Mitigating Workplace Violence and De-escalation Techniques

Nycole Oliver, DNP, APRN, RN, FNP-C, ACNPC-AG, CEN
Nycole.Oliver@yahoo.com

Disclosure

- Nycole Oliver, DNP, APRN, RN, FNP-C, ACNPC-AG, CEN has no financial relationships with commercial interests to disclose

Objectives:

- Define workplace violence (WPV), the prevalence as it relates to the Emergency Department (ED), and risk factors for WPV including clinical, environment, organizational, socioeconomic, and worker-on-worker.
- Illustrate different regulatory and professional agencies' statements on violence in the workplace, and prevention strategies for WPV from organizational and nursing standpoints.
- Elucidate different crisis intervention strategies and de-escalation techniques when faced with violence in the workplace, the potential consequences of WPV and appropriate steps in the aftermath of WPV.

Workplace Violence (WPV) Definitions

- "The act or threat of violence, ranging from verbal abuse to physical assaults toward persons at work or on duty" National Institute for Occupational Safety and Health (NIOSH), Occupational Safety and Health Administration (OSHA), Centers for Disease Control and Prevention (CDC), Emergency Nurses Association (ENA)
- "Physically and psychologically damaging actions that occur in the workplace or while on duty" American Nurses Association (ANA)
- "Incidents where staff are abused, threatened, or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being, or health" World Health Organization (WHO), International Council of Nurses (ICN)

ACEP (2016a); ANA (2017); ILO, ICN, WHO, & PSI (2002); NIOSH (2018a)

Prevalence

- The Emergency Department (ED) has more frequent occurrences of workplace violence because of a higher risk patient population.
- According to the Bureau of Labor Statistics, 21,130 healthcare workers experienced workplace violence in 2017, with a majority (13,080) being intentional injury by another person.
- More than 50% of ED nurses experience verbal or physical assault regularly.
- 78% of emergency physicians have reported being targets of workplace violence in the past 12 months.
- About 74% of workplace assaults occur in the healthcare setting.

Bureau of Labor Statistics (2017); Cheney (2019); NIOSH (2018b); Thompson (2015)

Regulatory and Professional Agencies' Statements

- The Joint Commission (TJC)
- American College of Emergency Physicians (ACEP)
- American Nurses Association (ANA)
- Emergency Nurses Association (ENA)
- Occupational Safety and Health Administration (OSHA)
- National Safety Council (NSC)
- National Institute for Occupational Safety and Health (NIOSH)

The Joint Commission

- Put out a *Sentinel Event* alert for physical and verbal violence against healthcare workers in April 2018.
- Verbal abuse is often overlooked as workplace violence.
- States that each episode of violence or credible threat to healthcare workers warrants notification to leadership, internal security, and law enforcement prn.
- It is up to every organization to specifically define acceptable and unacceptable behavior and the severity of harm that will trigger an investigation.
- The most common type of violence in healthcare is patient/visitor to worker.

The Joint Commission (2018)

The Joint Commission

- Episodes of workplace violence are grossly underreported due to:
  - Uncertainty of what constitutes as violence
  - Belief that assailants are not responsible for their actions due to conditions affecting their mental stat
  - Thinking that violence is "part of the job"
- The most common characteristic exhibited by perpetrators of workplace violence is altered menta status associated with:
  - Dementia
  - Delirium
  - Substance intoxication
  - Decompensated mental illness

The Joint Commission (2018)

The Joint Commission

- Actions suggested:
  - Clearly define WPV and put systems in place across the organization that enable staff to report WPV instances, including verbal abuse.
  - Recognizing that data come from several sources, capture, track, and trend all reports of WPV- including verbal abuse and attempted assaults when no harm occurred.
  - Provide appropriate follow-up and support to victims, witnesses, and others affected by WPV, including psychological counseling and trauma informed care if necessary.
  - Review each case of WPV to determine contributing factors. Analyze data related to WPV, and worksite conditions, to determine priority situations for intervention.

