

Workplace Violence Prevention: Best-Practices in Health Care Environments

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BLUF

The VHA Workplace Violence Prevention Program (WVPP) Model and Process:

- Emphasizes multi- and interdisciplinary team best practice
- Meets the IAHSS Health Care Standard
- Aligns with TJC, OSHA, DHS, FBI, ASIS/SHRM, and ATAP best practice guidelines and recommendations
- Is scalable to health care systems of highly varied sizes and complexities
- **Works!**

Acknowledgements

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- J. Reid Meloy, PhD, ABPP
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- Lt. David Okada
- Gregory Roth
- Mario Scalora, PhD
- Shoba Sreenivasan, PhD
- Bridget Truman, PhD
- Charles Urwyler, LCSW



- John van Dreal, MA
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- Stephen Weston, JD
- John Whirley, PhD
- Stephen White, PhD
- Ronald Wyatt, MD, MHA, DMS (HON)

**In memory of health care providers who died
March 9, 2018,
at the Pathway Home in Yountville, CA**



Dr. Jennifer Gonzales, 29
*Clinical Psychologist, San
Francisco VA Medical Center*
Unborn Child
7 months developed



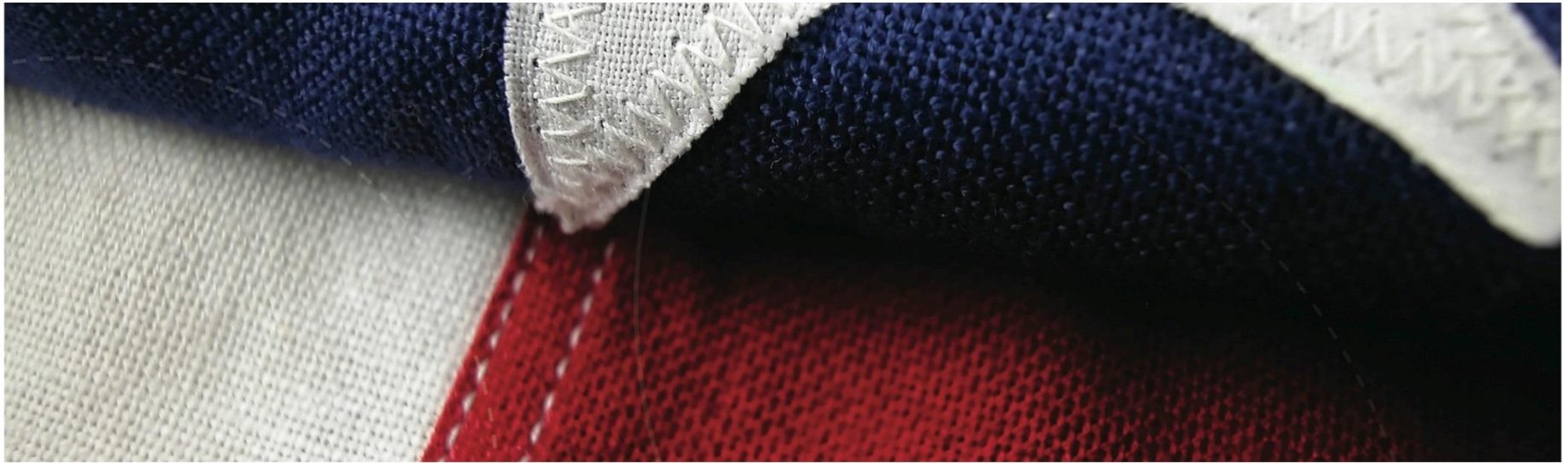
Christine Loeber, 48
*Pathway Home Executive
Director*



Dr. Jennifer Golick, 42
*Pathway Home Clinical
Director*

Agenda

- US Veterans Health Administration
- Workplace Violence Prevention Program Model: Implementation Essentials and Overcoming Challenges
- Violence Risk and Threat Assessment in Health Care:
 - Fundamentals of Multi- and Interdisciplinary Practice
 - Evidence-Based Threat Assessment: Types of Violence and Pathways
- Does Behavioral Threat Assessment and Management Work in Healthcare Workplaces?
- Strategic Collaboration

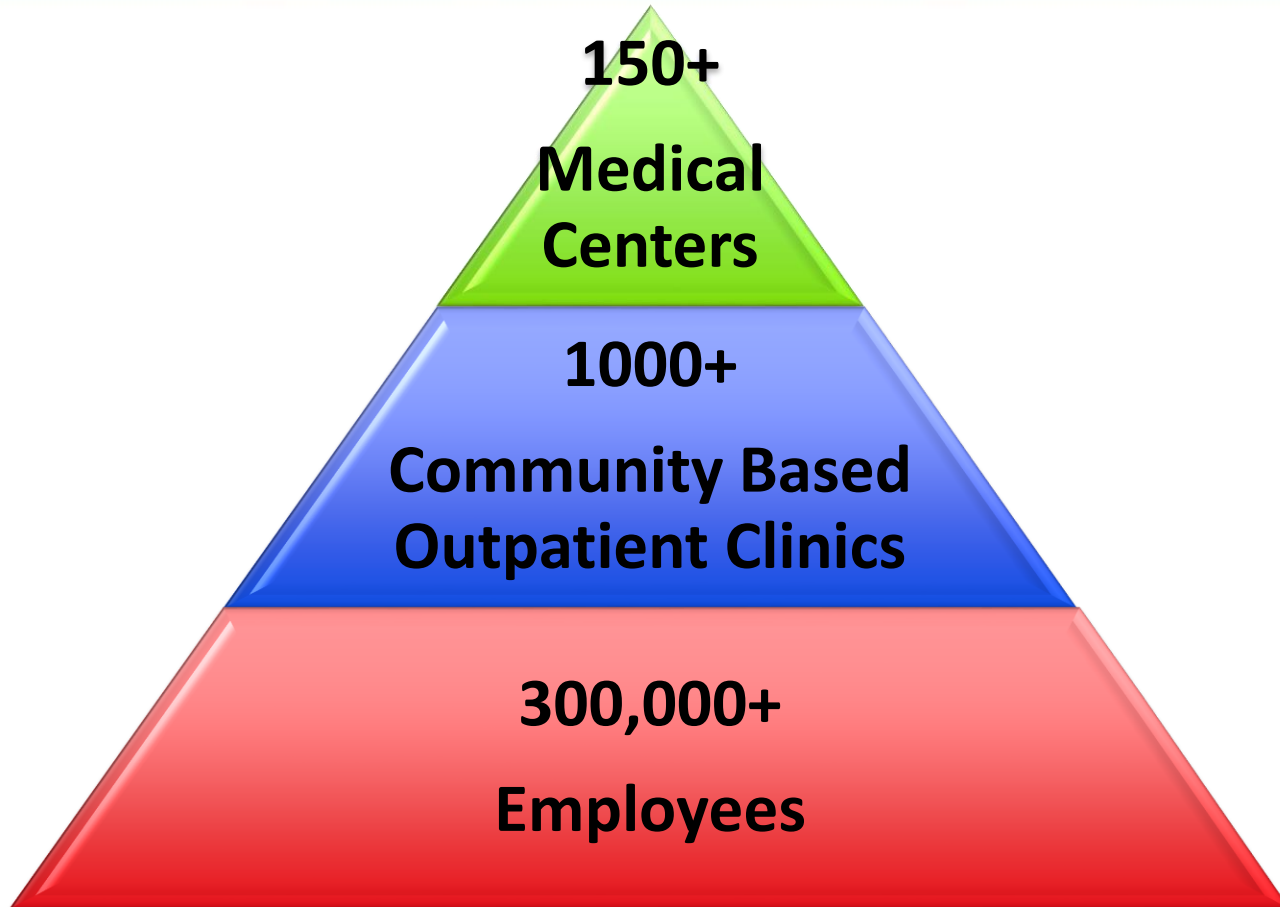


US Veterans Health Administration (VHA)



VA
HEALTH
CARE | Defining
EXCELLENCE
in the 21st Century

US Veterans Health Administration (VHA)



US “Health Care Community Standard” vs. VHA

BANNED
from
HEALTH CARE

VHA MUST rise to a high standard of providing comprehensive workplace violence prevention programs and organizational infrastructure.

What VHA CAN Do

**Keep Veterans in VHA health care:
The care VHA provides can address
the 6 key protective domains.**

**Access to care is a violence risk
mitigation strategy.**



Workplace Violence Prevention Program Model: Implementation Essentials and Overcoming Challenges



WVPP Personnel



**Kelly E. Vance,
MD**
Director,
Prevention and
Management
of Disruptive
Behavior
Program



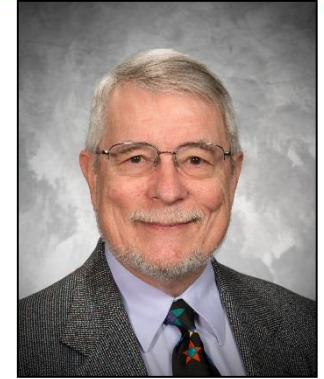
**Scott Hutton,
Ph.D., MBA,
RN, FAAN**
Director of
Operations



**Ashley Jepsen,
BS**
Program
Analyst



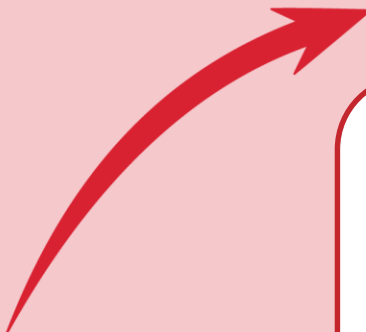
**Bridget Truman,
PhD**
Violence
Prevention
Specialist



**John Whirley,
PhD**
Violence
Prevention
Specialist

All Personnel

Employee

- 
- Bystander to “Upstander”
 - Education and Awareness
 - Skills

All Personnel

Employee

- All employees
- Easy and short
- “Return Receipt”

Report

Leadership

Assess

- Multi- and Interdisciplinary
- Evidence-based, Data-driven
- Structured Professional Judgment

Employee

Report



Leadership

Assess

Management
Plan

- Collaborative with Patient
- Spectrum of "Confrontation"

Employee

Report

Leadership

Assess

- What is the Safety/Treatment Plan?
- What ACTION should staff take to stay safe?

