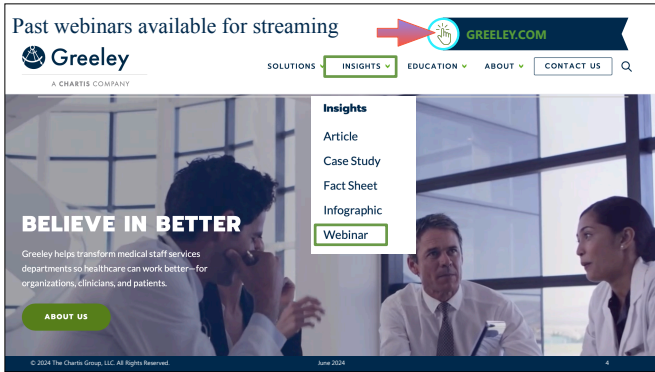
Webinar schedule & topics

**THE 3RD THURSDAY OF EVERY MONTH:
10AM Pacific, 1PM Eastern**

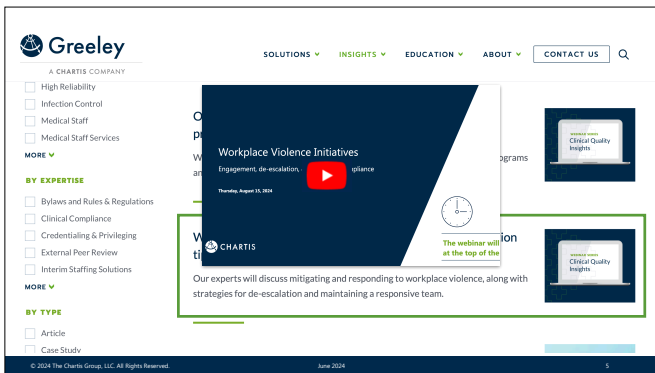
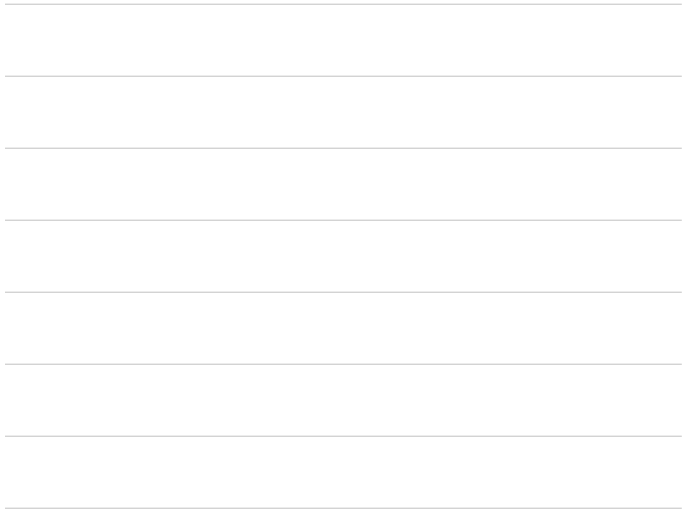
SEPTEMBER
Optimizing your Clinical Documentation Integrity (CDI) program for Quality