The Joint Commission (2018)

The Joint Commission

- Actions suggested cont.
  - Develop quality improvement initiatives to reduce incidents of WPV.
  - Train all staff, including security, in de-escalation, self-defense, and response to emergency codes.
  - Evaluate WPV reduction initiatives.

The Joint Commission (2018)

American College of Emergency Physicians

- Put out a *Policy Statement* for protection from violence in the ED in April 2016
- WPV is a preventable and significant public health problem.
- Optimal patient care can be achieved only when patients, healthcare workers, and all other persons in the ED are protected against violent acts occurring within the department.
- Advocates for increased awareness of violence against healthcare workers in the ED and for increased safety measures in all EDs.
- Encourages all states to enact legislation that provides maximum punishment against individuals who commit violence against healthcare workers in the ED.

American College of Emergency Physicians (2016b)

American College of Emergency Physicians

- To ensure the safety and security of the ED environment, the hospital and administrators have the following responsibilities:
  - Provide an ED security system based upon institution-specific risk assessment, that includes adequate security personnel with sufficient training, physical barriers, surveillance equipment, and other security components.
  - Conduct ongoing assessments of the ED security system performance.
  - Coordinate the hospital security system with local law enforcement agencies.
  - Develop written protocols (with input from employees) for violent situations occurring in the ED to ensure the safety of patients, visitors, and healthcare workers alike.

American College of Emergency Physicians (2016b)

American College of Emergency Physicians

- To ensure the safety and security of the ED environment, the hospital and administrators have the following responsibilities cont.
  - Educate staff through formal, regular training on early recognition of individuals with potential to become violent, techniques for de-escalation, non-violent crisis intervention, and importance of seeking assistance.
  - Develop and enforce a mandatory reporting policy that requires employees to promptly report any verbal or physical assault.
  - Adopt a zero-tolerance policy for employees, patients, and visitors that states any violence in the ED is unacceptable, and is not considered "part of the job".
  - Provide appropriate post-incident support for employees involved in violent events including prompt medical treatment, debriefing, counseling, and employee assistance.

American College of Emergency Physicians (2016b)

American College of Emergency Physicians

- To ensure the safety and security of the ED environment, the hospital and administrators have the following responsibilities cont.
  - Pursue maximum criminal prosecution, when deemed appropriate, against those individuals who commit violent acts against healthcare workers.
- ACEP also recognizes that EMS are an integral component of emergency care and supports and encourages efforts to protect EMS personnel against physical violence in the prehospital environment.

American College of Emergency Physicians (2016b)

American Nurses Association

- Put out a *Position Statement* for incivility, bullying, and WPV in July 2015
- The nursing profession will no longer tolerate violence of any kind from any source.
- Those who witness workplace violence and do not acknowledge it, who choose to ignore it, or who fail to report it are in fact perpetuating it.
- The entire nursing profession must actively drive a cultural change to end… violence in the workplace.
- Strategies are characterized by primary, secondary, and tertiary prevention, then further by RNs and employers.

American Nurses Association (2015)

American Nurses Association

- Primary Prevention Strategies:
  - Actively participate in developing workplace prevention program.
  - Understand organizational policies and procedures related to WPV prevention and response.
  - Actively participate in education related to WPV prevention.
  - Understand importance of using situational awareness to identify the potential for violence before it occurs.

American Nurses Association (2015)

American Nurses Association

- Primary Prevention Strategies cont.
  - Learn how to anticipate, prevent, and respond in crisis situations.
  - Be aware of and know how to use environmental controls to both prevent and reduce violent incidents.
  - Continually incorporate personal health and wellness strategies that will minimize workplace stressors.
  - Provide and be open to receiving constructive, timely, and respectful feedback from colleagues, healthcare consumers, family members, and other relevant stakeholders.

