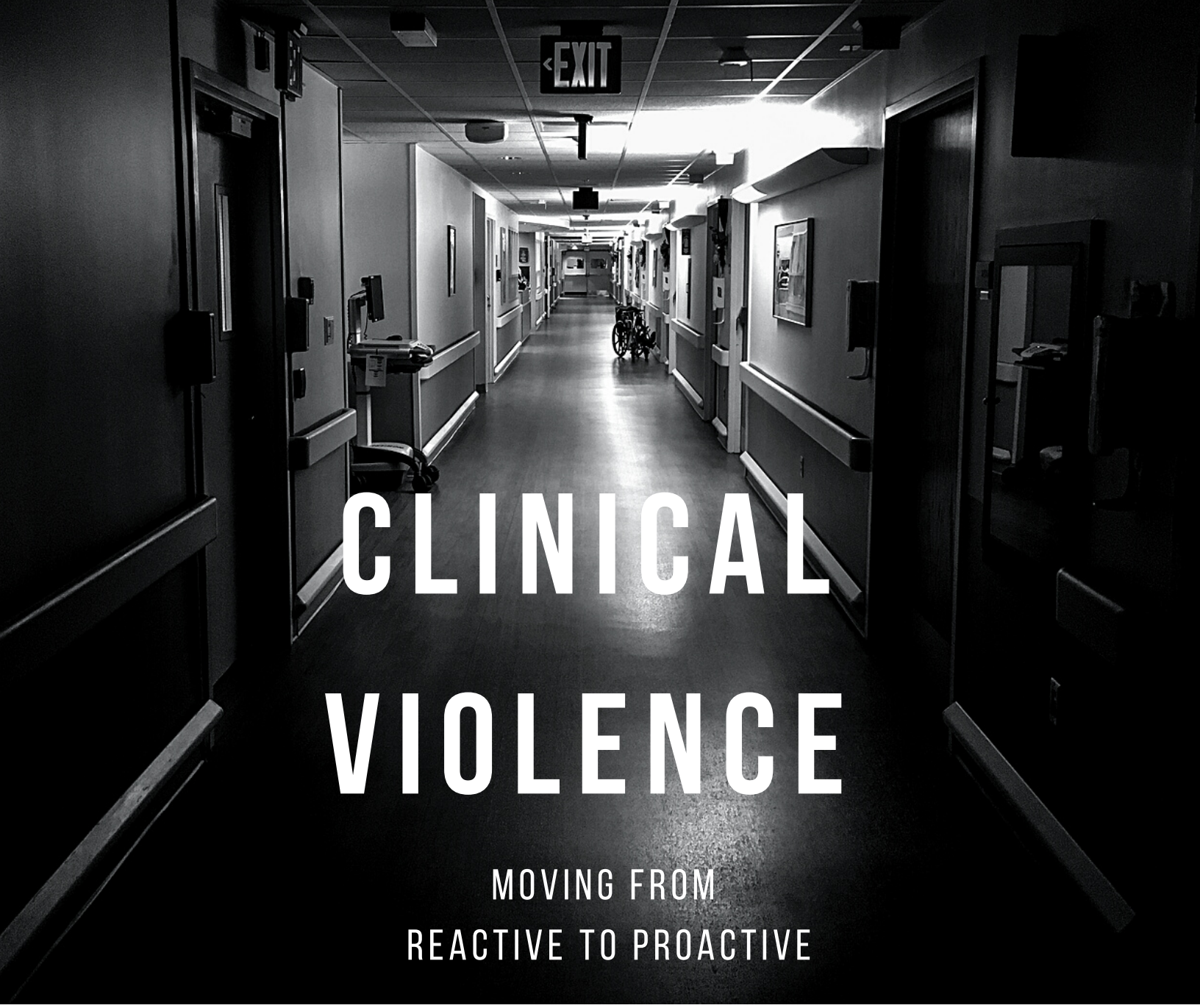

CLINICAL VIOLENCE

MOVING FROM REACTIVE TO PROACTIVE

WHO CARES FOR THE CAREGIVERS?

