VIOLENCE ON THE WARD

What health care is doing to keep its own out of harm’s way

BY HOWARD BELL
ST. CLOUD HOSPITAL NURSING DIRECTOR JOY PLAMANN HAD AN ENOUGH-IS-ENOUGH MOMENT IN 2010.

It happened after a six-week stretch that started with an agitated patient verbally assaulting several nurses and then throwing a computer monitor into the paging system, causing $10,000 in damage. Then a chemotherapy patient, delirious and agitated, threatened to harm another patient and repeatedly tried to enter that patient’s room. After a third patient threw a lamp through a window, spraying glass toward staff, Plamann decided she needed to act.

She sought help from mental health unit staff, who were experienced in de-escalating situations in which a patient or visitor becomes aggressive. “I learned mental health had gotten a lot of requests for help,” she says. “Staff were being assaulted all over the hospital.” Years earlier, Plamann herself had been trapped in a room with an angry patient who was verbally abusing her and about to physically assault her. “I escaped by being faster than he was,” she says, “and using a duck-and-dodge move I learned in junior high basketball.”

With backing from administration, Plamann helped create the hospital’s Aggressive Incident Prevention Committee in December of 2010. The group, which included doctors, nurses, and staff from mental health, administration and security, started by collecting stories. “We heard an explosion of examples of verbal and physical abuse from every nursing unit, in dialysis, even the lab,” she says. “Some staff had been injured seriously, and the risk was growing. We needed procedures for reporting these incidents and preventing them.”

The committee identified 96 ways to do that. Most have been implemented. Since then, the number of severe incidents of violence at the hospital has fallen, thanks to greater staff awareness of the problem and training in how to de-escalate aggressive behavior. CentraCare Health, which includes St. Cloud Hospital, is now a national leader in patient-visitor violence prevention. Staff members have spoken at conferences nationwide.

Many of the strategies put forth by the committee found their way into a “road map” created by the Prevention of Violence in Healthcare Workgroup—a statewide effort involving the MMA, Minnesota Department of Health, Minnesota Hospital Association (MHA), Minnesota Nurses Association, Care Providers and LeadingAge of Minnesota—to help facilities identify and correct weaknesses in their violence-prevention programs.

More than 100 Minnesota hospitals, clinics and long-term care facilities have now signed a pledge to make workplace violence prevention a top priority. Each of the facilities has or is in the process of establishing violent incident reporting procedures, training staff in violence de-escalation, screening patients for risk of becoming violent and creating a zero-tolerance culture that encourages staff to report incidents. Many are using tools and resources made available by the workgroup.
assaults occur in health care and social service settings—mostly hospitals.

Health care workers miss work because of serious injuries intentionally caused by others at a rate that’s four times higher than the U.S. rate overall. Most victims are nurses. In a 2010 survey of nurses in general hospital units across the country, 95 percent said they’d experienced patient-visitor violence. Forty-two percent said they’d experienced it in the past month, 14 percent in the past week. The problem is growing. In Minnesota, worker’s compensation indemnity claims by health care workers injured because of assaults by patients or visitors rose from 134 in 2008 to 299 in 2014. Indemnity claims account for only about a fifth of compensable claims but represent the ones with the most severe injuries.

Most often, patient-visitor violence takes the form of verbal assaults—threats, intimidation and any use of language that makes staff and other patients feel fearful and unsafe. Too often, though, incidents escalate into physical assaults. During a recent series of six webinars on preventing workplace violence sponsored by the Department of Health, MHA and MMA, staff from hospitals and clinics around the state shared stories about being choked, groped, kicked, punched, slapped, scratched, bit, spit on, and attacked with objects, weapons or body fluids. One patient at a Duluth hospital ripped a toilet off a wall, smashed it and used the shards to attack staff. A medical/surgical nurse at an Allina hospital had just returned to work after having abdominal surgery when an elderly patient with dementia and a history of violence that was unknown to the nurses struck her in the abdomen, leading to a second surgery, months of pain and work restrictions. Last November, a 68-year-old patient at St. John’s Hospital in Maplewood went on a rampage brandishing a metal bar, hitting four nurses and causing a collapsed lung, broken wrist and multiple cuts, bruises and abrasions.

Emergency departments, psychiatric units, medical/surgical units and ICUs are the most violent places in a hospital, according to a 2008 literature review. Seventy-eight percent of emergency physicians who responded to a 2011 national survey about violence in the ED out of West Virginia University said they’d been victims of or had witnessed a significant act of physical violence toward staff in the past year.

Harm caused by verbal and physical abuse may linger for months, even years. Victims miss work, require modified duty, and suffer PTSD and burnout at rates higher than those of others. They’re more likely to experience compassion fatigue that includes lingering distrust, resentment or anger toward all patients, an insensitivity to patient needs and a diminished ability to provide good care.

