Developing a Comprehensive Workplace Violence Prevention Program

Mike Hodges, MA, CHSS
Lorie Arata, FNP-BC
The Face Of Workplace Violence
Objectives

• Identify the key OSHA definitions and recommendations associated with workplace violence prevention, and understand the reality of violence in healthcare.
• Identify the core components of a comprehensive workplace violence program.
• Demonstrate proactive workplace violence prevention tools.
• Define future work and program development opportunities.
Definition: Workplace violence is any *act or threat* of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. *Occupational Safety & Health Administration*

- Currently no specific standard – falls under general duty clause.
  - Standard in development
- 26 states, Puerto Rico and U.S. Virgin Islands have OSHA approved State Plans.
- One of OSHA’s 5 areas of interest.
- 2015 OSHA published an update to its *Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers* – voluntary guidelines.
The Reality In Healthcare

- Bureau of Labor Statistics data shows that Healthcare is the #2 industry in the United States for Workplace violence.

- The American Psychiatric Nurses Association (APNA) has reported that nearly 500,000 nurses experience verbal and physical violence each year.

- The Occupational Health & Safety Administration’s (OSHA) data shows that of the approximately 25,000 workplace assaults reported annually; 75% occur in the healthcare industry.

- According to OSHA, 80% of all violence against healthcare workers is perpetrated by their patients.
A Quick Comparison – 2002-2013 Study

What are the effects on our employees?

**Significant Impacts on a Quality Care Environment**

- Bureau of Labor Statistics Reports
  - 7% increase in Absenteeism
  - 6% increase in Turnover
  - 21% increase in Fear Levels
  - 9% decrease in Productivity

- Median days away from work as a result of intentional injury by another person is **7 days**.
- For healthcare workers, assaults comprise **11%** of workplace injuries involving days away from work, as compared to **3%** of injuries of all private sector employees.

**Violent Environments result in Decreased Employee Engagement and Promote Poor Quality Care**
What are the effects on our business?

**Massive Impacts on our Business**

- **OSHA Reports Direct and Indirect Costs for WPV Injuries**
  - $57,773 for a concussion
  - $41,397 for a laceration
  - $64,988 for mental stress

- **The ENA report turnover costs inclusive of recruitment, hiring, and training**
  - $82,000 per RN

- **Based on numbers from ASSE and the ANA we can estimate**
  - $1.6 Billion annually for healthcare organizations

**Violence Impacts all Aspects of our Business**
WPV: Where We Were

• No common reporting or not reported at all
• Cultural Acceptance: Employees not aware of what is considered WPV
  – “this happens all the time”
  – “he was just demented”
  – “she was just a little old lady”
• Limited Communication between Public Safety and Employee Health
• Delayed knowledge of incident
• “Reactive” view of Public Safety employees
• Disjointed management input – left hand vs. right hand
Initial Efforts

- Collaborative discussions between EHS and Public Safety
  - Redefined OUR relationship
  - Identified common issues

- Started reporting employee safety events at daily safety huddle

- Re-categorized the variance reporting: single stream reporting
  - Employee Event – Violence Against Staff

- Re-categorized the Employee Health Data base to identify violence
Where We Are

Our Construction of a Collaborative WPV Program

Management Actions

Employee Training & Engagement

Management Oversight

Employee Response
Employee Training

Training through various channels:

• Escalating Behavior Recognition and Response
  • **Level I** – All Employees
    • Understanding Causes of Escalation in Healthcare
    • Recognizing Escalation – Threat Levels
    • Early Stage Proactive Protection Measures
    • Workplace Violence Prevention Tools
  • **Level II** – Clinical Employees
    • Review of Level I
    • Practical Self Defense
  • **Level III** – High Risk Employees
    • Review of Level II
    • Enhanced Practical Self Defense
Education is Foundational

Two Primary Reasons
• Builds Confidence
• Informs Response
Employee Engagement

Finding Avenues to engage staff and gain feedback

• Follow-up Incident Investigation
  Continuous review of incidents resulting in follow-up interaction with victims and staff

• Proactive Patrolling
  Adjusting Officer Presence and activity to match metrics. High Visibility and Engagement.

• Hazard Rounds
  Regular unit inspections and response tool engagement
Employee Response

- **Preventative/ Proactive Tools**
  - Threat Levels
  - Proactive Patrolling
  - Key Alerts: CRACK & BOLO Posting/ Reporting, Alert Flags
  - Hospital Individual Threat Database
  - Threats and Harassments Reporting
  - ED Violence Risk Assessment
  - Security Threat Assessment Team
    - Inter-disciplinary Involvement
    - Bed-Side Threat Analysis
    - Mitigation Planning
  - Threat Assessment Protocol (TAP)
  - Threat Management Team
  - Patient Flags

- **Reactive Tools**
  - Security Alert – Public Safety Needed
Standard Threat Levels

Low Level Threat: LLT
A LLT is a subject or incident that presents minor disruptions to normal facility operations, and presents a low threat of violence.