Communicate

Employee

Report

Leadership

All Personnel

Assess

Disruptive Behavior Committee (DBC) and Employee Threat Assessment Team (ETAT)

Employee

Prevention and Management of Disruptive Behavior (PMDB)



Management Plan

Increase Protective Factors and Decrease Risk Factors; Order of Behavioral Restriction (OBR)

In-Person or Virtual Conversation; Patient Record Flag (PRF)

Disruptive Behavior Reporting System (DBRS) and Workplace Behavioral Risk Assessment (WBRA)



Communicate

Report

All Personnel

Employee



Prevention and
Management of
Disruptive Behavior
(PMDB)



PMDB Program Structure

PMDB Director

- Promotes, Trains, Recalibrates Master Trainers via
- Train The Trainer and Annual Recalibration

Master Trainers

- Train and Recertify Facility Trainers via
- Train The Trainer Course and FTRAs

Facility Trainers

- Train and Refresh Frontline Employees via
- Level II, III, and IV of PMDB In-Class Training

**Front Line
Employees**

- Learn PMDB Skills through 4 Levels of PMDB Training

PMDB Employee Curriculum

Level I

- Online
- Introduction to Violence Prevention Concepts

Level II

- In Class
- Customer Service, Observation, Assessment, and Verbal De-escalation Skills (Verbal Protection)

Level III

- In Class
- Limit Setting and Personal Safety Skills (Physical Protection)

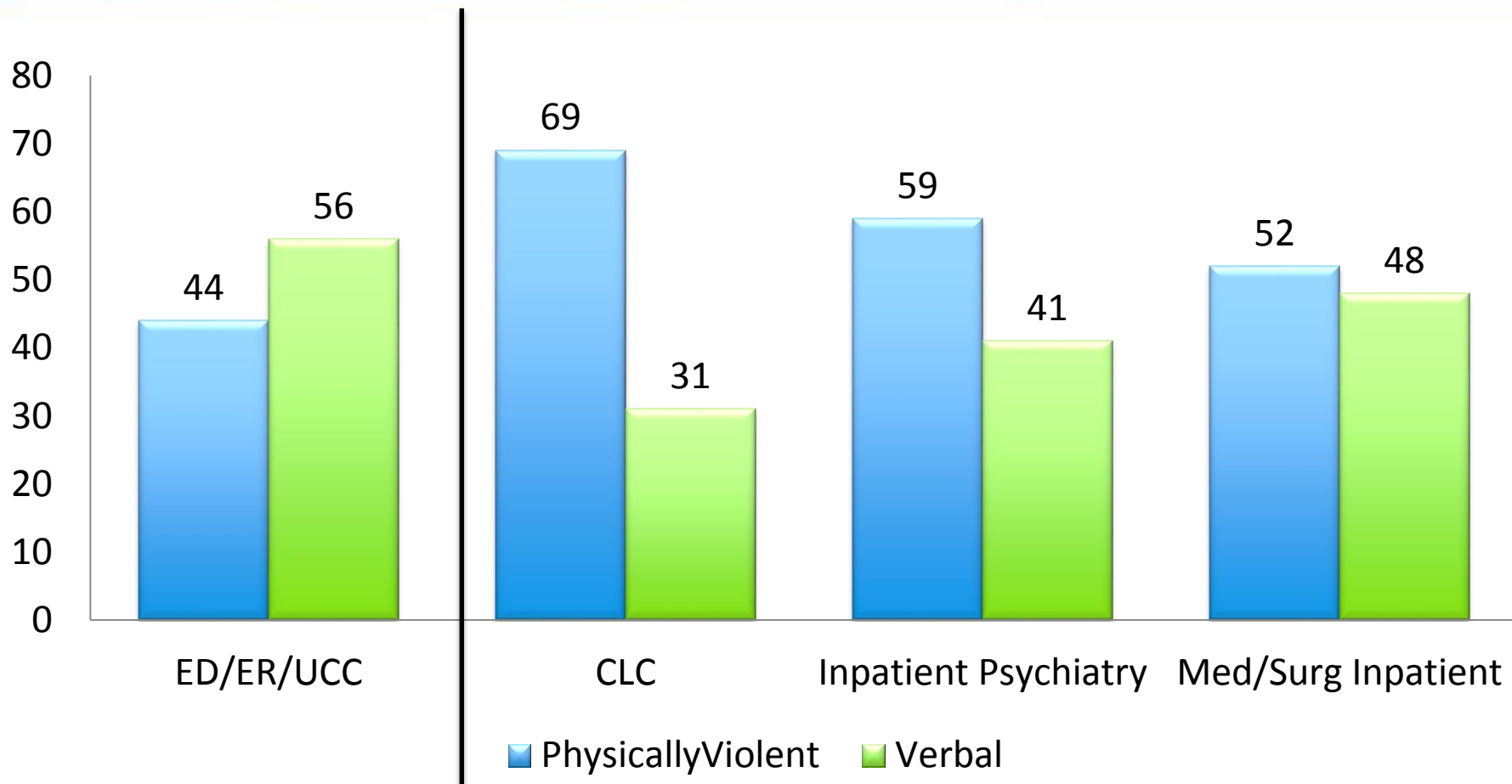
Level IV

- In Class
- Therapeutic Containment (Patient intervention to control physically violent acts)

Matching PMDB Training Levels to Risk Definitions

RISK LEVEL	DEFINITION	TRAINING NEEDED
HIGH	Exposure to physical disruptive behavior (DB) requiring therapeutic containment	Levels I, II, III, IV (Customer Service/Verbal, Physical Skills, Therapeutic Containment)
MODERATE	Exposure to both physical and verbal disruptive behavior (DB)	Levels I, II, III (Customer Service/Verbal, Physical Skills)
LOW	Exposure to only verbal disruptive behavior (DB)	Levels I, II (Customer Service and Verbal Skills)
MINIMAL	No exposure to any type of disruptive behavior (DB)	Levels I Only Intro. to WVP concepts

Percent Physically Violent Incidents Concentrated in Areas With and Without Mandatory PMDB Employee Training



All Personnel

Employee



Disruptive and Violent Behavior Incident Reporting

Challenge

20% Reporting Rate

- Similar rate internationally, across health care systems
- Multiple probable causes:
 - Competing demands—reporting takes time
 - Not want to “label” patients
 - Concern for own reputation
 - Beliefs as to whether reporting will do any good

Solution

Successful Reporting Systems:

- Accessible
- Short and Simple
- Trusted and Secure
- Optional Anonymity
- Result in Identifiable Outcomes
- Labor *and* Management Support

Voice for Concerns

Reporting an Incident

Location & Time

- Facility
- Date and time

Who is Reporting?

- Contact information

Who Experienced?

- Who *experienced* the disruptive behavior

Who was the Disruptor?

- Brief information about the disruptive individual

Incident Details

- Description of the incident and other related details

Leadership

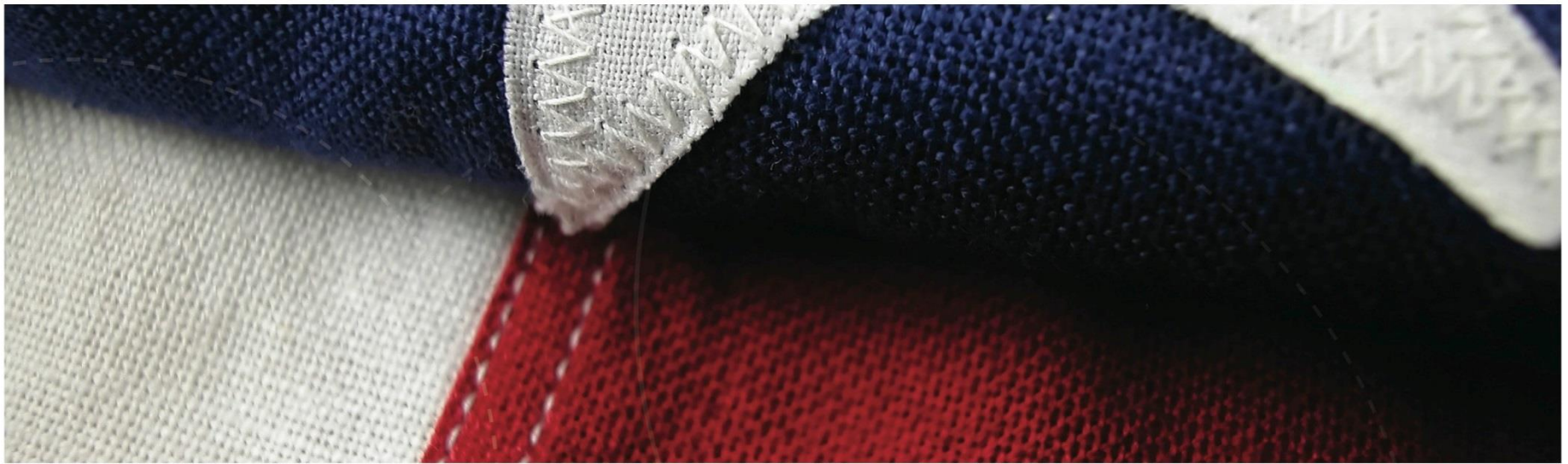
Assess

- Multi- and Interdisciplinary
- Evidence-based, Data-driven
- Structured Professional Judgment