OCTOBER
Turning Data into MEANINGFUL Information about Quality and Safety

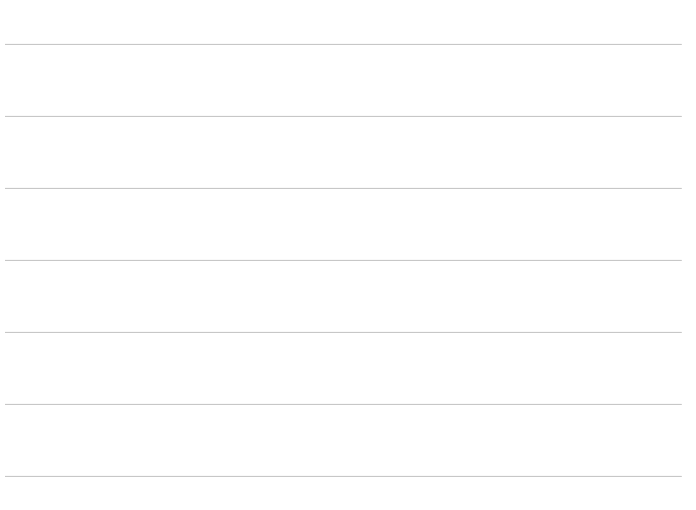
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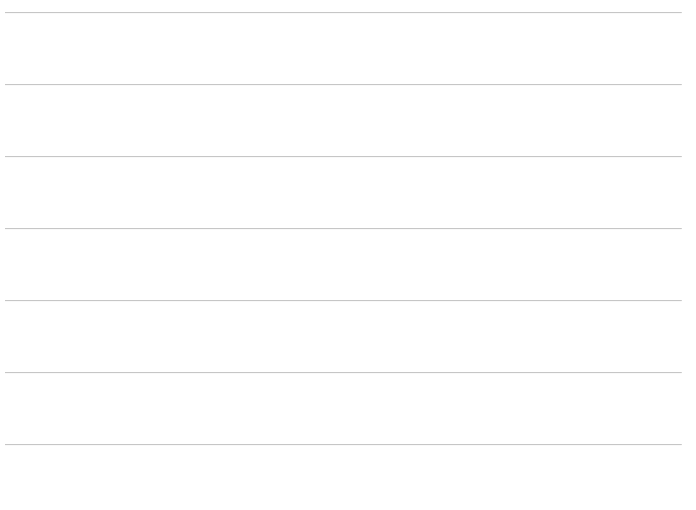
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SIMPLIFY & COMPLY

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TODAY'S DISCUSSION

Workplace Violence Initiatives



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Consultant Emeritus

“ Keeping up with change Planning for tomorrow ”

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Today's agenda

Regulatory Implications for Healthcare

- Patient and Associate Safety
- Review of Overlapping Requirements

Workplace Violence Initiatives

- Minimizing Escalation in the Behavioral Health Setting
- Building a sustainable program

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Adverse events involving violence

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Adverse Events Underlie the Lion's Share of Adverse Actions by CMS

The most highly cited regulation leading to CMS termination actions for accredited hospitals is EMTALA.

The highest cited Conditions of Participation are Patient Rights and Nursing Services, both of which are associated with adverse event and medical error.

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About Adverse Events

The types of adverse events that are considered "workplace violence" should be very clearly defined and all staff members educated.

Reporting of all adverse events
Number of "harm" events

To optimize the value of incident reports as a credible monitor of quality and safety there MUST be a high level of inter-rater reliability (consistency) in the designation of incident categories and level of harm/analysis.

Sifting Through Adverse Events

ESS	Description	Infrastructure	Harm?	Analysis
Zero (0)	No Variance: No known or suspected error or adverse state. Includes recommendation for improvement.	✓	No Harm	Fact Finding
A	Unsafe: There was an increased capacity for error, even though no error was identified.	✓	No Harm	Fact Finding
B	Captured: An error occurred but it did not reach a person or infrastructure.	✓	No Harm	Fact Finding
C	No Monitoring: An error occurred that reached a person or the infrastructure, but there was no reach for monitoring or intervention.	✓	No Harm	Fact Finding
D	Monitoring was necessary to look for potential signs of harm or damage. Monitoring includes non-invasive diagnostic testing.	✓	No Harm	Fact Finding
E	An intervention was necessary to avoid further harm to the patient or infrastructure.	✓	Harm	ACA* (Samples)
F	The error led to an initial or prolonged hospitalization.	✓	Harm	ACA* (Samples)
G	The error contributed to permanent harm to a person or the infrastructure.	✓	Harm	RCA*
H	Resuscitation: Intervention necessary to sustain life that involved advanced life support protocols.	✓	Harm	RCA
I	Death	✓	Harm	RCA
S	Defined Sentinel Event	✓	Harm	RCA

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Issues with Reporting WPV

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WPV is significantly underreported

- Data analytics on WPV is difficult to obtain & not public knowledge
- In a survey of emergency room nurses, 76% said their decision to report would be based on whether the patient was perceived as being responsible for their action. - Violence Against Nurses, NACNEP 5th Report
- Cumbersome reporting process
- Feels punitive (must use PTO for follow-up care)
- Lack of support from administration if they want to press charges
- Fearful the patient or visitor will know their name and retaliate in the future
- Lost wages if human resource policies do not support paid time off
- Feeling like "nothing will change"

WPV regulations

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Medicare certified hospitals have a regulatory obligation to care for patients in a safe setting under the Medicare Hospital Conditions of Participation (CoPs) at §482.13 and under the Medicare Hospital Emergency Preparedness CoP at §482.15.

