Preventing Workplace Violence
Our Organizational Approach
Penn State Health

• Our Campus
  – Adult Hospital
  – Children’s Hospital
  – Outpatient Clinics
  – Academic, level I regional trauma center and quaternary care provider
  – Shared Resources
**ANNUAL STATISTICS**

<p>| | |</p>
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Nursing Department Profile

Total RNs: 2,794
Percent Certified: 41.4
Percent BSN or higher: 81.2
Initial Steps

• Staff Safety Team Formed
• Violent or disruptive behavior reported at a Daily Safety Brief (DSB)
• CNO calls injured nursing staff
• Built “easy-button” in event reporting system (MIDAS) for staff to report violence
• Enrolled in national benchmarking database - Assaults on Nursing Personnel Indicator
Workplace Violence

– 2 serious assaults in 2018 resulted in staff harm
– Staff verbalized fears of coming to work
  • “We don’t feel safe”
  • “Every night I wonder if I will get hurt”
– Increased number of injuries caused by violence in the workplace
Workplace Violence: Need for Action

Staff shared concerns with leadership

• “We don’t feel safe.”
• “Every night, I wonder if I will get hurt.”
• “What are you doing to prevent this?”
• “It is not enough.”
Re-Assessing Methods

- Maintain the bedside nurse’s voice via a committee
- Continue to use Midas, but with the addition of a quick click
- Define workplace violence and severity and communicate out to our staff
- Proactive interventions
- Reactive interventions
- Supportive interventions
- Track and trend
Creation of Organizational Initiatives

• Signage
• Admission Packet Statements
• Behavioral De-escalation Response Team
• Organizational Security Assessment
• Personal Duress Button Project
• Proactive Patient Assessment
  – Integration of alerts into EMR
SAFETY FIRST

PATIENTS, FAMILIES and VISITORS

This is a healing environment. Aggressive behavior toward patients, families, visitors and staff will not be tolerated.

Examples of aggressive behavior include:
- Abusive language
- Verbal aggression (including profanity)
- Sexual advances—verbal or physical
- Threats
- Physical assault

No weapons (including guns or knives) are permitted on campus for everyone’s safety.

Security will be notified if aggressive behavior continues after initial intervention from staff.

We will not tolerate aggressive behavior on our campus. Please respect our staff as our staff respects you.

PennState Health
Crisis Behavior Assessment Tool

- Current aggression (5)
- Current agitation (5)
- History of aggression (5)
- History of agitation (5)
- Confused (4)
- Sundown behavior (4)
- Dementia behavior (4)
- Cognitive delay (4)
- Depression behavior (3)
- Substance Withdrawal (3)
- None (0)

Low 0-12
Medium 13-24
High 25-38

*Subset of the Broset assessment.
- Validated and Evidence Based tool
- Information is found in multiple areas in the patient’s chart
QI Mpage (Patient List View)
Displays **red** for high-**orange** for medium and **green** for low

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Things to consider when interacting with a Potentially Agitated, Aggressive or Paranoid Individual

LOW

- REMEMBER: each patient is unique. What may work for one patient may not work or be appropriate with another patient
- Be aware and mindful of your speech. Speak clearly and slowly with a low tone
- Use short, simple sentences when speaking with the patient and when explaining what you plan or are going to do
- Consider use of distraction to help redirect the patient if he is getting upset
- Camouflage devices that are causing distress to the patient
- Treat the patient as you would want to be treated

MEDIUM

- REMEMBER: each patient is unique. What may work for one patient may not work or be appropriate with another patient
- Use all interventions under low risk
- Ask questions one at a time
- Allow time for the patient to process and to respond to the question asked
- Be consistent
- Be aware of potential triggers and report off to next shift what worked well
- Be aware and mindful of your own thoughts, feelings, and actions in relation to the patient
- Be aware of nonverbal behavior and cues. If the patient appears to be getting upset, frustrated or angry, he may be tired, or overstimulated. Remove yourself from the room if needed

HIGH

- REMEMBER: each patient is unique. What may work for one patient may not work or be appropriate with another patient
- Use all interventions under low and medium risk
- Be aware that if the patient feels you getting upset, frustrated or angry, it is probably going to upset him and potentially cause agitation or an outburst
- Chaperone care
Aggression Assessment Frequency

• Task every 4 hours to the IVIEW band for **High** and **Medium** risk

• Task every 8 hours to the IVIEW band for **Low** risk
# Teletracking

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Ten Commandments of Effective Listening

• Stop Talking
• Put the speaker at ease
• Pay attention to nonverbal
• Listen for what is not being said
• Know exactly what the person is saying
• Be aware of “Tune Out” words (calm down, I understand)
• Concentrate on hidden emotional meanings
• Be PATIENT
• Hold your temperament
• Empathize

Time for a Demonstration!
Developing a Behavioral De-escalation Response Team (BDRT)

- Small multidisciplinary workgroup was formed to create the process for the BDRT
- Met bi-monthly to move the project forward
  - Nursing and executive leadership
  - Security
  - Pastoral Services
  - Physician (psychiatry)
  - Nursing education
Why Create a Response Team?