Employee

Report





Violence Risk and Threat Assessment in Health Care: Fundamentals of Multi- and Interdisciplinary Practice

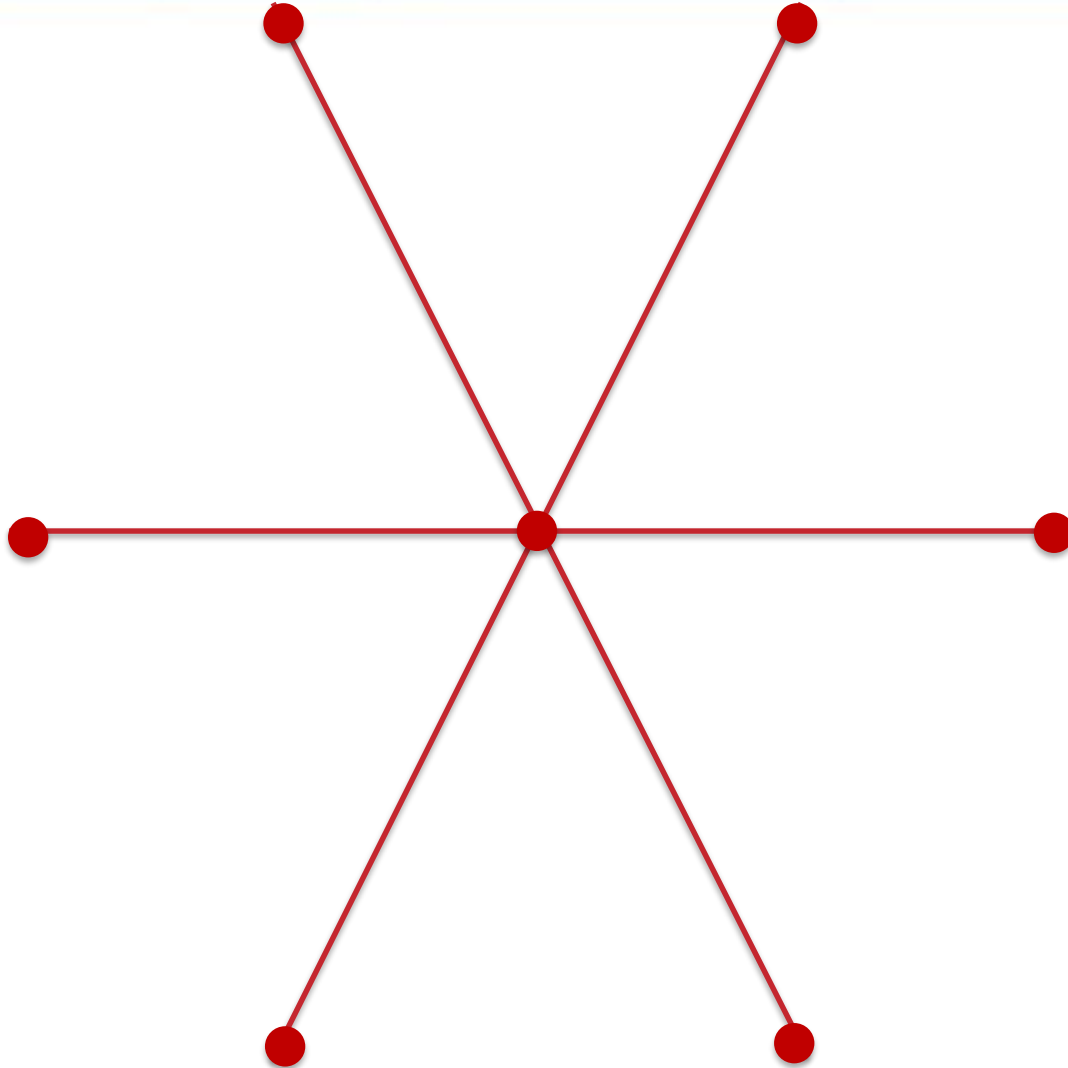
Multidisciplinary Teams Matter



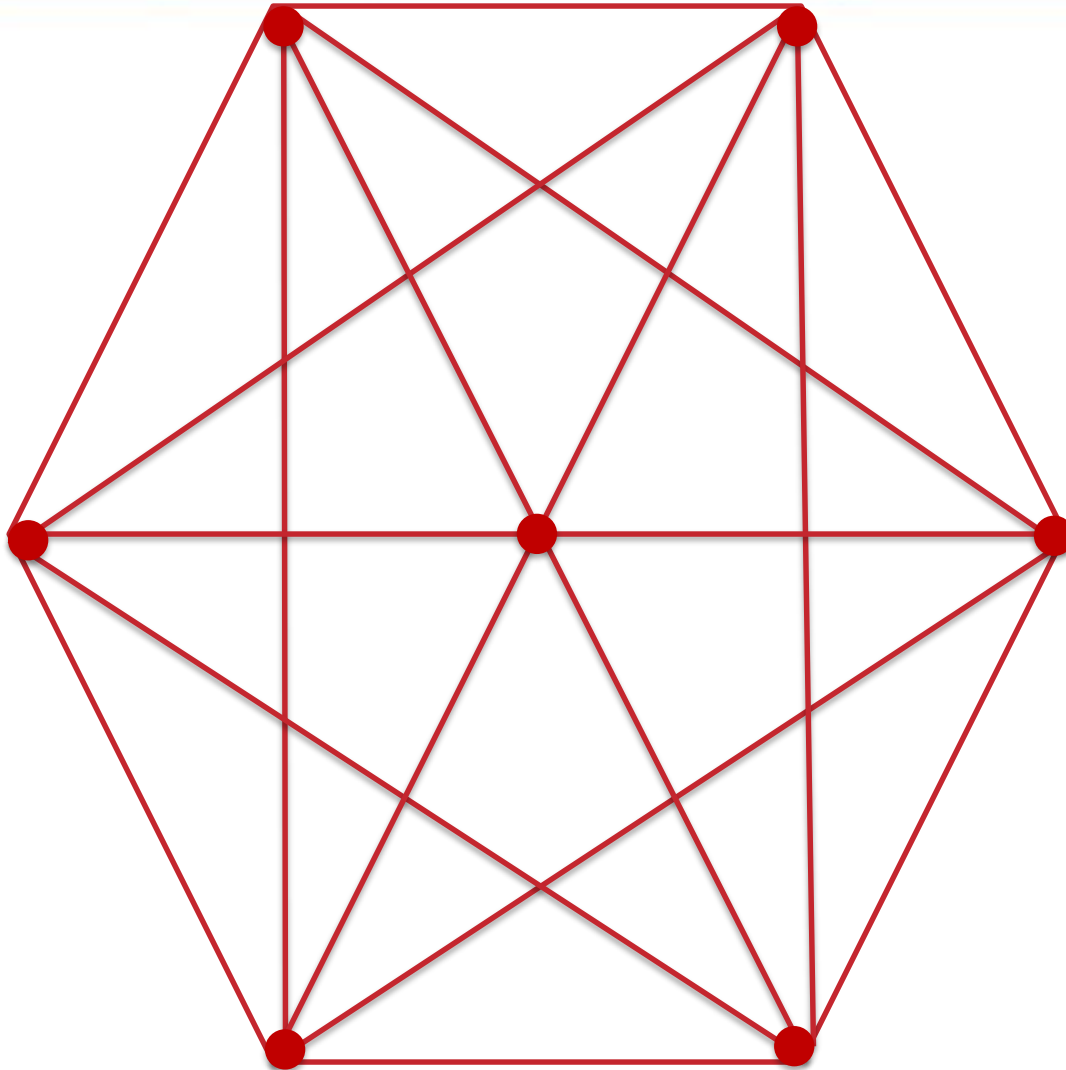
Multidisciplinary Teams Matter



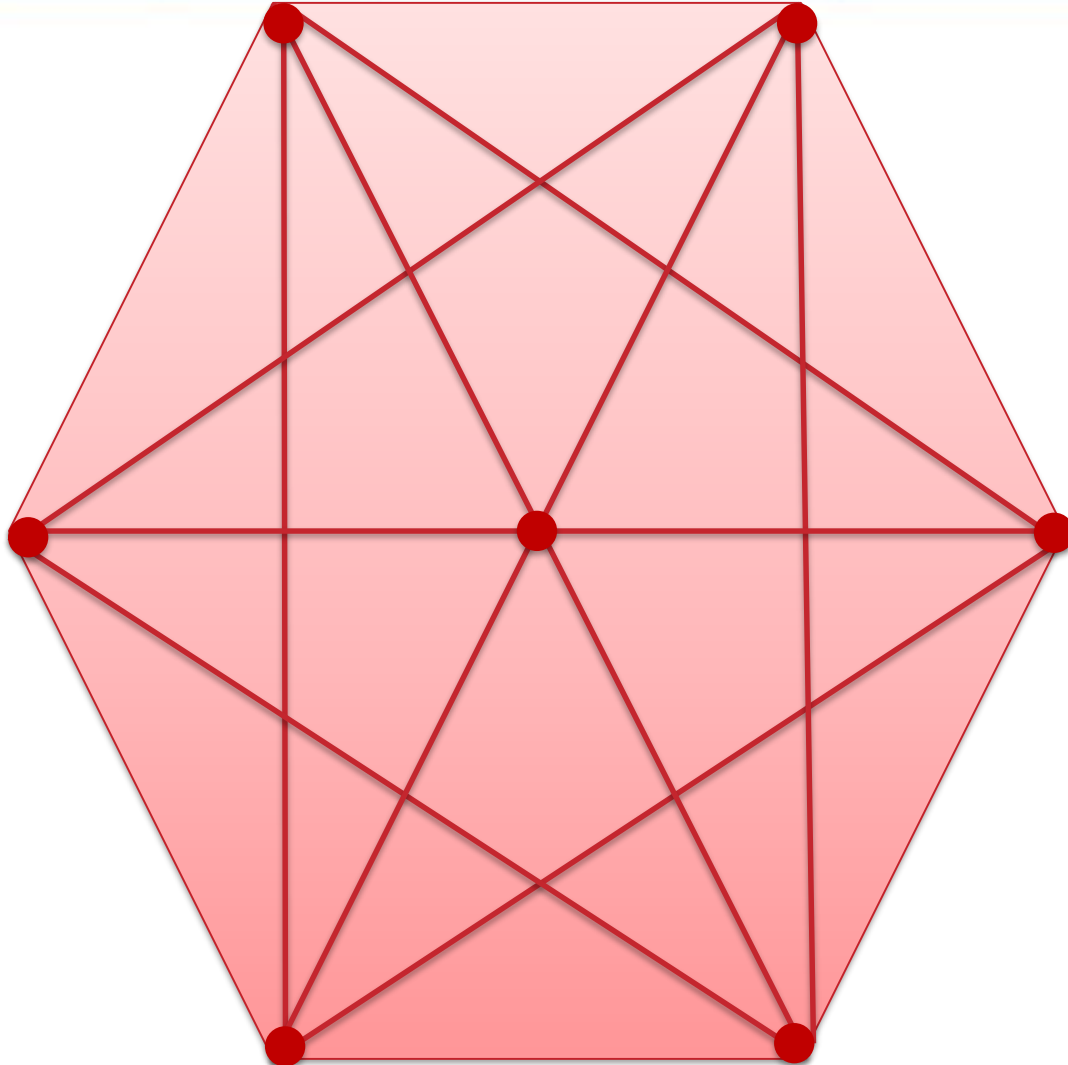
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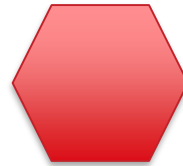
Multi- AND Interdisciplinary Teams Matter



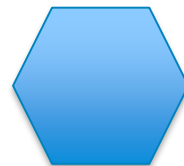
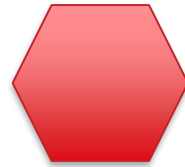
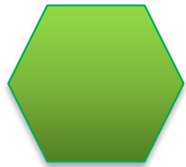
Multi- AND Interdisciplinary Teams Matter