The CMS Quality, Safety, and Oversight Group (QSOG) provided a Memorandum Summary regarding workplace violence for hospitals on November 28, 2022 stating: (handout provided) *CMS will continue to enforce the regulatory expectations that patient and staff have an environment that prioritizes their safety to ensure effective delivery of healthcare.*

Types of WPV

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Type 1: Criminal intent

the perpetrator has no legitimate relationship to the business or its employees and is usually committing a crime in conjunction with the violence (robbery, shoplifting, trespassing).

Type 2: Customer/client

is the most common in healthcare settings. CDC considers the customer/client relationship to include patients, their family members, and visitors. Research shows that this type of violence occurs most frequently in emergency and psychiatric treatment settings, waiting rooms, and geriatric settings but is not limited to these.

<https://www.cdc.gov/workplaceviolence/WHOIC/WHOIC1002019.pdf>

Type 3: Worker-on-worker

This violence between coworkers is commonly referred to as lateral or horizontal violence. It includes bullying and frequently manifests as verbal and emotional abuse that is unfair, offensive, vindictive, and/or humiliating, though it can range all the way to homicide. Worker-on-worker violence is often directed at persons viewed as being "lower on the food chain," such as a supervisor to supervisee, or doctor to nurse, though incidences of peer-to-peer violence are also common.

Type 4: Personal relationship

The perpetrator has a relationship with the staff member outside of work that spills over to the work environment. For example, the husband of a nurse follows her to work and threatens her, with implications for the nurse and for her coworkers and patients.

Contributing factors to WPV

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- WPV is not built into the culture/not a prioritized strategic initiative
- Lack of effective policies and procedures
- Lack of staff awareness about WPV
- Lack of staff reporting/accurate data
- Lack of funding
- High staff turnover rates
- High-risk patient populations due to substance dependency, psychiatric disorders, chronic cognitive conditions, etc.
- Staff's insufficient de-escalation skills/lack of training
- Unsecured, open physical environments
- Extreme levels of patient and family stress/fear/pain may lead to unpredictable behaviors
- Spillover from current events/societal and political issues
- Overall variability and unpredictability of healthcare settings in general

Impacts of WPV

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- Significant psychological impacts to staff, patients and families
 - Increased staff burnout
- Staff are traumatized by repeat verbal & physical abuse
 - Repeated exposure to high-risk situations and traumatic WPV incidents can increase MH symptoms
 - Physical injuries have a serious impact on staff MH
- Negatively affects the delivery, quality and accessibility of health care
- Adversely affects victims
- Undermines employee morale
- Lowers retention/high turnover rates
- Lowers employee productivity
- Staffing resource availability
- Employees' rights
- Impacts patient care
- Violence produces a fearful atmosphere

What we need to understand

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- WPV is prolific and across all industries, not just healthcare
- WPV will not decrease without implementable interventions
- WPV prevention requires a cultural shift within the organization
 - This is not just a "new policy" or leadership – this is understanding there's a lot of work involved to undue a lot of the stigma, bias, shame, and antiquated practice around managing WPV
 - It is a systems issue and needs a systems approach
 - Organizational safety as a core value is critical to advance WPV strategic measures

First steps—don't panic

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1. Review the specific regulations pertinent to your state and accrediting agency
2. Review existing WPV efforts
 - Understand where deficiencies, gaps, and opportunities exist
 - Transition to a collaborative approach that embraces transparency
 - Train teams to feel empowered to identify and safely manage security concerns proactively
 - Be a champion for change and embrace the struggles