Not taking it anymore

The first step toward preventing violence in hospitals and clinics is changing staff attitudes about patient-visitor aggression, says Jeffrey Ho, MD, director of Hennepin County Medical Center’s (HCMC) emergency medical services who teaches about prevention at hospitals around the state. “It’s historically been under-reported because health care workers often feel violence is just part of the job. We need to realize that our work puts us at risk and that there are steps we can take to protect ourselves, Step 1 being to recognize that violence of any kind is not acceptable,” he says.

This seemingly obvious point is often an “ah-ha moment” for the nurses and doctors Ho talks to. “I’ve had people say to me that no one’s ever told them that the abuse is not OK, that I need to think about my safety and how to protect myself.”

Plamann says getting staff to buy in to this zero-tolerance mindset was a crucial part of St. Cloud’s violence-prevention initiative. “Years ago, staff might not have even recognized a violent event for what it was because they thought it was just part of their job. Now we’re all eager to protect each other and create a safer working environment. It’s been a major cultural shift.”
Such culture change takes time, warns Ho, who says he still encounters health care workers who don’t want to report violent incidents. A nurse at Allina’s Buffalo Hospital, for example, declined to report a patient who sexually harassed her because she didn’t want to get the patient in trouble. “She accepted it as part of her job,” says Margaret Binsfeld, RN, BSN, the hospital’s emergency department nursing manager.

Getting buy-in from administration is crucial to creating a culture of non-violence, as they provide the money and means to develop policies and procedures. That might include setting up an incident reporting protocol, training staff to assess risk and de-escalate situations, and helping them recover emotionally if they are victimized. “The violence problem won’t be solved,” Ho says, “unless administrations throughout health care see that this is a serious problem, a common problem and a costly problem that affects quality of care.”

Seeing the signs
Doctors and nurses have been trained to recognize the signs of disease, but not the warning signs of violence. Many incidents that escalate do so because staff failed to see them coming, Ho says. Warning signs include a past episode of violence or aggression toward a health care worker, drug or alcohol impairment, dementia or delirium, psychotic symptoms, hostility, impulsivity, making demands and violating personal boundaries. In some cases, there are no warning signs. Patients who may be “recreational fighters,” for example, simply enjoy confrontation and seek it out.

Comments such as “There’ll be hell to pay if you don’t...” “You’d better hurry, or else...” or “What do I have to do to get you people to listen?” might precede aggression. Many physically violent assailants have a mental illness, Ho says, although that’s not always the case. “Unfortunately, some of the fatal incidents are caused by someone who follows a spouse or partner to the hospital or clinic to do them harm.”

Most hospitals now flag the patient’s electronic health record if they’ve been aggressive in the past or show potential for violence to give staff a heads-up. St. Cloud Hospital takes it a step further and has security proactively make rounds on every flagged patient.

St. Cloud also screens all of its in-patients using the Broset tool. It identifies signs including confusion, irritability, boisterous behavior, physical or verbal threats, and attacks on objects such as kicking a wall. If a patient exhibits three or more of these, there is a one in three chance he or she will become violent within the next 24 hours. For that reason, patients exhibiting two or more such behaviors are reassessed every 12 hours. “A risk-screening protocol is one of the first things a hospital should implement in their violence-prevention program,” says Joseph Mercuri, MD, a hospitalist and member of St. Cloud Hospital’s violence-prevention committee.

The art of de-escalation
Ho, who has been physically assaulted twice, says both times he quickly neutralized the perpetrator using methods he learned as a Meeker County deputy sheriff, a job he does on his days off. He knows others who haven’t been able to do that. “I have three colleagues elsewhere in Minnesota who have been permanently disabled from an assault and can no longer work because they have major orthopedic or traumatic brain injuries.”

Ho says fewer incidents progress beyond verbal threats when staff are trained to de-escalate a situation. “The first thing to realize is that escalation takes two people,” he says. “What are you doing or saying that’s making the situation worse?” It might be body language or tone of voice.

Finding out why the assailant is upset is crucial. “You have to connect with them,” Plamann says. “That’s the art of de-escalation.” She tells the story of an older patient on the medical unit who grew hostile and threatening, swearing loudly and refusing treatment. With security posted outside, the charge nurse entered his room to find out why he was upset. In a firm-but-empathetic tone she explained that it was not OK to swear and threaten the nurses. Then, she asked a simple question—What can we do to make you feel better about what’s going on here? The patient opened up and told her that there were too many interruptions disturbing his sleep. He went on to tell her that he was upset because he was ill and had lost control of his life and his independence. Through tears, the patient apologized. He had no further outbursts. “The charge nurse de-escalated the situation by listening and acknowledging why he was upset,” Plamann says. “She also drew a line for what’s acceptable behavior, but did so in an empathetic, coaching way. And she solved his problem by asking that his care be clustered so he’d be interrupted less.”