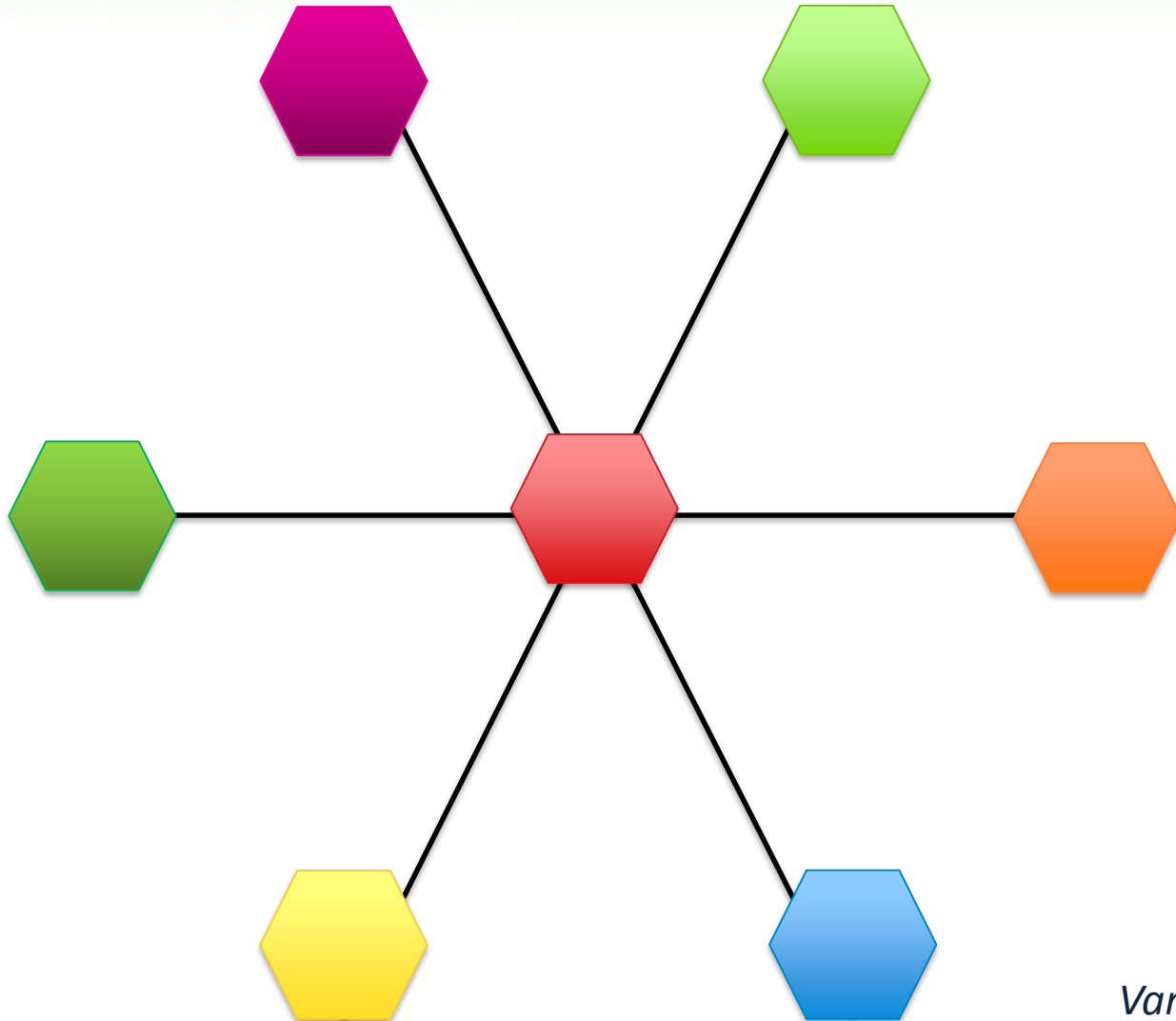
Multi- AND Interdisciplinary Teams Matter



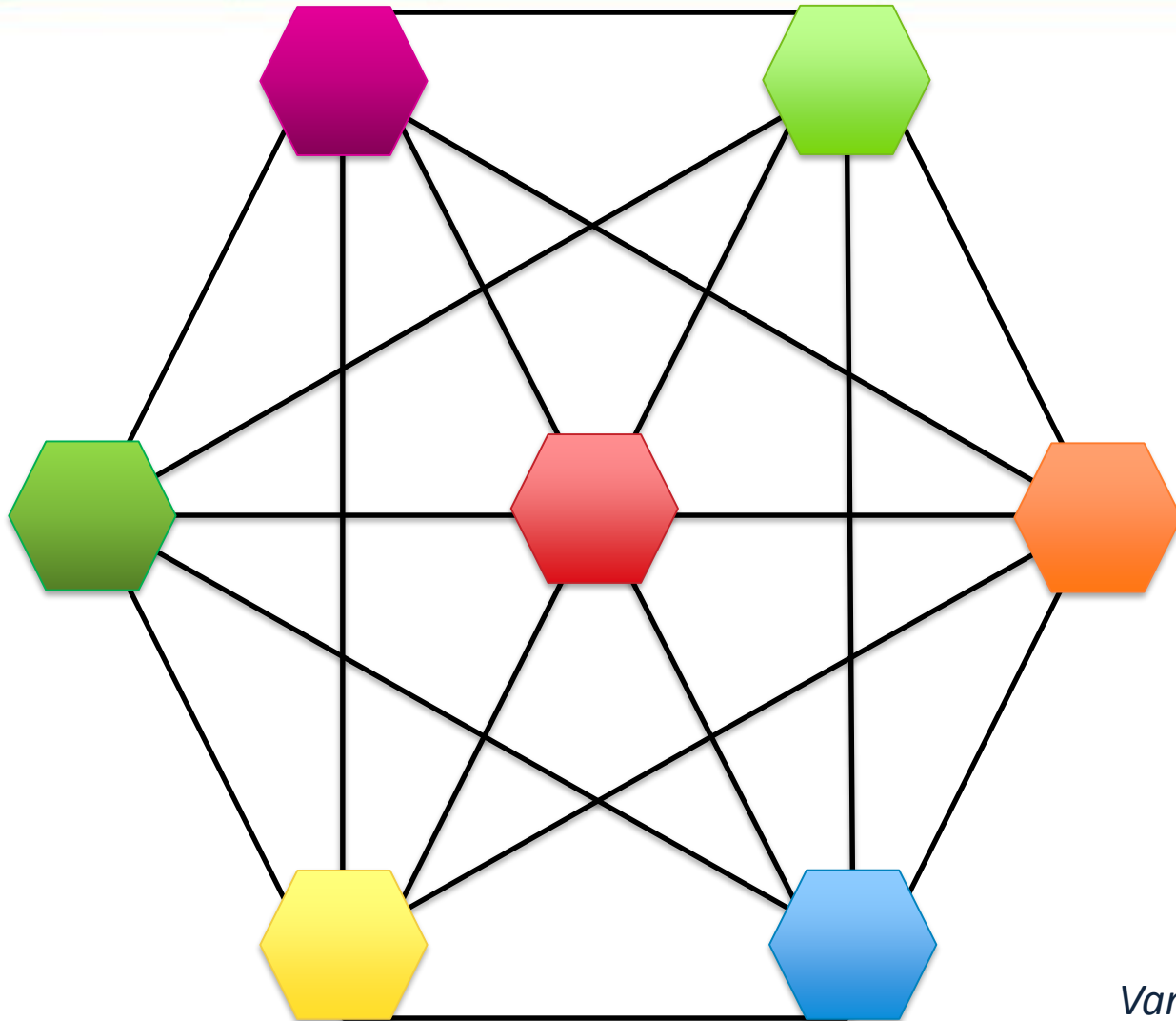
Multi- AND Interdisciplinary Teams Matter



Multi- AND Interdisciplinary Teams Matter



Multi- AND Interdisciplinary Teams Matter



Multi- AND Interdisciplinary Teams Matter



International Association of Hospital Security and Safety (IAHSS)



01. Program Administration
09. Violence in Healthcare
03. Threat Management

Healthcare Facilities (HCFs) should establish a process and multi-disciplinary team to identify, assess, validate, mitigate and respond to threats of violence or other behaviors of concern.