The Canadian Federation of Nurses Unions. n.d. "Workplace Violence." <https://nursesunions.ca/employeeviolence/>.
Watson, A., M. Lefel, and A. Sarti. 2020. "The Perceived Prevalence of Violence against Health-Care Workers." *The American Journal of Managed Care* 26 (32): 4071-6. <https://doi.org/10.37765/ajmc.2020.8843>

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WPV program task checklist

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Task	Effort	Presumed Owner
Appoint a leader for the workplace violence program	Low	Quality/Patient Safety
Charter a standing workplace violence committee or working group (mission-membership-reporting-functions/responsibilities)	Low	WPV Leader
Complete a baseline workplace assessment before December 31, 2022 (or asap!)	Moderate	WPV Leader
Inventory existing policies and procedures that deal with workplace violence. Examples of policies/procedures already in place might be: <ul style="list-style-type: none">▪ Active Shooter Protocol (code silver)▪ Management of Assaultive Behavior▪ De-escalation▪ Code Security▪ Culture of Safety▪ HR Policies related to Aggression/Harassment, Staff Injury/Time Off▪ Restraint and Seclusion, Discharge AMA Process▪ Other _____		
Develop and implement training during orientation and annually for all staff members (across the entire organization)	High	Nursing Education and Medical Staff Office

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Workplan specifics

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1. Review/Develop Security Management Plan regarding workplace violence
2. Identify appointed owner of Workplace Violence Program (**does not mean they do it all**)
3. Review workplace violence committee charter
 - Identify roles/responsibilities
 - Review meeting minutes including reduction activities, actions, and follow-ups
4. Identify collateral subcommittees where WPV is discussed and review meeting minutes
5. Review workplace assessment and action plan
6. Review most recent governing body report on WPV
7. Review collateral policies related to workplace violence
8. Review training including new hire orientation and annual training
9. Review Incident Reports related to workplace violence (both security reports and main reporting system)
10. Review WPV reports that address trends/patters (specific units, staff, shifts, etc.)

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Workplan specifics

Review Policies & Procedures related to WPV

- Active Shooter
- Security or Police Activation
- Contraband Management
- Management of Aggressive/Assaultive Patients
- Clinical De-escalation and Restraint Management (Violent Restraint)
- AMA/Elopement Policy as it relates to Mental Capacity and Cognitive Impairment
- Legal Requirements – Involuntary holds, danger to self or others
- Human Resources
- Family and Support Person Visitors
- Culture of Safety

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Engaging with behavioral health patient and reducing violent escalations

Deliberate, meaningful interaction that **establishes trust** and **builds helpful relationships** with patients & family

According to Maslow's Hierarchy of Needs, only **physiological needs** are more important than safety needs. The therapeutic relationship is a basic concept of psychiatric nursing and patient care.

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Team *culture*



Traits common to well functioning teams include:

- A desire to care for a vulnerable population
- The ability to listen empathetically and demonstrate authentic caring
- Continual focus on patient care and safety during work hours
- Being kind, friendly, and respectful to all patients, visitors, and staff
- Being accountable for your own actions and the ability to hold others accountable


Staff and hospital culture is a predominant force that is readily noted by patients, visitors, and co-workers alike

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Goal of engagement

To proactively **ENGAGE** with the patient-family-visitor to prevent an escalation of negative verbal interactions and physical behaviors

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Signs of agitation

Increasing voice volume, **yelling, cursing; slamming** down phone

Repetitive motion and non-goal directed behaviors


Body movements including **foot tapping, pacing, hand wringing, hair pulling, fiddling** with clothes or other objects

Repetitive **thoughts** exhibited by vocalizations such as, **"I've got to get out of here, I've got to get out of here"**

Irritability and heightened **responsiveness to stimuli**

Agitation may be connected to different underlying emotions (**anger, sadness, guilt**)

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Immediate actions to avoid

Do not **argue** or overtalk

Do not use adjectives or **labels** to describe the person or use disparaging comments (they hear you)

Do not restrict the person's **movement**

Do not touch the person or make **sudden moves**

Do not **threaten** the person

Do not **press** for explanation about their behavior

Do not take the person's behavior or remarks **personally**

Do not make a **promise** that you cannot keep

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