THE HIDDEN HEALTH CARE PANDEMIC

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A NURSE'S STORY

JULIE'S STORY BEGINS

Julie hopped in her car and slowly pulled out into traffic and headed towards the freeway. She was feeling happy and well-rested after four straight days off following a five day stretch of 12-hour shifts working as a nurse on a medical/surgical unit at her local hospital. She was happy to see light traffic on the freeway as she made her way into the hospital. This would be a quick and easy commute. During the drive she reflected on her time off and how pleased she was to have completed some household projects while spending time with family. **As she drove into the hospital, she could feel herself getting tense.** Her grip on the steering wheel tightened and she started fidgeting in her seat while a feeling of dread came over her. She has been a nurse for seven years now and most of that time had been exciting and rewarding. Over the past couple months though, she found herself with increasing anxiety as her days off ended and it was time to begin another series of shifts. Was this just some mid-career angst? **Was it some unresolved personal matter that was nagging at her, or was it something else?**

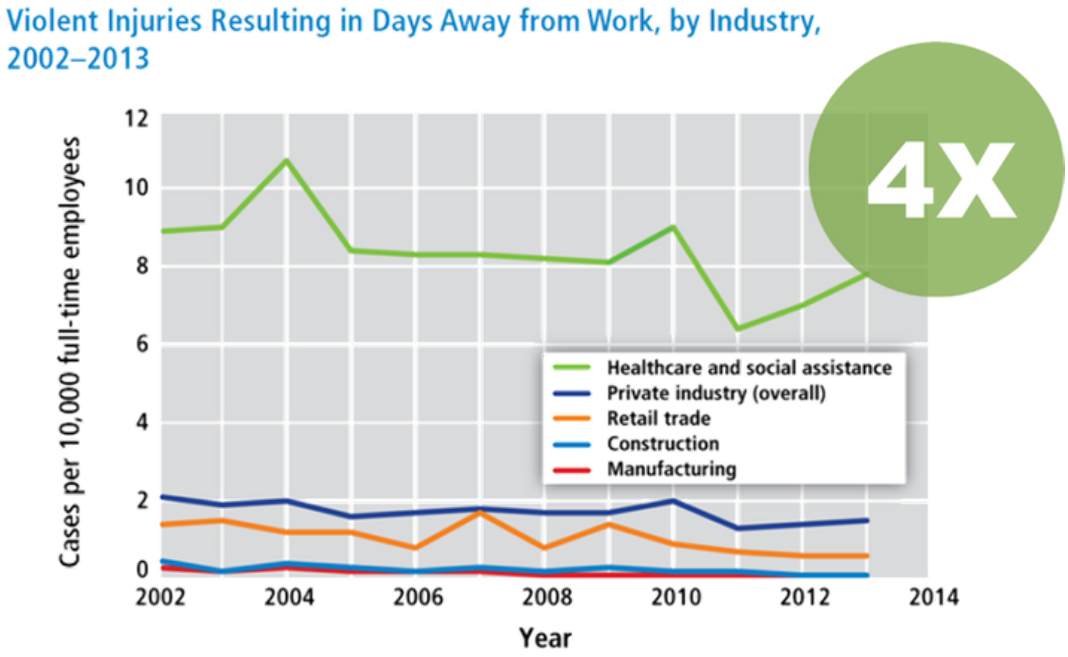
As she exited the freeway and made her way towards the employee parking lot at the hospital **she was overcome with anxiety and a feeling of dread.** "Oh no, I hope I'm not assigned to Reginald again," she thought. Reginald was a long-term patient on the 5 North unit. Social services had been trying to find a discharge placement for him for weeks now, but they were having difficulty finding a facility willing to take him due to his aggressive behavior. He had several, complex medical conditions but that was not the reason for her anxiety. Reginald was known to be verbally aggressive and insulting with staff, and he had a particularly hard time interacting with female staff and frequently used racist and sexist language. He had even been known to punch and hit staff in the past. Reginald clearly had his favorites; some staff escaped his wrath, but Julie always seem to catch the worst of it. **These feelings troubled her.** She became a nurse to help people, but now she felt guilty for having these misgivings about a patient she was supposed to care for. **She began to doubt herself, thinking, "Maybe I'm not cut out for nursing? How do the other staff do it?**" Julie didn't even have a way to label what she was experiencing, which would have helped her in recognizing and understanding what was happening.