Evidence-Based Threat Assessment: Types of Violence and Pathways



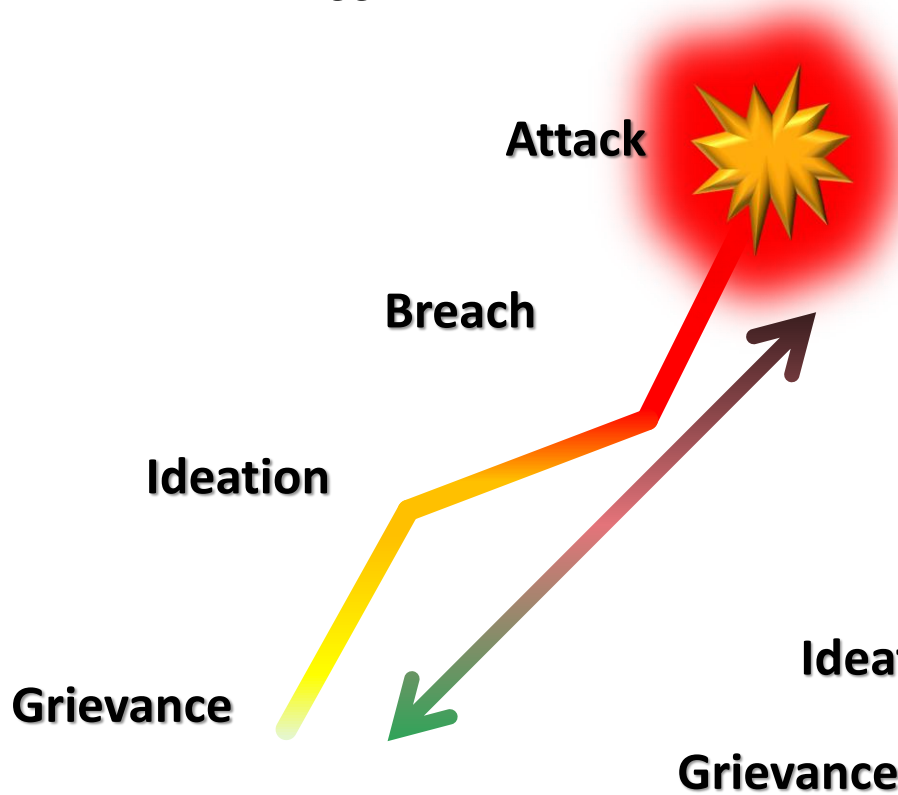
Bimodal Theory of Violence

Predatory vs. **Affective**

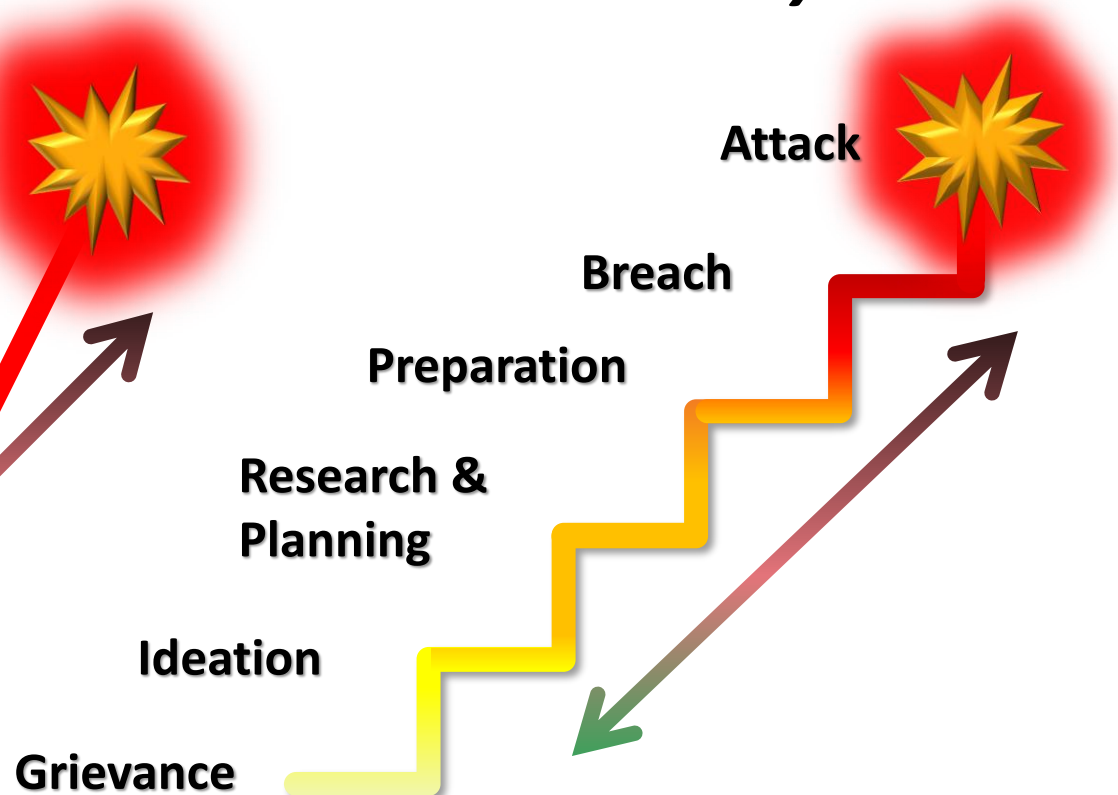


Pathway to Violence

Affective



Predatory



Leadership

Assess

Disruptive Behavior
Committee (DBC)
and Employee
Threat Assessment
Team (ETAT)

Employee

Report

DBC's are Multi- and Interdisciplinary Threat Assessment and Management Teams

Operate under the authority of, and report to, the
Chief of Staff: ***DBC's are Clinical Care***



Disruptive Behavior Committee

Inter- and multidisciplinary *Clinical Care* team:

- Senior Clinician (Chair)
- Union Safety Representative
- Training Program (PMDB) Representative
- Quality Management
- Legal Counsel (ad hoc)
- Support/Clerical staff



Disruptive Behavior Committee

Inter- and multidisciplinary *Clinical Care* team:

- Law Enforcement
- Representatives from High Risk Areas
- Patient Advocate
- Privacy Officer (ad hoc)
- Patient Safety or Risk Management
- Clinical Trainees



DBC's Fulfill Critical Functions

Consultation



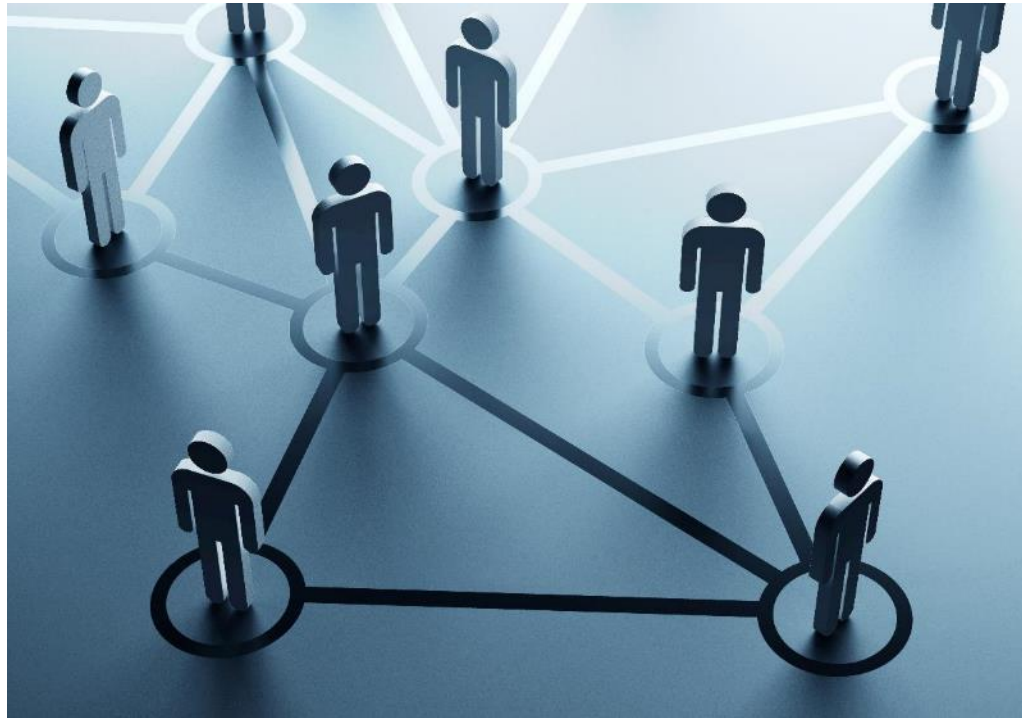
DBC's Fulfill Critical Functions

Individualized Assessment



DBC's Fulfill Critical Functions

Treatment and Safety Plan Communication



DBC's Fulfill Critical Functions

Education



Disruptive Behavior Committee

- Advises clinicians, clinic managers, and the Chief of Staff on a coordinated approach for addressing patient disruptive behavior; promotes the safe and effective delivery of health care
- Encourages disruptive behavior reporting
- Trends disruptive behavior data
- Completes violence risk assessments
- Develops risk mitigation recommendations