American Nurses Association (2015)

American Nurses Association

- Secondary Prevention Strategies:
  - Participate in implementation of comprehensive WPV program.
  - Use crisis intervention and management strategies to assess, plan, and intervene in order to reduce the potential of WPV.
  - Use existing administrative controls.
  - Use existing environmental controls (visitor access, panic buttons, etc.)
  - Use the approved reporting system.
  - Report concerns about weaknesses in the system in order to improve processes and communication.

American Nurses Association (2015)

American Nurses Association

- Tertiary Prevention Strategies:
  - Engage in evaluation and continued improvement of the WPV prevention program.
  - Participate, as appropriate, in post-incident meetings.
  - Use counseling programs after an incident of WPV.
  - Refer bystanders, surviving colleagues, and family members to grief and bereavement counseling or other appropriate health services following the injury, death, murder, or suicide of an employee or patient.
  - Express sympathy and provide support to bystanders and survivors after a colleague or patient is injured or dies during a violent workplace incident.

American Nurses Association (2015)

Emergency Nurses Association

- Developed a *Position Statement* for violence in the emergency care setting in 2014
- Incidence of WPV is 3.8 times higher in the healthcare industry than in the private industry.
- The ED is a highly vulnerable area for WPV.
- Acts of violence can cause physical and/or emotional harm to emergency nurses as well as the patients for whom they provide care.
- ED nurses often do not report WPV because "they did not sustain and injury", and "it's part of the job".

Emergency Nurses Association (2014)

Emergency Nurses Association

- ENA Position:
  - Emergency nurses are at significant occupational risk for WPV.
  - The mitigation of WPV requires a "zero tolerance" environment instituted and supported by hospital leadership.
  - Emergency nurses have the right to personal safety in the work environment.
  - Emergency nurses have the right to education and training related to the recognition, management, and mitigation of WPV.
  - Emergency nurses have the right and responsibility to report incidents of violence and abuse to their employer and law enforcement without reprisal.

Emergency Nurses Association (2014)

Emergency Nurses Association

- ENA Position cont.
  - Emergency nurses have the right to expectations of privacy, appropriate injury care, and the option for debriefing and professional counseling.
  - Protection against acts of violence include effective administrative, environmental, and security components.
  - State legislation in support of emergency nurses who have experienced WPV may lead to more effective WPV programs.
  - Emergency nurses have a vested interest in and a responsibility to conduct and participate in research and quality improvement initiatives aimed at preventing, mitigating, and reporting WPV.

Emergency Nurses Association (2014)

Emergency Nurses Association

- ENA has a WPV Toolkit available on their website www.ena.org
- Developed Guiding Principles in collaboration with the American Organization of Nurse Executives (AONE) in 2015 to help hospital leaders develop policies and procedures to systematically reduce violence in the workplace.

Emergency Nurses Association (2014); Lenaghan et al. (2018)

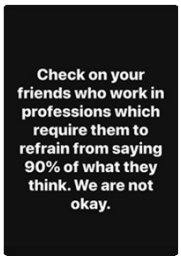
Occupational Safety and Health Administration

- Published *Guidelines* for preventing WPV for healthcare and social service workers in 2015
- Media attention seems to focus on reports of workplace homicides, yet the vast majority of WPV incidents result in non-fatal, yet serious injuries.
- WPV is underreported.
- Highest risks for WPV in healthcare:
  - Inpatient and acute psychiatric settings
  - Geriatric LTC settings
  - High volume urban EDs

OSHA (2015)

Occupational Safety and Health Administration

- Factors that can cause agitation and violent behaviors:
  - Pain
  - Devastating prognoses
  - Unfamiliar surroundings
  - Mind and mood altering medications and drugs
  - Disease progression



OSHA (2015)

National Safety Council

- Every year, 2 million American workers report having been victims of WPV.
- WPV is the third leading cause of death for healthcare workers.
- Every organization needs to address workplace violence through development of a policy that includes:
  - Employee training
  - Creating an emergency action plan
  - Conducting mock training exercises with local law enforcement
  - Adopting a zero tolerance policy toward WPV

NSC (2019)

National Institute for Occupational Safety and Health

- Offers a free course on WPV prevention for nurses with FREE CE's!
- The risk for fatal violence is greater for workers in sales, protective services, and transportation.
- The risk for nonfatal violence resulting in days away from work is greatest for healthcare and social assistance workers.
- The ED and inpatient psych settings have the most recorded incidents of WPV.