A NEW TERM: CLINICAL VIOLENCE

We would like to introduce the term, **Clinical Violence, defined as violence directed against health care workers principally by patients and/or visitors.** Clinical Violence can include verbal aggression, sexually inappropriate comments or advances, verbal threats, and/or physical assault. While violence directed against health care workers is included under the very broad umbrella definition of workplace violence, and while it is not our intent to minimize the impact of interpersonal violence afflicting other disciplines in the workplace, we do think it's important to highlight the epidemic of violence directed against health care workers.

Violence against health care workers has significantly increased in the past decade or so, with some studies suggesting as much as a 1**10% spike in the rate of violent injuries against healthcare workers in the last 10 years. These studies also show that violence against health care workers is under reported by a factor of at least 70%.**

Violence against health care workers is a significant occupational health problem and can affect performance, job satisfaction, employee turnover and retention, as well as patient satisfaction. Studies have shown that between **35% and 80% of hospital staff** have been physically assaulted at least once during their careers. According to 2009 data from the Bureau of Labor Statistics, among health care practitioners, **46% of all nonfatal assaults and violent acts requiring days away from work were committed against registered nurses.**

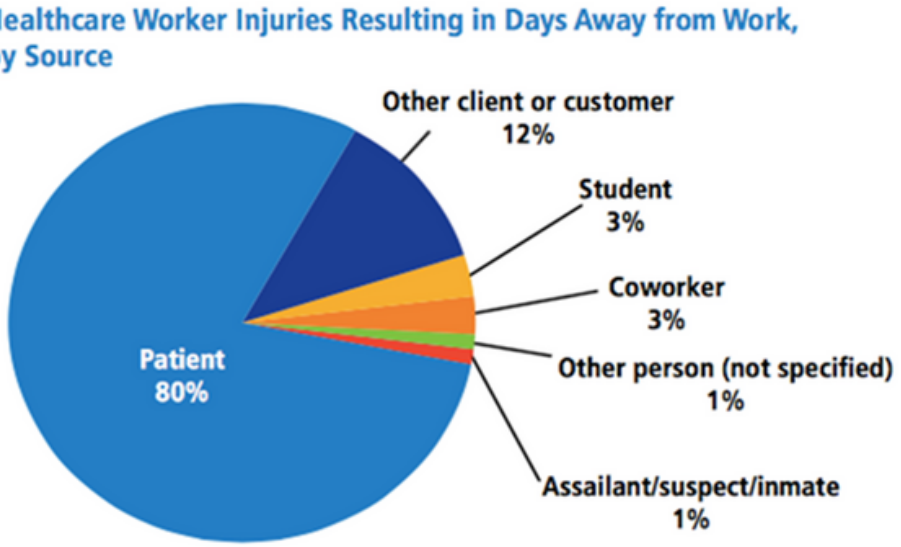


In 2018, with the support of major nursing unions and other health care advocacy groups, legislation was introduced in congress calling on the Occupational Safety and Health Administration (OSHA) to promulgate specific regulations requiring hospitals and other health care facilities to develop and implement comprehensive violence prevention programs for staff as well as provide aftercare for those employees victimized on the job. **The Joint Commission Issued Sentinel Event Alert #59 which provided seven detailed actions for organizations to implement in order to prevent and/or mitigate acts of violence directed towards staff.**

INCIDENTS OF SERIOUS WORKPLACE VIOLENCE WERE FOUR TIMES MORE COMMON IN HEALTH CARE THAN IN PRIVATE INDUSTRY, ON AVERAGE. - OSHA

Additionally, a July 2015 report from the American Nurses Association (ANA), **cites that 43% of nurses and nursing students had been verbally or physically threatened by a patient or a patient's family member, and 24% had been assaulted.**

More than **70% of ED nurses report physical or verbal assault by patients or visitors**, and U.S. Department of Labor reports that healthcare workers are nearly four times more likely to be injured and require time away from work as a result of workplace violence (WPV) than all workers in the private sector combined (Bureau of Labor Statistics [BLS], 2013).



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Data source: Bureau of Labor Statistics (BLS), 2013 data. These data cover three broad industry sectors: ambulatory healthcare services, hospitals, and nursing and residential care facilities. Source categories are defined by BLS.