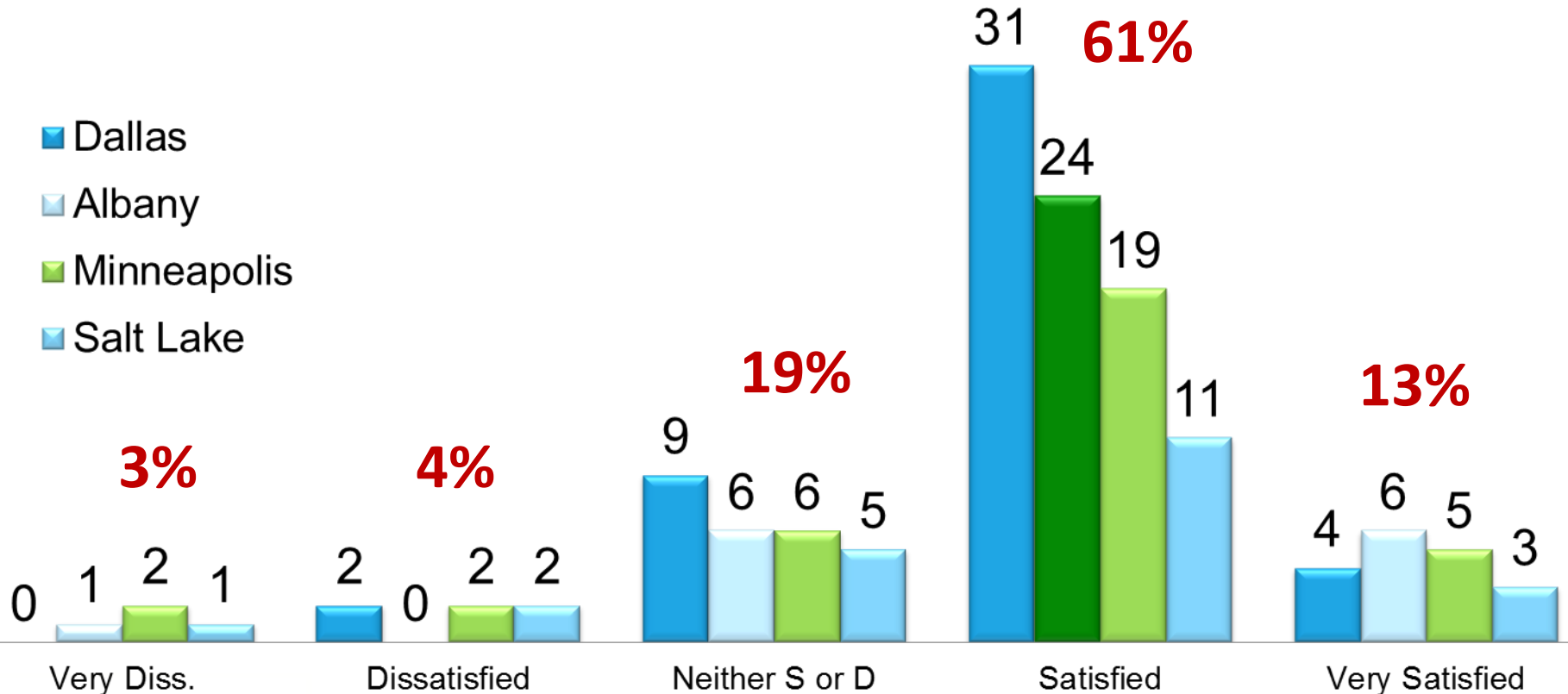
Disruptive Behavior Committee

- Recommends whether an electronic medical record alert would help reduce risk
- Oversees training in Prevention and Management of Disruptive Behavior (PMDB)
- Brokers debriefing as requested for individuals traumatized in violent incidents
- Advises the Chief of Staff and the Facility Director about systems issues that may be contributing to disruptive patient behavior

DBC Chair Satisfaction with DBCs

The majority (74%) of DBC Chairs report being satisfied or very satisfied with the overall function of their DBCs. However, there is variability among chairs with a minority feeling dissatisfied or very dissatisfied.

- Dallas
- Albany
- Minneapolis
- Salt Lake



Number of DBC Chairs self-reporting satisfaction with DBC overall function.

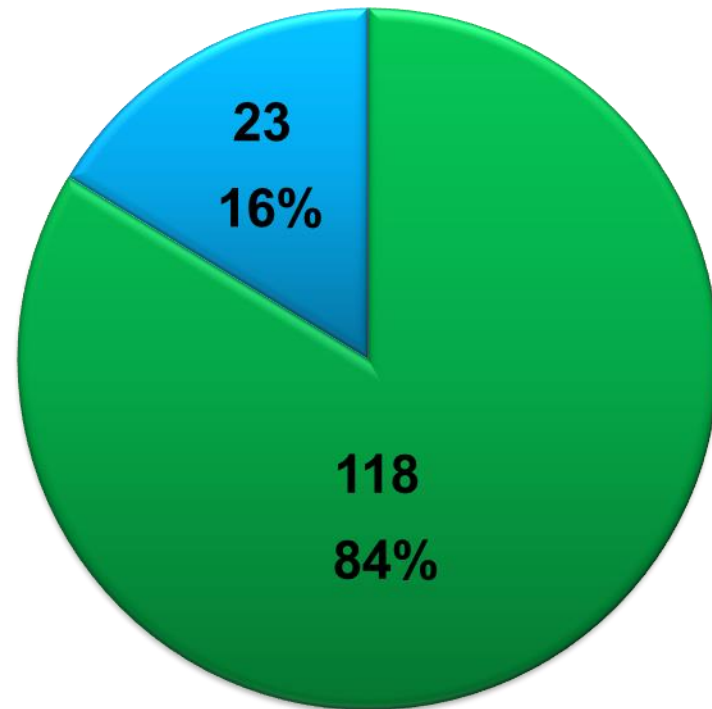
Source: DBC Chairs Conferences, 2014-2016.

Leadership Satisfaction with DBCs (HAIG Survey, 2015)

When surveyed, 84% of VHA facility leadership teams found the threat assessment and management activities of their DBCs very effective, with the remaining 16% reporting DBCs were somewhat effective. No facilities reported finding their DBCs ineffective.

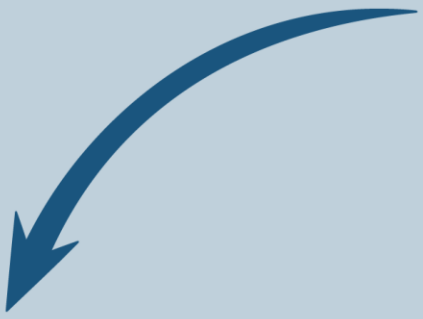
2015 N=141

- Very Effective
- Somewhat Effective



Leadership

Assess



Management Plan

- Collaborative with Patient
- Spectrum of "Confrontation"

Employee



Report



Collaborative with Patient

People tend to support what they, themselves, create.

