

Securing the Workplace: Preventing Violence against Health Care Providers’ seminar on February 29, 2008.

Breakout Session Notes – All groups

Objective:

Identify best practices to prevent work place violence in each of the following specialty areas:

1. Behavioral Health
2. Acute Care
3. Home Health

In addition we want to identify information/educational needs for nurses, staff and facilities in each specialty area.

▪ **Questions for the Behavioral Health group:**

1. Do any of your facilities have a WPV prevention program that tracks QI indicators/outcomes – if so what do you track?
 - a. What makes your program successful
 - b. What were barriers to implementation and how did you overcome them

Discussion Notes

Healing environments +

“aesthetically pleasing”

What reduces S/R

“Best Practices”

- 1) Intervene early
- 2) De-escalate
- 3) Relaxing environment
- 4) Staff training in Pro-Act or other
“include all staff”
- 5) Teamwork beh. Health + transportation / security
- 6) Recovery Model
“More structural activities”

Bridger Program – to train peer counselors or mental health facilities

Support for WPV

- 1) Consequences to perpetrator of assault or violent beh.
- 2) Judicial / Law Enforcement Program
- 3) Networking

More clearly defined “assault” + “violence”

2. Seclusion and restraint policies – effective and non effective practices

Discussion Notes

S/R Policies

Are they well-written & effective?

- A. OSH has policy of it entire time of S/R
- B. Confusion between medical vs. psych patient issues

Effective Policies

1. Continuous 1 to 1
2. Clarification of law as applied to psych patients
3. Availability of seclusion rooms
4. Documentation of what you are doing

Medical patient with post anesthesia / delirium – 2 doc hold

3. De-escalation techniques - effective and non effective practices

Discussion Notes

De-escalating Clients

1. Show of force / Last Resort
 2. Talk with patient dialogue
 3. Show of force – conditions
 1. Intimidating beh. from pt.
 2. Continued escalation
 - Offer PRN or regular medication
 - 5. Differentiate pt “on drugs or detox”
 - 6. Practice + Role play training by staff
- (Debriefing following the incident)

4. Staff training - effective and non effective practices

Discussion Notes

OSH Experience

1200 employees trained in PRO-ACT
16 hours in Pro-Act about “de-escalating”
Final phase is focused on “hands-on response”

*Training in communication skills important.

5. If money was no issue, what is the best solution that you would recommend to address WPV in behavioral health care to ensure staff and patient safety?

Discussion Notes

If \$ were not an issue

1. More staff
2. Chemical dependency programs
3. “Culture of Caring”
 - Training
 - Work on self + self knowledge

6. What resources or assistance would you like to see from professional HC organizations or others to assist you with your WPV program?

Discussion Notes

***CONTINUE THE DIALOGUE!
***REPORT!

■ Questions for the Acute Care group:

1. Do any of your facilities have a WPV prevention program that tracks QI indicators/outcomes – if so what do you track?
 - a. What makes your program successful
 - b. What were barriers to implementation and how did you overcome them

Discussion Notes

a. Success

Driven by staff / felt need

+ Δs based on staff input

Δ Security company

Δd bldg. design

+ Effect on morale

↓ Injuries

Δd responses / use of teams

(Code Green), focus on prevention

Team approach (PMAT) with lots of training; most experienced person manages

Off the ground:

2 mo. ago

Impetus was an incident

Prog focus prevention in ER

use response teams = PMAT (9 to assess all aspects)

MOAB program

Indicators

- Injury
- Type of violence (V, Phys)
- Workers comp
- Seriousness
- Nonphysical effects (OHSU)
- Who affected: pt, visitor, staff
- Staff / pt satisfy / staff level (RVMC) + productivity
- 50% ↓ in staff injuries in 1 yr
- Training (some mandatory)
- Data R/to PMAT

b. Barriers / Issues

- Who is the leader?

- When do those → WPV take responsible for actions?

- Some models have strength in one part (phys) but not another part (common skills)

- Financing

- # of hrs of training / level of training for all staff

- Best thing for pt

- Possibly of specifying levels of training for various HCPs

2. Seclusion and restraint policies – effective and non effective practices

Discussion Notes

S/R policies

Trend: ↑# in ER, → use of behavioral restraint

Effective

- Freq. toileting + other NIV. known to be effective

Tool / Checklist

Coupled with calm

- Many have prompting policies
Restraint when used
Use log book / lists of reviews of pt on restraint
- Next day audit → use date

Noneff / Prob

Intervention for elderly / delirious is not evid-based (sitter, Rx)

Effective control...

- Follow up on Q1
- Look @ alignment of practice/policy

3. Deescalation techniques - effective and non effective practices

Discussion Notes

Effective

- PROACT – responsive learners have Δd
(Δ attitude)
(Δ culture in ER + Beh Health)
 - New knowledge
Diffusion across practice areas
ER – BH → steer
 - All employees trained
 - Calm app

 - ID'd ldr
 - Knowledge of pt, of self
 - How to remove self without injury
- OK to set personal boundaries

Not effective

- Don't go it alone
- Don't shout over people

4. Staff training - effective and non effective practices

Discussion Notes

Staff Training Effective

- PMAB
- CPI
- MOAB
- Do yr own Eclectic
- Standing safety issue on staff agenda
- Fix customer relationship (early)
→ Gift certificate
Service Recovery

Noneff / Prob

Issue knowledge of safety of techniques used

→ Have data on legalities but not Ebased Px
Kinesthetics R/to this

Noneff

Program evolves, decay / degenerate over time

5. If money was no issue, what is the best solution that you would recommend to address WPV in acute health care to ensure staff and patient safety?

See Q 4

Discussion Notes

6. What resources or assistance would you like to see from professional HC organizations or others to assist you with your WPV program?

Discussion Notes

- A. ↓Access (all beds full) pt → Med Surg + practices / competency varies → M/S nurses get prep to care for,
- B. ←RVMC: Psych (work on BH) Ns on staff in ED
→ round to other units to assist, rotate 24/7,
- C. Range of training needs / approaches
→ 3 levels
 - a. New employee (everyone)
 - b. Everyone in pt care
 - c. Psych/ED/Security

Content (a-1) in bill form documentation

▪ Questions for the Home Health group:

Discussion Notes

This was more general discussion re HH issues

Home Health Risks

Unpredictable environ.
Dog bites / animals (goats)
Weapons – access to
Family in homes + others
Meth lab + drug use
Med abuse (family)
Isolation – work alone
Patient condition –
Inadequate help – hope
Acute care ↑ in home

Rural – easier to have knowledge re patient + family knowledge base ↑
Urban – risk getting to home (DRG)
Critical access criteria – re LOS (3 days)

Threat Assessment

*Add to home assessment – care plan
care date on fridge!
*Similar triggers – pain, previous hx of violence/aggression, etc
*Handoff – acute care to home health, more than a referral form.
Social succ / PT/OT etc conference – prior to discharge
(Doesn't cover all)

Challenge re discharge to safe environ.
- Serious threat – many facilities have policy – get out + discharge
- Underlying issues – underreporting (not seen as violence)
- Unpredictable behavior – day to day assessment

*Training piece
Debriefing post incident

HC workers – issue where patient is employee

Acute care nursery vs. Home care RNs

What is the incidence of violence?

+ type

Training. De-escal, assess, communicate / what to rpt