• Noted an increase in behavioral and degenerative neurological diseases
• Trend in injuries caused by workplace violence
• Nursing staff safety work group had been developed by staff who had experienced injuries from a violent and/or disruptive patient
Behavioral De-escalation Response Team (BDRT)

• Activate when a patient, family, visitor or staff member is unable to be de-escalated
• Call 8888 and ask for the BDRT team to respond
• Response is 24/7, weekends and holidays
• Team Members: Nursing Leadership, Pastoral Care Services, Nurse Resource Coordinator and Security
• Ad Hoc Team Members: Child Life, Care Transitions & Patient Relations
BDRT Response Steps

• Gather information and assess scene security
• Huddle outside, but away from the room
• Notify provider team and request to join huddle
• Determine who will address the patient and be on point for de-escalation
• Implement plan
• Give Security clear direction
BDRT Response Steps

- Primary nurse will document in the interdisciplinary narrative the plan of care
- Facilitate a PAWS (staff debrief)
- Designate who will complete the Midas (safety event report)
- Security completes after-action review of event
- Include in patient hand-off the plan of care, including triggers & what works well
BDRT Education and Training

• Step 1: online education on communication and the art of verbal de-escalation
• Step 2: Crisis Prevention Institute (CPI) training is completed by each BDRT member
• Step 3: simulation training
  – Standardized patients (actors) were used to provide a realistic scenario the team would encounter
  – Team worked together to de-escalate the situation and were debriefed after completion
BDRT Workgroup Actions

• Subgroup committee members continue to meet monthly since the activation of BDRT
  – MIDAS reports from BDRT activation are reviewed
    • Looking for common themes in activations
    • Assess for growth opportunities
  – Feedback from nursing leadership is used to make improvements to the process
Barriers and Lessons Learned

• Barriers:
  – Not everyone was invested at the start
  – Ongoing education needed; training for new BDRT members

• Lessons learned:
  – Improving communication between staff, patients, and families is key
  – Early intervention with verbal de-escalation limits a potential physically violent response
  – Encourage team to debrief with staff after the event
  – Perform a post-vention with the person in crisis later in the day or within 24 hours. *This is the biggest opportunity we have to prevent a future crisis!*
BDRT Anecdotal

• “My first experience calling the de-escalation team was yesterday after being verbally and (the threat of) physically abused by a pt. Past protocol in my many, many years of nursing meant dealing with it within the unit, maybe calling security if the pt. didn't calm down, and being questioned by management as to what happened and how I could have avoided the situation.

• The team yesterday was nothing short of phenomenal. I thanked them all individually multiple times. The quick response, and quick results provided us all (most of all me) with a safe feeling.

• I truly never thought in my nursing career (32 years), I would see such a sorely needed implantation for caregiver safety...

• I thank you from the bottom of my heart for making this happen and I know I can speak for "Nursing" to Thank You for providing us a way to keep us all safe.”
# Reported Staff Assaults

## July-2018 to June-2019

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Duress Alerts – 3 Phases

Phase 1 – Duress Alert Notification
Staff Terminal to Security

Phase II – Duress Alert Notification
Staff locator badge to Security

Phase III – Duress Alert Integration
Wireless phone short cut key to Security
Pagers receiving messages
Key Takeaways and Lessons Learned

• Leadership commitment is key to success
  – CNO communicates directly with staff involved
  – Support non-productive costs to train staff
• Inter-professional team approach
• Develop proactive and reactive methods
• Changing culture is challenging
  – Change the way we support “People in Crisis”
Financial Considerations & Adaptability

Financial:
• Education and training
• Technology
• Security assessment
• Recurring costs

Adaptability:
• It can be done!!
Next Steps

• Complete our GAP analysis
• Define what support means to our staff and develop a long term plan
• Order equipment that staff can utilize to prevent biting and scratching
• Prioritize our Autism population
Questions?

WORKPLACE VIOLENCE
IT'S NOT PART OF THE JOB!
in NURSING
References


2. The Joint Commission [Emerging Health Care Concern: Preventing Workplace Violence 8/18/16, Sentinel Event Alert issue 59, 4/17/18]

3. The National Association of Mental Health Program Directors (NASMHPD) [Six Core Strategies for Reducing Seclusion and Restraint Use, revised 11/20/06]

4. The Occupational Safety and Health Administration (OSHA) [Preventing Workplace Violence: A Roadmap for Healthcare Facilities, 12/15]

5. The Substance Abuse and Mental Health Service Administration (SAMHSA) [Promoting Alternatives to the Use of Seclusion and Restraint March 2010]