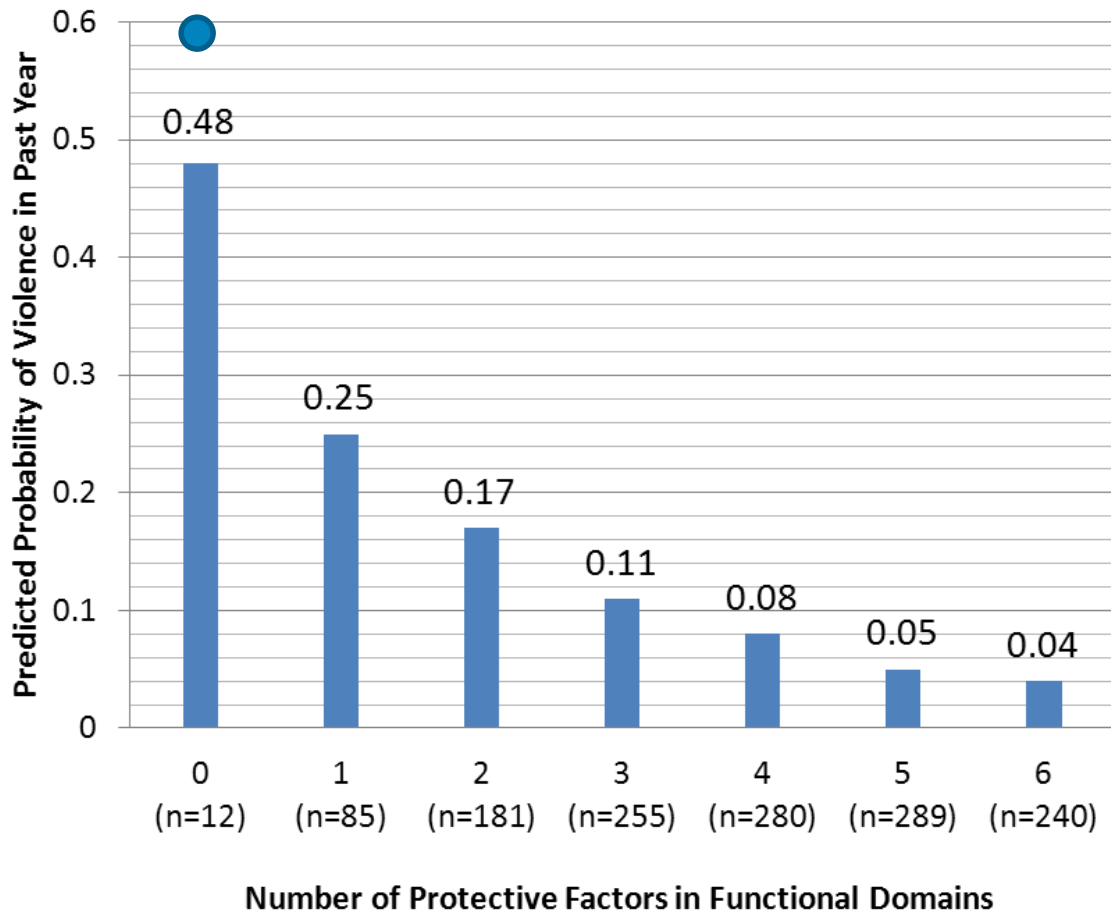


Synthesize Risk and Protective Factors Into a Safety Plan

- Under what circumstances is the person at highest risk?
- How can the person lower risk by either increasing protective factors or reducing dynamic risk factors? Or both?
- What are the person's perceptions about lowering risk and what level of engagement does s/he have in developing a safety plan? And sticking to it?



Protective Factors and Violence in Veterans



Protective factors indicate health and well-being in the following domains:

Living

Work

Financial

Psychological

Physical

Social

Leadership

Assess

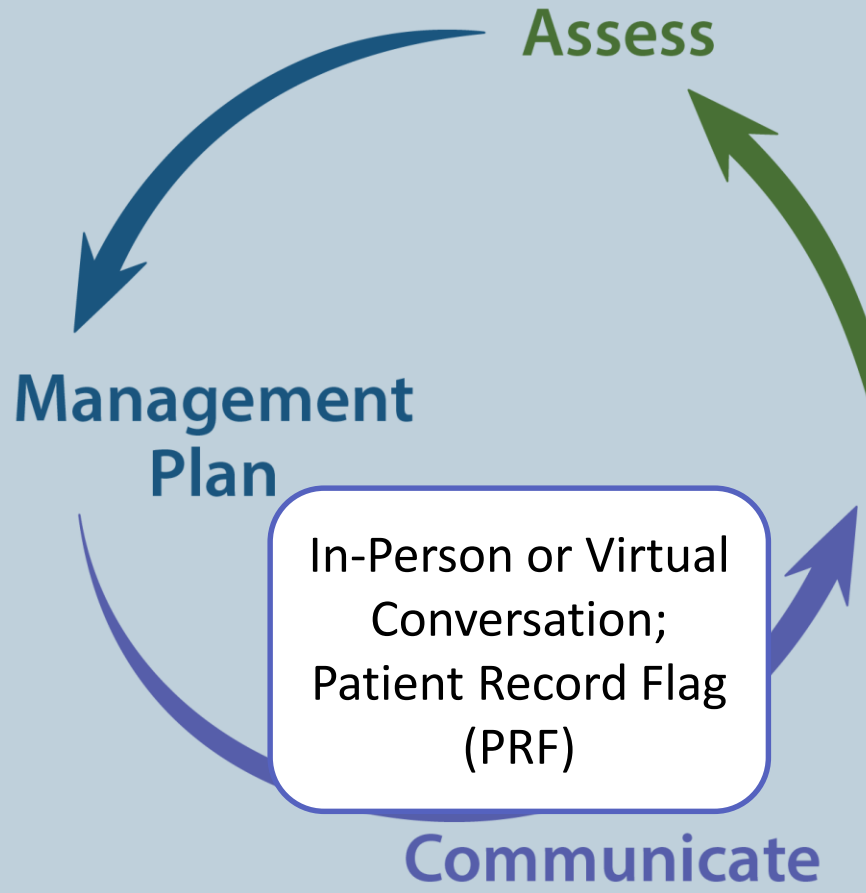
- What is the Safety/Treatment Plan?
- What ACTION should staff take to stay safe?

Communicate

Employee

Report

Leadership



In-Person or Virtual
Conversation;
Patient Record Flag
(PRF)

Employee



What Are Appropriate Uses of Patient Record Flags?

“PRF were...Developed for the specific purpose of improving safety in providing health care to patients who are identified as *posing an unusual risk for violence.*”

“...Patient Record Flags (PRF) immediately alert [employees] to the presence of risk *that must be known in the initial moments of a patient encounter.*”

Patient Record Flags: Content

PROBLEM

1-2 sentences describing the problem determined to pose a safety threat:

“Patient has a history of concealing firearms on his person while on VHA property.”

“Patient has a history of violence toward staff, resulting in injury, particularly while intoxicated.”

PLAN

1-2 sentences describing action to take to promote safety:

“Patient must check-in with VA Police when on VHA property. Police may search if there is probable cause.”

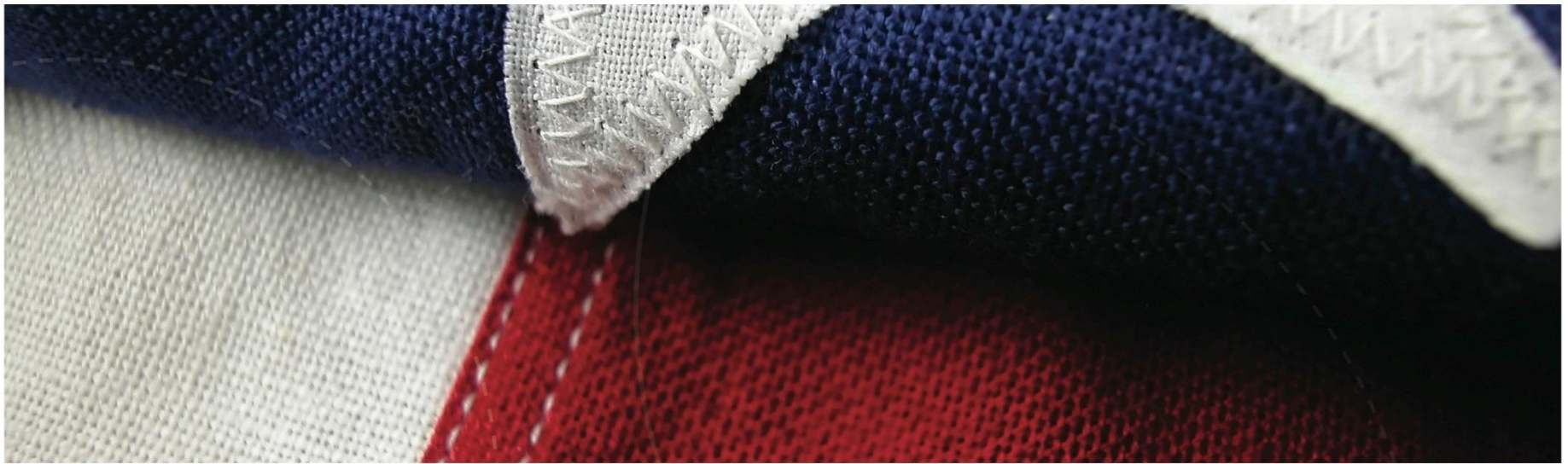
“Staff should have a low threshold for notifying VA Police when Patient presents for care under the influence of substances.”

Patient Record Flags Are Road Signs, NOT the Road Itself

WARNING



CHALLENGES AHEAD



Does Behavioral Threat Assessment and Management Work in Health Care Workplaces?



Please Remember:

The Existence of a PRF ***REQUIRES*** that
the Threat Assessment and
Management Process Occurred

