

UC San Diego

UC San Diego Previously Published Works

Title

Patient Violence: Providing More than Duck and Cover Training to Protect Employees

Permalink

<https://escholarship.org/uc/item/8m12172x>

ISBN

9783031169823

Authors

Jenkins, Danisha

Lauzon, Vanessa

Publication Date

2023

DOI

10.1007/978-3-031-16983-0_17

Peer reviewed



Patient Violence: Providing More than Duck and Cover Training to Protect Employees

17

Danisha Jenkins and Vanessa Lauzon

Abbreviations

HCW Healthcare worker
WPV Workplace violence

Learning Objectives

1. The reader will identify the ways in which trauma-informed communication is necessary for safety.
2. The reader will identify the importance of addressing the pathology in preventing aggressive behavior
3. The leader will identify structural and societal contributors to violence in the workplace.

17.1 Presentation of the Science

Healthcare workers, particularly those working in acute care settings, are the most vulnerable professionals to workplace violence [1]. While violence in the workplace may be experienced in many forms, such as lateral violence and bullying; for the purposes of this chapter, we define workplace violence (WPV) as any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site, and may include threats and verbal abuse to

D. Jenkins (✉)
University of California, Irvine, CA, USA
e-mail: danishj@uci.edu

V. Lauzon
Department of Psychiatry, University of California, San Diego, San Diego, CA, USA

physical assaults and homicide [2]. Meta-analysis of rates of workplace violence demonstrates 61.9% of HCW reported exposure to any form of WPV, 42.5% reported exposure to nonphysical violence, and 24.4% reported experiencing physical violence in the past year. Verbal abuse is the most common form of nonphysical violence, followed by threats and sexual harassment [3]. Across occupations, studies have demonstrated that nurses have the highest exposure to any form of WPV, followed by physicians and other healthcare professionals [3]. It is important to note that this data is frequently based on reported incidences of WPV, and both under-reporting and lack of processes for reporting WPV are both prevalent barriers to fully understanding the extent of this phenomenon [4]. Significant physical violence is experienced most frequently in emergency and psychiatric departments, and the sequelae to healthcare workers is profound, including anxiety, anger, depression; all of which present direct impacts to workforce retention and engagement [5].

The National Institute for Occupational Safety and Health (NIOSH) groups risk factors that lead to violence in healthcare are clinical (pain, fear, anger, altered mental status, history of violence, and the influence of drugs and alcohol), environmental (department layout and design), and organizational (understaffing, long work shifts, inadequate security procedures and protocols, discouragement to report and difficulty in reporting violent incidents, acceptance by management and staff that violence is “part of the job,” and lack of staff training and preparedness) [6]. Despite the known complexities of socioecological and environmental conditions leading to WPV, training, if provided at all, often heavily prioritizes self-defense training, placing the onus on an individual to be able to physically protect themselves in the face of physical violence. While such training has shown value in the imminent response to physical harm [7], in this chapter, we attempt to shift the focus to the *upstream* contributors to workplace violence, to move beyond duck-and-cover toward resources, and processes that humanize both healthcare workers and patients in the prevention of violence in the workplace occurring at all.

17.2 Application of Principles into Wellness Practice

17.2.1 Pre-licensure Application in the Academic Environment

In the pre-licensure environment, it is critical that burgeoning healthcare workers are enculturated through education to understand that violence in the workplace should never be accepted as “part of the job.” It is the responsibility of the individual, the community, and the institution to protect healthcare workers and patients. Assure that students are educated to the multitude of evidence-based interventions proven to reduce risk of workplace violence in the care setting and are prepared to assess and advocate for including early identification of prodromal symptoms, environmental safety considerations, de-escalation techniques, and trauma-informed communication. Pre-licensure curricula must aide in fostering foundational understanding of not only disease processes but also the structural violence that potentiates such risk factors for agitated and potentially violent behavior including unaddressed pain, substance dependence, mental illness, and racism. Introduce

students early to the appropriate use and the dangers of restraint utilization, and an early emphasis on respect for autonomy and trauma-informed communication are essential.

17.2.2 Clinical Application Post-licensure

In exploring the causes of agitated and potentially violent behavior, be curious about the underlying etiology. All behavior is a form of communication, and healthcare workers must ask “what is being communicated?” Focus on identifying the behaviors, and refrain from clouding one’s assessment with judgements of motives, character, or morality. Critical for safety is the simultaneous setting of appropriate and clear limits regarding behavior and enforcing safety mechanisms.

There are a multitude of clinical issues that may underlie aggressive behavior, including traumatic brain injuries, strokes, neurodegenerative disorders, seizures, and central nervous system infections, hypoxic injury, and cognitive impairment and disability. Medical and nursing assessment may inform considerations regarding patient’s level of legal responsibility for behavior, including awareness of right and wrong, appreciation of consequences, and the ability to regulate behavior accordingly. Assessing a patient’s cognitive capacity, or ability to understand their own current behaviors and potential consequences to those behaviors, is a necessary and often overlooked step in developing an interdisciplinary safety and care plan. Psychiatric issues, substance intoxication and withdrawal, history of psychological trauma, and maladaptive responses to stress may also potentiate violent behavior, and few of these etiologies can successfully be managed in the same way. However, setting clear limits, redirecting in developmentally and clinically appropriate ways, consistency across time and team members, and leadership support for front-line clinicians is universally critical in managing agitation and preventing violence and injury.