JULIE'S STORY CONTINUES

When she reached her floor and clocked in, Julie looked up at the assignment board at the nurse's station and with dismay noted that she would indeed be assigned to care for Reginald. She took a deep breath, sighed, and told herself, **"I can do this. I'm a professional. I won't let him get to me this time!"** She remembered what some of the veteran nursing staff had told her about setting good clinical boundaries and vowed that this shift would be different. She then busied herself with the multitude of tasks needed to get ready for her twelve-hour day. She checked on her other two assigned patients, saving Reginald for last. She knew she couldn't delay forever so finally, outside Reginald's door, she took another big breath and walked into the room with an apprehensive smile on her face and greeted him. Reginald seemed indifferent, he barely looked up or acknowledged her presence in the room. She completed her tasks, smiled, and hurriedly walked out of the room. "Well," she said to herself, "that wasn't so bad. Maybe this time will be different."

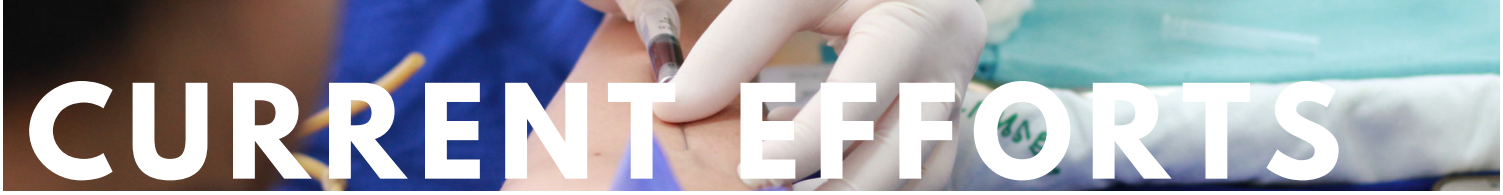
CURRENT EFFORTS

We analyzed Clinical Violence data from a 330-bed community hospital in the Pacific Northwest.

In 2018, from January 1 through September 28, staff at this facility experienced 107 acts of physical violence from patients resulting in staff injury. This number only reflects those incidents that were actually reported and resulted in injury to the employee. There was no reliable data regarding acts of violence not resulting in injury or attempted acts or threats of violence. Likewise, there was no reliable data documenting the incidence of verbal aggression or abuse from patients directed towards staff. These events were simply not reported or documented. It's reasonable to assume that the number of actual episodes of Clinical Violence at this facility were significantly higher than reported although we have no way to reliably quantify this.

This same facility had only limited aftercare capabilities offered to victimized employees. The organization had a contracted Employee Assistance Program (EAP) that could be telephonically contacted. However, there was no formal Post-Critical Incident Stress Management Program other than two employees who conducted interventions as a collateral duty. Even this limited capability was not widely known within the organization, and referrals were largely based on word-of-mouth reporting. **Reflecting this lack of program exposure, less than 10 such sessions were conducted with employees who had been victimized in 2018.**

Additionally, the electronic health record utilized by this organization did not have the ability for a behavioral flag or warning regarding potentially violent behavior. Information regarding prior assaults was either buried deep in the patient's chart or detailed in security incident reports available only to the hospital Security Department. **Typically, news of an assault on staff was spread by word-of-mouth amongst the nursing staff.**



CURRENT EFFORTS

Virtually all health care organizations have some sort of response plan for clinical violence. This could be as simple as a call to the hospital security department, use of the ubiquitous “Code Gray” to alert a response team, or some other level of multi-disciplinary response. A small minority of health care facilities in the country are establishing specialized multidisciplinary teams to respond, not only to acts of violence, but to round on, and evaluate, patients that either have a prior history of violence against health care workers, or who may be displaying some pre-incident indicators that place them at a greater than normal risk for committing an act of violence.

Similarly, most health care organizations have some form of resiliency support for their employees. Most common is a contracted EAP where an employee needing support is provided with a telephonic point of contact that coordinates referrals to local resources. Other organizations maintain their own organic Critical Incident Stress Management (CISM) program and provide limited debriefings and follow-up services to their staff. We are encouraged by the emergence of more formal, active and peer-led programs such as the Resilience in Stressful Events (RISE) program developed by Johns Hopkins Medical Center. This peer-led program has enjoyed great success and could be a strong foundation for a more formal employee resiliency and recovery program.