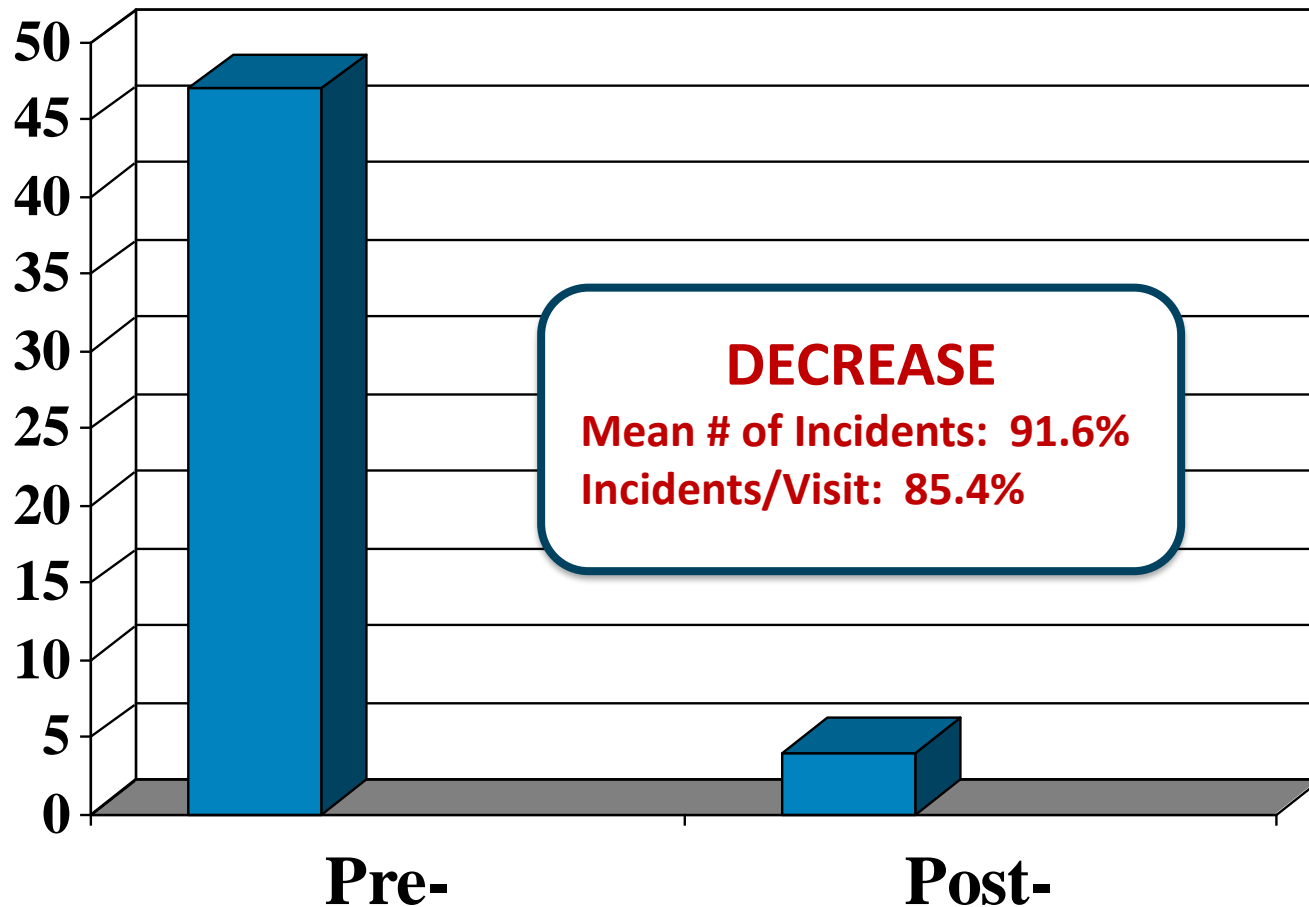
Repeat Offenders Account for 40% of All Incidents



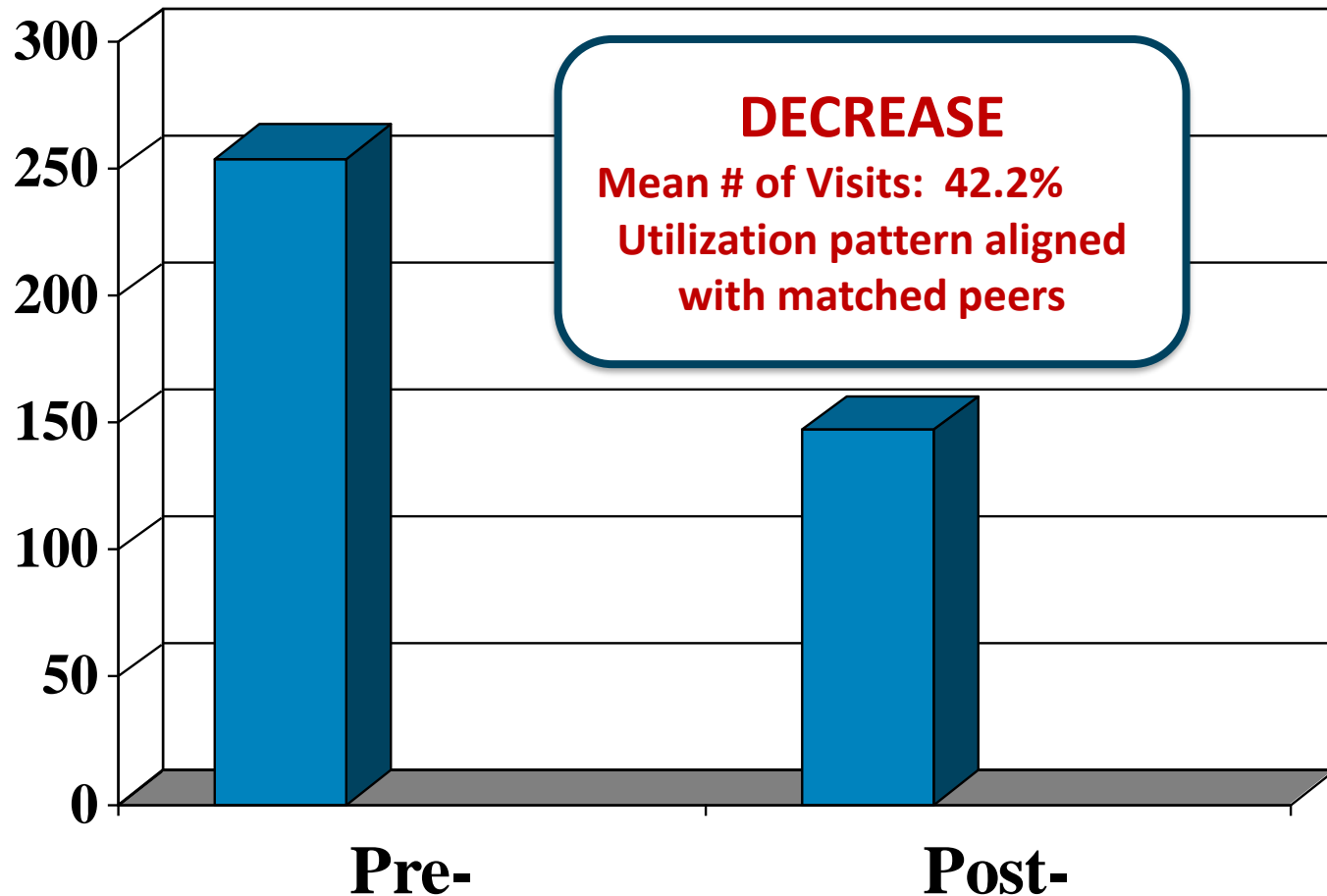
Incident Types for Patients with Patient Record Flags

<u>Incident</u>	<u>Number</u>	<u>%</u>
Physical Assault	14	30
Assault with weapon	11	23
Repeat Verbal threat	8	17
Weapons/explosive	7	15
Suicide attempt at VA	3	6
Hostage Taking	3	6
Repeated disruption	2	4

Change in Disruptive Behavior for Patients with Patient Record Flags (N=36)



Healthcare Utilization for Patients with Patient Record Flags (N=36)



Leadership

All Personnel

Assess

Disruptive Behavior Committee (DBC) and Employee Threat Assessment Team (ETAT)

Employee

Prevention and Management of Disruptive Behavior (PMDB)



Management Plan

Increase Protective Factors and Decrease Risk Factors; Order of Behavioral Restriction (OBR)

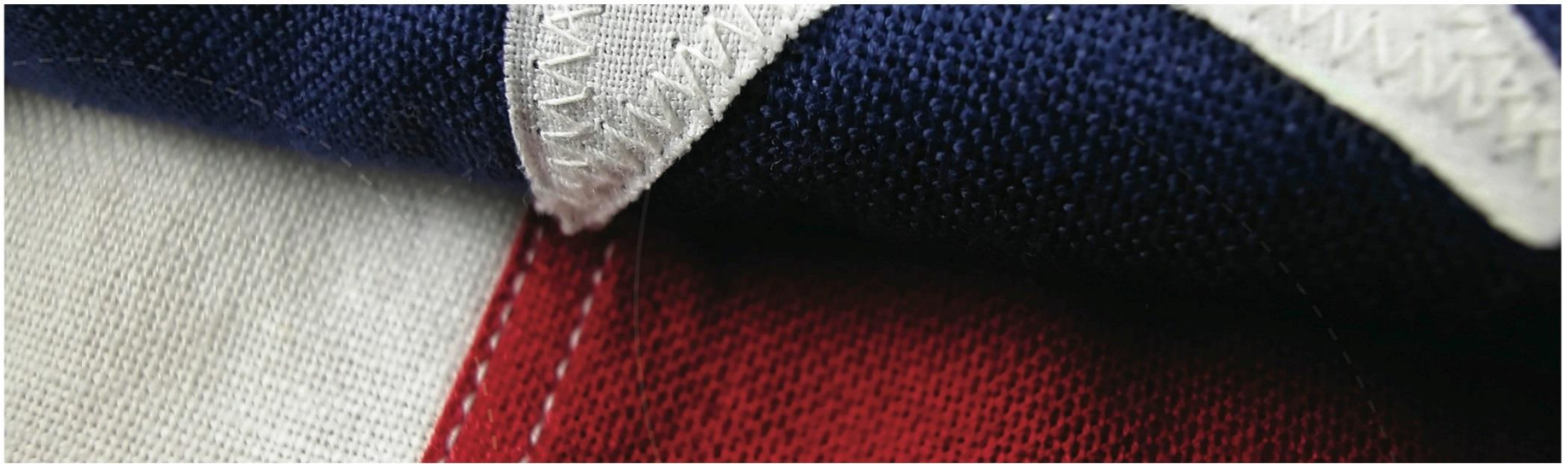
In-Person or Virtual Conversation; Patient Record Flag (PRF)

Disruptive Behavior Reporting System (DBRS) and Workplace Behavioral Risk Assessment (WBRA)



Communicate

Report



Questions?

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