NIOSH (2018a); TJC (2018)

National Institute for Occupational Safety and Health

- Categorizes WPV into 4 categories:
  - Type I: Criminal Intent
    - Perpetrator has no legitimate relationship to the business or its employees, and is usually committing a crime in conjunction with the violence (robbery, shoplifting, etc.)
  - Type II: Customer/Client
    - Referred to as client-on-worker violence. Includes patients, family members, and/or visitors.
  - Type III: Worker-on-Worker
    - Includes bullying, and frequently manifests as verbal and emotional abuse that is unfair, offensive, vindictive, and/or humiliating and can range all the way to homicide.
  - Type IV: Personal Relationship
    - Perpetrator has a relationship to the healthcare provider outside of work that spills over to the work environment.

CDC (2013)

So I Think We Can All Agree Here…

- WPV is a growing problem
- WPV is grossly underreported for various reasons
- EDs should have written protocols regarding WPV (prevention, intervention, and follow-up) and provide a means for and encourage reporting it
- ED staff should be trained in early recognition of violent behavior, de-escalation and self-defense techniques
- Hospitals should adopt a zero tolerance policy for WPV
- Hospitals should provide appropriate post-incident support for employees involved in WPV

Risk Factors for WPV: Clinical

- Under the influence of alcohol and/or drugs
- Cognitive impairment
- In pain
- History of violence
- In the criminal justice system
- Certain psychiatric diagnoses and/or medical diagnoses
- Angry about clinical relationships (feel out of control)

CDC (2013)

Risk Factors for WPV: Environment

- Opportunities to gain access or avoid detection; unmonitored entries or stairwells, insufficient lighting, blind corners, unsecured rooms or closets
- Increased stress; poor weather conditions, insufficient heat or air conditioning, signage that is confusing, difficulty parking or accessing a building, disturbing noise levels
- Opportunities that could be used as weapons; fixtures, decorative items, unsecured furniture, office or medical supplies
- Limitation of staff's ability to appropriately respond to violent incidents; lack of security systems, alarms, or devices

CDC (2013)

Risk Factors for WPV: Organizational

- Staff shortages
- Absence of strong WPV prevention programs
- Inadequate staff training and preparedness
- Nonexistent or weak policies for reporting and managing WPV
- Careless attitudes toward WPV prevention

CDC (2013)

Risk Factors for WPV: Socioeconomic

- Socially disorganized neighborhoods
- Social and cultural norms that encourage violence
- High concentrations of poverty
- High levels of family disruption
- Low community participation

CDC (2013)

Risk Factors for WPV: Worker-on-Worker

- Behaviors in co-workers that might signal future violence:
  - Excessive use of alcohol or drugs
  - Unexplained absenteeism, change in behavior, or decline in job performance
  - Depression, withdrawal, or suicidal comments
  - Resistance to changes at work or persistent complaining about unfair treatment
  - Violation of company policies
  - Emotional responses to criticism, mood swings
  - Paranoia

NSC (2019)

Prevention Strategies: Organizational

- Building blocks for developing an effective WPV prevention program include:
  - Management commitment and employee participation
  - Worksite analysis
  - Hazard prevention and control
  - Safety and health training
  - Recordkeeping and program evaluation

OSHA (2015)

Prevention Strategies: Nurses

- Become familiar with your organization's WPV prevention program and policies.
- Attend personal safety training programs offered by the organization.
- Participate in safety and health committees as well as security committees.
- Alert supervisors to any concerns and report all incidents asap through recognized reporting procedures.