Ho says it’s especially important for staff in the emergency department to understand why patients may be upset. “They may be having the worst day of their lives. They may be there against their will because they’ve broken the law,” he says.

The importance of training
Many Minnesota hospitals and some clinics now require staff to complete several hours of classroom training in violence prevention. Mayo Health System’s Southwestern Minnesota Region, which includes six hospitals and 30 clinics, uses a training package offered by the Milwaukee-based Crisis Prevention Institute that
can be customized for specific areas of hospitals and clinics. Refresher modules are even more customized. “The training makes employees more aware of the causes of violence and more confident in how to respond to it,” says Stephen Daniel, regional security manager for the southwestern region.

At St. Cloud Hospital, staff can take a course that includes what Mercuri calls “ultimate role-playing that can be disturbing to watch” because participants get so emotionally involved. Staff complete refresher classes every two years and do annual online training that includes simulated events based on actual incidents involving aggressive patients at the hospital. Mercuri is currently determining how much training physicians should receive. “Historically, physicians have been exempt from training, but we need it for our own safety and to help foster the hospital’s no-tolerance culture.”

Ho says training is partly about getting staff into the habit of being mindful about danger. “It’s what in law enforcement we call ‘situational awareness.’ You’ve got to come to work every day with your game face on. Leave other worries and distractions at the door. Always have an escape route in mind, and learn to recognize the signs of potential trouble and how to respond to them.”

Other ways to mitigate risk

Many hospitals create customized plans for handling patients they think might become physically or verbally abusive. They may cluster care to reduce interruptions or post a security officer outside the patient’s room. It’s important to find out what the patient’s triggers are. “Maybe they don’t like the lights left on,” Plamann says. “Maybe they have PTSD or had a bad experience in a hospital before. Note these triggers in the medical record so you have shift-to-shift consistency in awareness and response.”

At Buffalo Hospital, nurses have safety huddles at shift changes to communicate about the status of patients and visitors. They also do shift change reports at the patient’s bedside and include the patient and their family in the discussions. “It helps patients and family buy into and feel part of what’s happening,” says Christy Secor, RN, MSN, a quality-improvement specialist. Including them can go a long way toward preventing the frustration that can lead to violent outbursts.

A patient who starts to swear or threaten staff at Mayo Health System facilities may be asked to sign a behavioral expectation contract. By signing the contract, the patient agrees to not swear, yell, intimidate or threaten staff; to respect staff’s personal space and privacy; and to accept that some patients may be seen before they are because their situation is more urgent. “We have an honest, respectful conversation with them,” Daniel says. “We explain that we’d like to continue providing their care, but not if they keep behaving in a threatening way toward staff. We’re down-to-earth about it, and acknowledge that maybe some of the misunderstanding is our error, and for that we apologize.” He says most patients agree to sign the contracts.

Some hospitals deploy behavioral emergency response teams (BERTs) that include security, mental health staff and others with additional training in de-escalating situations. St. Cloud began testing the concept last October. “We get three to four BERT calls each week,” Plamann says. When the team arrives on the scene, it “huddles” with attending nurses to discuss what’s happening, what’s been tried to de-escalate the situation, and whether the patient has any known emotional triggers. “Sometimes it’s important to have a show of force and have security enter the patient’s room,” Plamann says. “Other times, that aggravates the situation.” Based on what the BERT learns, they create a plan that might include a medication change or some other change in the patient’s care that addresses their distress. Plamann says the concept is working well so far. “Physicians are in total support of it.”

Small hospitals have fewer staff and resources and may have to approach violence prevention differently. Daniel says these facilities have controlled-access doors and panic buttons employees can press if they feel threatened. If someone
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—JOSEPH MERCURI, MD

At St. Cloud Hospital, lost work days caused by aggressive incidents plum-meted 4,600 percent from 2013 to 2014; modified duty days decreased 328 percent, and hospital costs from aggressive incidents dropped 1,100 percent. “This steady, significant decline shows that our efforts are working,” Plamann says. But even so, the total number of reported incidents rose from 182 in 2013 to 237 in 2014. She attributes that increase in part to the fact that more employees recognize violence and report it more often.

Mercuri, who has been verbally assaulted and has witnessed attacks on nurses, believes that because of “a coarsening of our culture,” violence will continue to be an issue in health care. “We’re an impatient, instant-gratification, multi-tasking, violence-in-the-media-saturated society,” he says. “Life in the hospital is different than it was 20 or even 10 years ago.”

Howard Bell is a medical writer and frequent contributor to Minnesota Medicine.

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