JULIE'S STORY CONTINUES

It was lunch time. Encouraged by her uneventful encounter with Reginald in the morning, Julie walked in to see how he was doing shortly after his lunch was delivered. As she approached the bed Reginald erupted with a string of expletives and abusive language and began throwing food items from his tray. Julie was hit in the head just above the eye by a coffee cup and had the majority of Reginald's lunch thrown at her, splattering the front of her scrub top.

Several other staff members came in to help and to clean the room, and Julie returned to the staff lounge to change into a new shirt. As she was changing, Kathy, her friend from nursing school, came in to see if she was OK. “You really should report that,” said Kathy. **“What's the point?” said Julie. “It'll take me more than an hour to fill out the forms and you know nothing's ever going to happen. I'll just shake it off and get on with my day. I have better things to do.”**

Kathy sighed, squeezed Julie’s arm sympathetically, and left to answer a call light. Julie sat down at the breakroom table, her face still hot with embarrassment. She pulled out her phone and texted her spouse about the latest incident at work. Julie then pulled up her phone’s web browser, took a deep breath, and tentatively scrolled through job listings. **“This isn’t worth it,” she thought to herself, “There’s got to be something better out there.”**

CURRENT EFFORTS

In our study of other health care organizations, we've seen a limited use of electronic health record flagging to help identify patients with a history of clinical violence or with a diagnosis or behaviors that put them at risk for committing a violent act. While at first glance it may seem difficult to identify those patients who present a higher risk for committing an act of violence, we believe some preliminary threat assessment is possible. While there are violence risk assessment tools for health care, most notably the Broset Violence Checklist, these tools require observation over time and may be ill suited for an initial screen for potential violence. **Prior history of violence in a health care setting will be the best predictive indicator of the potential for future violence.** Other pertinent facts of medical history are memorialized in electronic health records, yet history of violence against health care workers is not uniformly tracked and often, specific incidents are not even charted at all.

Reviewing data for approximately 18 months of clinical violence events at one facility indicated that approximately **75% of all acts of clinical violence were committed by patients with a primary diagnosis of dementia.** Surprisingly, in our analysis, the second largest category of patients committing violent acts against staff were those with some previously undiagnosed infectious process. This was an interesting observation for us and raised the question, **"when is behavior considered a physical symptom of illness?"**

The recognition that dementia patients account for the vast majority of those committing acts of clinical violence also raises questions about the typical escalated or combative patient response protocol in health care organizations. In most health care organizations, when a Code Gray or other alert is sounded, a large response team rushes to the site of the incident. This team typically includes members of the nursing staff, nursing management, security personnel, and depending on the organization, a host of other employees. In many situations, this overwhelming show of force does have a beneficial effect in helping to de-escalate the situation. However, in dementia cases, **research shows that a large and overwhelming response has the exact opposite effect and will often further escalate a dementia patient (Zeller et al, 2017).**

A NEW PLAN

In order to move from reactive to preventive, we recommend a three-pronged approach to Clinical Violence prevention and response.

ASSESSMENT, PREVENTION, AND MITIGATION

Health care organizations should develop a system to identify patients who have committed acts of Clinical Violence in both their electronic health record systems and their registration systems. While we're not proposing that a history of prior Clinical Violence become a form of "medical scarlet letter" that would follow a patient from facility to facility, we have recognized the need to record the information and build in safeguards for subsequent encounters. Depending on the level of severity of a prior act of Clinical Violence, a patient with a prior history should be contacted during the intake and admission process, and an assessment should be conducted to determine a current level of risk at the moment of intake.

REACTIVE RESPONSE AND INTERVENTION

We also believe that any response to an active clinical violence event must be "right-sized," which is to say that the response should be scaled and tailored to the specific context of the event. For example, if a large show of force and multiple personnel are required for the safety of all, such a response should be implemented. However, if the patient committing the act of violence has a history or diagnosis of dementia, the response should be calibrated to minimize harmful stimuli to the patient. This does not mean that a larger response team should not be available, however. We recommend that the appropriate number of personnel respond to ensure the safety of all, however those having direct contact with the escalated patient should be limited to a core team. Of course, calibrated, and dynamic responses, as just described require a robust internal training program, which could be integrated with current safety training.