CDC (2013)

Prevention Strategies: Nurses

- Dress for safety:
  - Tuck away long hair
  - Avoid any jewelry that can be pulled
  - Clothing not overly loose or tight
  - Use breakaway safety cords or lanyards for glasses, keys, or nametags
- Be alert to your environment:
  - Note exits and emergency phone numbers
  - Be aware of confusion, background noises, and crowding
  - Increased disruptive behaviors occur most often during meal times, shift change, and while transporting patients

CDC (2013)

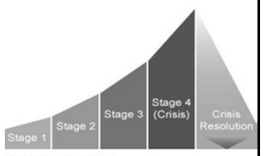
Prevention Strategies: Nurses

- Be aware of cues of possible violence (verbal and non-verbal):
  - Speaking loudly or yelling, threatening tone of voice
  - Swearing
  - Clenched fists
  - Arms held tight across chest
  - Pacing or agitation, heavy breathing
  - Anxious look
  - A fixed stare, sudden changes in behavior
  - Throwing objects
  - Aggressive or threatening posture
  - Indications of inebriation or substance abuse

CDC (2013)

Intervention Strategies

- Crisis Development Stages:
  - Stage I: Normal stress and anxiety level- minor annoyances and frustrations of everyday life. Rational and in control of emotions and behavior.
  - Stage II: Rising anxiety level- heightened condition- rapid HR and RR, lost, confused, accelerated speech patterns, high-pitched voice, nervous habits.
  - Stage III: Severe stress and anxiety- diminished reasoning, fixed on the present. Boisterous or disruptive behavior. Yelling, verbal threats, pacing, clenched fists.
  - Stage IV: Crisis- unbearable anxiety with loss of cognitive, emotional, and behavioral control. Urgent need to end emotional pain. Unable to solve problems or process information rationally without help. Erratic and unpredictable behavior.



The Crisis Continuum
The final stage depicts the ideal positive "resolution" of crisis and avoiding negative resolution.

CDC (2013)

Early and Middle Stage Intervention Strategies

- Verbal Skills:
  - Allow the person to express concern
  - Use a shared problem solving approach
  - Avoid being defensive or contradictory
  - Apologize if appropriate
  - Follow through with their problem
  - Avoid blaming others

CDC (2013)

Early and Middle Stage Intervention Strategies

- Non-Verbal Skills:
  - Be calm (or at least act calm)
  - Keep hands open and visible
  - Actively listen
  - Respect personal space
  - Approach the patient from an angle or from the side
  - Demonstrate confidence in your ability to resolve the situation
  - Demonstrate supportive body language
  - Avoid laughing or smiling inappropriately

CDC (2013)

Crisis Prevention Institute Top 10 De-Escalation Tips

- Be empathetic and non-judgmental
- Respect personal space
- Use nonthreatening nonverbals
- Avoid overreacting
- Focus on feelings
- Ignore challenging questions
- Set limits
- Choose wisely what you insist upon
- Allow silence for reflection
- Allow time for decisions

CPI (2016)

Late Stage Intervention Strategies

- Previous interventions plus:
  - Enlist help of security or colleagues
  - Be prepared to use your panic device
  - Physically remove yourself if necessary
  - Position yourself to exit easily
  - Remove other patients or visitors from the room
- Setting limits
  - Use a command form to express the desired behavior
  - Provide a logical and enforceable consequence for non-compliance

CDC (2013)

Consequences of WPV

- Low morale and productivity
- Increased medication errors
- Loss of team cohesiveness
- Absenteeism
- Family turmoil
- Turnover
- Anxiety/Depression
- Substance abuse
- Retaliatory violence
- Chronic illness
- Suicide
- Burnout

CDC (2013)

Post-Event Response for the Nurse

- File an incident report and willingly participate in employer investigative actions.
- Report any injuries (physical or emotional) through appropriate channels.
- Seek counseling when appropriate.
- Learn about and utilize support resources offered by the employer.
- Work with criminal justice authorities if legal action is called for.

CDC (2013)

Any Questions??

For a full list of references (or if you just want to send me funny memes), please e-mail me at Nycole.Oliver@yahoo.com
(479) 414-9410