Medium Level Threat: MLT
A MLT is a subject or incident that presents major disruptions to normal operations and presents the possibility for violent action.

High Level Threat: HLT
A HLT is a subject or incident that presents major disruptions to normal operations and has a verified history of violent action.

Critical Level Threat: CLT
A CLT is a subject or incident that presents a known and immediate threat of significant bodily harm or death to patients, staff or visitors.
Investigations & Intelligence

• **Key Alerts:**
  – Be on the look out (BOLOs)
  – Critical Incident Watches (CIW)
  – Critical Response and Critical Knowledge (CRACK)

• **Hospital Individual Threat Database (HITDB)**

• **Regular Intelligence Reporting**

• **Threat Investigation & Assessment**
Threat Assessment Protocol (TAP)

- Deeper Investigation of Potential Threats
  - Criminal Background
  - Contributing Medical History
  - Previous History with Subject
  - History with other facilities
  - Recommended Threat Level and Protocol
Threat Management Team

Meets Monthly
• Reviews TAP Workups
• Identifies Recurring Issues
• Develops Preventative Protocol
• Flags for Situational Awareness

Membership
• Public Safety
• Lead Hospitalist
• Social Work
• Nursing Administration
• Risk Management
Metrics for Assessment

• Workplace Violence Indicators
  - Damage to Property
  - Disorderly Conduct
  - Drugs/Alcohol Found
  - Elopements
  - Medical Assist
  - Threats
  - Harassment

• Assaults
  - Actual Assaults of all types
Proactive Patrolling

• Based on our Operational Intelligence
• Shifts Patrol Focus: Week to Week – Month to Month
  – Increased Suppression through Presence
  – Decreased Response Times
• Interactive Engagement with Clinical Staff
Threats & Harassments Program

• For employees dealing with a threatening or harassing situation in or outside the organization.
  – Threat Investigation
  – Liaison with HR
  – Liaison with Law Enforcement
  – Assist with Protective Orders
  – Provide Escorts
  – Specialized Parking
  – Panic Alarm
Security Threat Assessment Team

• Designed to address *prevention* needs.
• Based on *collaboration and resourcing* for full spectrum care.
• Utilizes:
  – Public Safety/ Security Staff – Leading the analysis
  – Bedside Clinical Staff
  – Social Work Staff
  – Patient Experience Staff
Threat Analysis

Key considerations:

• Disruption to operations

• Type of acting out behavior

• Number of subjects involved

• Special considerations

Add the scores together to get the total threat value for threat level assignment.
Planning Worksheet

Once the concerns are identified the planning begins.

**Section 1:**
Key Concerns and threat level.

**Section 2:**
Clinical

**Section 3:**
Social Work

**Section 4:**
Patient Experience

**Section 5:**
Public Safety

**Distribution:** 1 copy to each team member/ 1 to paper chart.
Management Oversight

Collaborative Workplace Violence Prevention Committee

- Meets Quarterly
  - Review Incidents and Analytics
  - Discusses
    - Barriers
    - Trends
    - Root Causes

Membership

- Chief Medical Officer
- Chief Operations Officer
- Chief Nursing Officer
- Physician Practice Leadership
- Behavioral Health Physician
- Public Safety
- Employee Health
- Safety
- Emergency Department Management
- Quality Improvement Department
- Employee Education
Management Action

Collaborative Workplace Violence Prevention Committee

Based on incident and analytics review

- Recommend/ Implement Training Process Changes
- Recommend/ Implement Policy Changes
- Recommend/ Implement Process/ Procedure Changes
- Recommend/ Implement Reporting Changes
Feeding Continuous Improvement

“Nothing wilts faster that laurels that have been rested upon.” *Unknown*
Results

Year over Year: 17%
Incidents Per Month: 8.4
Patient Population: 7%
Our Future Objectives

• System Expansion
• Increasing Targeted Education
• Pursuit of Legislation
• Interagency Partnerships
• Data and Metrics Refinement
What Can You Do?

**Professionally**
- Promote Deterrent Legislation
- Demand Professional Education

**Organizationally**
- Educate your employees
- Develop your Security Forces
- Build Proactive and collaborative Tools
Questions?

Mike Hodges, MA, CHSS
Director of Public Safety
mike.hodges@piedmont.org
706-475-3482

Lorie Arata, FNP-BC
Director of Employee Health
lorie.arata@piedmont.org
706-475-3373