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RISKTOPICS

Traditional Approaches to Workplace Violence Prevention in Healthcare Facilities

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Prevention of workplace violence events in healthcare settings is a priority for many of today's management teams. This Risk Topic discusses traditional approaches to addressing healthcare workplace violence prevention. Non-traditional approaches are discussed in a separate Risk Topic. When developing or re-assessing an exisiting program, both approaches should be evaluated and considered.

INTRODUCTION

Workplace violence encompasses many types of incidents, but aggressive actions by patients and residents are the mostly commonly experienced events in today's healthcare environment. Unfortunately, healthcare organizations today using the traditional approach to address these types of aggression are not experiencing significant risk reduction. It is important that organizations evaluate the effectiveness of current methods and develop strategies to make their programs more effective in reducing injury rates and improving the overall safety and security of their facilities.

DISCUSSION

The traditional approach to addressing patient and resident aggression prevention concentrates on employee training, basic incident investigation, use of physical barriers, and Security Department personnel assistance (see Figure 1). These are essential program components, but each come with challenges that can limit their effectiveness in controlling violence. Table 1 provides a synopsis of these program components and their corresponding limitations. Each of these program components is reviewed below with recommendations on how to strengthen these key elements.

Figure 1. Traditional Workplace Violence Program

Table 1

Program Component	Basics of Component	Potential Limitations
Employee training	Level 1 De-Escalation training provided to a limited number staff members, usually ED and Psych areas	• Limited staff participation • Inadequate training frequency • Restrictive training techniques
Incident Investigation	Basic investigation performed by unit supervisor	• Limited use of team approach. • Inadequate investigative process
Physical barriers	Designs incorporated to separate care workers and equipment physically from aggressive individuals	• Ineffective barrier use & design • Staff isolation from caregiving
Security Officer Intervention	Security personnel assist with intervention when care worker actions are ineffective	• Inadequate training • Variance in personnel qualifications • Restricted use of Security for interventions • Security staff level limitations

GUIDANCE

PROGRAM COMPONENTS AND RECOMMENDATIONS

Training

Due to time and cost restraints, crisis prevention intervention **training** is generally limited to care workers in the high risk departments. For hospitals, this is often Emergency and Psych departments. Employee training is generally limited to initial and annual Level I-De-escalation training, performed at hire and annually thereafter. The following questions illustrate the potential limitations of this practice. Do you remember everything you were taught six months ago if you have not practiced it? What employees do you have working in your high risk areas besides caregivers? Is the level of training given appropriate for your potential level of patient and resident aggression?

- Expand the annual program evaluation to address any additional areas or departments needing additional crisis prevention training. Other areas of training consideration might include Housekeeping, Food Service, hospital ICUs), Human Resources and other identified areas where there is the potential for interaction with aggressive individuals. Staff members who are incidentally working in areas that have potential for aggressive events (i.e. Housekeeping & Food Service) should have basic WPV prevention training.
- Conduct periodic refresher training during the year to aid staff in remembering proper techniques of de-escalation. Giving your creative staff members a chance to 'act out' a given scenario as part of your safety training can be fun and a learning experience for all.
- Review training in those departments that use crisis prevention/de-escalation techniques to evaluate program content against any existing codes, laws, rules, regulations and accreditation requirements to ensure the highest possible level of training (i.e. use of force or self-defense tactics) is performed.

Incident Investigations

Incident investigations are often performed by supervisors with limited training on proper investigative techniques and little time with which to allow the proper attention this process needs. This often restricts organizational opportunities to continuously improve their workplace violence program.

- Establish a policy that all employees should be encouraged to report all incidents promptly. Injuries from aggressive resident/patient actions should never be considered "just part of the job". Establish a method to reinforce this policy so it becomes ingrained in the organization.
- Utilize a team approach as the preferred method of investigation, including input from the unit/area supervisor. When supervisors in the area are the only persons investigating, they may not always address the root cause, particularly if the root cause is a reflection of their management skills. They may be hesitant in addressing the effects of restrictive staffing levels or their lack of departmental specific training of employees.
- Include nursing educators as key personnel for active involvement in review of incidents and resulting investigations. They may be able to identify gaps where additional training is desirous.
- Utilize accident/incident investigation to identify the root cause(s) and trigger events. Recommendations, controls and follow-up responsibilities are needed to ensure these improvements have been put in place and are successful. Root cause analysis does not come naturally to most of us. You may need specific training on this topic to be successful in incident investigations.

Physical Barriers

Physical barriers may include high partitions at nursing stations or entire walls of separation. There are differing opinions regarding having walls or high partitions separating care worker stations from the common areas of residents/patients. These barriers control access to computer equipment, office and medical supplies that might be used by an aggressive patient or resident to cause harm to himself or others, but they also may make the resident/patient feel isolated from direct care.

- Utilize a team approach including Security, Risk Management, Nursing and other parties to allow all members to voice concerns for employee safety and patient or resident care.
- Monitor staff to ensure that when barriers are in place, staff members are providing adequate direct caregiving and not merely sitting behind a desk as observers.
- Establish and enforce staff requirements that all patients and residents are prohibited from accessing the nursing station areas. Also, when barriers are present due to need, require staff members to use doors and locking devices in place to limit resident/patient access.

Security Officer Involvement

Security Officer Involvement during events varies greatly among facilities. This variance may be due in to the type of facility, management decisions on properly handling of aggressive actions and other factors. Qualifications range from Security Officers trained by the organization with little to no security experience, off duty Police Officers, and qualified Correctional Facility Officers. Some facilities limit Security Officer intervention during an event to only after care workers fail to control the situation. The ability of these Officers to be armed with guns, mace, pepper spray or other equipment is generally limited to those facilities housing forensic residents/patients or whose location necessitates such due to geographical crime activity.

- Utilize annual Workplace Violence program assessments to evaluate Security Officer qualifications, duties and capabilities.
- Establish protocols to facilitate a clear understanding between caregivers and security staff of when and how Security Officers are expected to interact during a crisis. The reasoning of their level of interaction should be based on both the care of the patients or residents and the safety of employees.
- Train Security Officers to understand when and how to intervene.
- Assign responsibility to an appropriate member of management to periodically evaluate Security staffing levels. Unfortunately, Security departments are often understaffed. As with other departments, their staffing levels are often based on outside consultants who look at FTEs and patient/resident load. These consultants may not fully understand or consider the need for Security staffing based on patient acuity or aggressive tendencies.

CONCLUSION

In summary, physical and verbal assaults by patients and residents continue to present challenges for healthcare workers. Best Practices dictate that employers evaluate the effectiveness of their traditional approach towards this type of workplace violence and incorporate program improvements that result in effectively reducing injury rates and strengthening their organization’s Safety and Security programs.

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