AFTERCARE

Aftercare and support to our victimized employees is one of the most critical, yet underserved, elements of most clinical violence response plans. While most organizations have reporting systems for risk management purposes, these applications are often not user-friendly and serve the needs of the risk managers -- not the needs of a victimized employee. Organizations should consider developing alternate reporting mechanisms that immediately address the concerns of the employee who has been the victim of or otherwise exposed to an act of clinical violence.

We have studied several different health care organizations who have implemented intervention and response programs with varying degrees of success. The most successful of those have implemented multi-disciplinary programs that address not only the reactive response portion, but have a robust and well-supported aftercare component along with a strong, uniformly implemented flagging and assessment process. In studying organizations that have successfully implemented such programs, as well as learning from those organizations who were less than successful in their attempts to address this problem, we've identified several factors that are critical to the success of any program to mitigate and prevent clinical violence.

EXECUTIVE SUPPORT

Support for a Clinical Violence Awareness, Prevention, and Intervention Program must come from the highest levels of the organization; specifically, the CEO, the Chief Medical Officer, and the Chief Nursing Officer. This support cannot be a one-time unenthusiastic launch followed by sparse communication and flagging resolve. Instead, executives must champion this project each step of the way and provide visible and vocal support for all efforts to reduce and mitigate Clinical Violence.

TRAINING

All patient-facing staff, as well as security personnel, must be trained on key knowledge, skills, and abilities such as conflict avoidance, verbal de-escalation, and personal security. Those members selected to be a part of the Clinical Violence response team must have advanced and ongoing training in all these subjects, to including additional clinical training on dementia and cognitive impairment.

STAFFING

A specific staffing plan for any Clinical Violence response team must be developed. While we recognize this may be challenging to realize fully, we recommend a 24/7/365 response posture. This does not necessarily mean a full-time team with the exclusive duty of clinical violence response, akin to a workplace violence fire department standing by for a violent patient. An effective team can be staffed with a variety of personnel having clinical violence response as a collateral duty.

KEY FACTORS

We also recognize there are several different options that organizations can implement when staffing this team. After studying several different models, we have concluded that a team composed of licensed clinical social workers is the right level of clinical support for such a program. Some organizations utilize registered nurses to staff their clinical violence teams. While nurses unquestionably provide a high level of medical and clinical expertise, in many cases, staffing a team such as this with nurses may increase labor expenses to a prohibitive level. In our view, utilizing licensed clinical social workers for clinical violence response team strikes the right balance between clinical expertise and fiscal reality.

COORDINATION

Any clinical violence response team needs to develop relationships not only with frontline clinical staff but with other specialized response teams within the organization. Some health care organizations have specific teams focused on support for geriatric and dementia patients. Such a team could be the foundation of a clinical violence response team or could work in parallel if appropriate coordination is ensured.

EDUCATION AND AWARENESS

Staff need to be aware of the program and how to access the team. We recommend making this as simple as possible. Use existing resources if your organization already has one number to call for internal emergencies, and that call center could be responsible for activating the team. We have also seen organizations utilize one specific duty phone for staff to contact the team. Whichever method is chosen, it must be simple and uniform.

FOLLOW THROUGH

This can be the most difficult element at times. Many projects go through a natural lifecycle of enthusiasm before being remanded to the graveyard of good ideas. **Simply declaring something a priority does not make it so.** Continued, sustained, visible, and passionate support from executive management and line nursing leadership is critical. Staff will only utilize this resource if they believe it will be a benefit to them. When developing a response protocol, management must design the process and the team from the perspective of the employee who will be utilizing the service. We never want to be in the position of inflicting a good idea on staff that, in the end, merely results in additional work for an already overloaded workforce.

JULIE'S STORY EVOLVES

As Julie was flipping through online job opportunities, Kathy sat down beside her and let out a big sigh. She said to Julie, "I know today was really hard and I'm sensing that you're pretty frustrated. But I want to share something with you that heard from the Chief Nursing Officer the other day. She said there was a team being assembled that was looking at ways to **provide comprehensive support to those of us that are on the front lines.** From what I heard, it sounded like a multi-disciplinary team that was looking at ways to help prevent, respond to, as well as mitigate, the long-term effects of what they're calling "Clinical Violence."

"Clinical Violence?" Julie said back to Kathy. "That's an interesting way to label it. Hmmm… I never thought of it like that before. It's like it's a real thing. Yeah, I think I could get behind that. How do you think we could help?"

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