To illustrate the importance of patient and pathology specific interventions, the following two examples are of patients who hit and scratch when being touched:

Case 1: A patient with hepatic encephalopathy hits and scratches the nurse when touched. The patient is being treated with lactulose. They are intermittently alert, extremely agitated upon arousal, and not oriented to person, place, or time.

Case 2: A patient with an acute traumatic frontal lobe injury hits and scratches the nurse when touched. The patient is alert, oriented to self, and intermittently oriented to place, and is extremely agitated and impulsive upon arousal.

In both cases, the healthcare worker can employ similar tactics to reduce agitation, potential injury, and harm such as clustering care to reduce interruptions in rest, maintaining distance if needing to wake the patient up, setting boundaries, and eliciting permission before touching. In the first case, however, given the patient’s orientation status, it is unlikely that the patient has the cognitive capacity to consider

consequences of actions, and will be unable to engage in providing consent. Addressing the pathology is imminently critical, and lowering the ammonia levels and aggressively managing hyponatremia are necessary to manage aggression. In this case it will be important that the healthcare worker not be alone providing care during periods of high agitation, and to create a coordinated plan to provide for safety (e.g., considering the use of mittens) prior to further care. A thoughtful plan shared with all those who have direct contact with the patient can prevent injury when engaging in activities such as waking the patient to provide necessary care or perform assessments.

For the second case, it will be especially important to keep the patient surroundings clear of objects that can be thrown, as the HCW knows that the highest risk period of agitation and impulsive behavior is immediately upon awakening. Additionally, this patient is somewhat oriented, so it will likely be valuable for the HCW to reorient the patient, explain what the HCW is there to accomplish, and elicit permission before approaching the bed. This might sound like “Hi Steve, I am your nurse Ray, and you are in the hospital right now. Can you tell me where you are right now?” After validating that the patient is oriented to the place, the nurse can continue, “It is time for me to take your blood pressure, may I come close to your bed and touch your arm? When I come close to you, I need to make sure we are both safe, can you please tell me that you are not going to hit or scratch me?” If the patient exhibits agitation, or threatens to hurt the HCW, do not approach the bedside at that time.

These examples illustrate just some of the ways in which managing behavior requires addressing the pathology. There is unlikely to be one clinical pathway or predetermined set of resources and interventions that will meet the needs of the patient, or the safety of the care team.

17.2.3 Respect for Personhood

Respect for autonomy and trauma-informed approaches are underutilized, and yet powerful tools. Simple processes such as eliciting permission before touching, explaining roles, explaining what will happen before doing it, giving choices, being consistent, and respecting personhood are essential. Healthcare workers must have a strong understanding of the high prevalence of trauma, especially for patients that live in intentionally marginalized communities. There are many experiences in the healthcare setting that can be re-traumatizing, and these experiences will impact how a person responds to healthcare interventions. Frequently throughout the course of healthcare interventions and services, patients will experience a lack of control, vulnerability, feeling frightened, or ashamed. These experiences are key triggers to re-traumatization and may elicit a self-defense response that can be dangerous for healthcare workers and the patient alike. Providing for safety, establishing trust, offering choice, preserving autonomy and dignity, and empowering patients to decide what is best for them are critical trauma-informed approaches, and must be preserved despite perceived inconveniences or individual clinicians’ perceptions of

what is best. Healthcare workers must work diligently to create an experience in which the patient makes their own choices, feels safe, and understood. In participating in trauma-informed approaches, we must acknowledge that healthcare institutions are historically very unsafe and traumatizing environments for many patients, particularly Black, Indigenous, persons of color, and people living with physical and mental disabilities. Historical and current data demonstrates that the feelings of mistrust and corresponding need to defend oneself is often a matter of survival, particularly in a hospital. Acknowledging and understanding such realities create space for empathy and open the door for working toward an authentic human connection. Such connections may lay a framework for trust and safety for patient and healthcare worker alike.

Healthcare workers caring for patient populations that are at high risk of agitated behavior, and therefore violence, face challenges. Such environments often include trauma departments, acute drug and alcohol detoxification units, and psychiatric intensive care units. In such departments, it is especially critical that healthcare workers identify and advocate for the resources needed to safely provide ethical and complete care. Additionally, HCWs frequently working in these settings must set boundaries for care for themselves including taking time off, advocating for rotating patient assignments when appropriate, and utilizing employee assistance programs (EAP) consistently. Many “evidence-based” policies and guidelines are not created to support the HCW in engaging in truly patient-centered care that offers autonomy, and the rigidity of hospital schedules and protocols may lead to increased frustration.

HCW’s must collaborate to meet the patient’s needs in ways that prioritize patient and HCW safety, even when this may not be the most productive or protocolized method of providing care. To help illustrate this recommendation, a case study will be discussed:

A patient who suffered a severe traumatic brain injury after their camp site was hit by an intoxicated driver. The patient had been unhoused for over a decade, and was accustomed to sleeping on the ground. Due to a combination of the brain injury and underlying psychiatric illness, the patient often moved very slowly, and would not take medication until all of their food was eaten, and their “camp” was organized, which would often take over an hour. The nurses would often attempt to pull the patient up off the floor. They were concerned the floor was dirty and would cause pressure injury, that the behavior disruptive the unit, and that they did not have time to wait an hour for every morning med pass. When being forcefully removed from the ground, the patient would become extremely combative, leading to security being called, four-point restraints being placed, and chemical sedation administered. The chemical sedation would render the patient unable to participate in therapies, increased delirium, and prolonged periods restrained.

When debriefing with the team after both a nurse and the patient were injured, the team discussed the top priority, which was to provide for safety. When asking the nurses what being safe looked like, they said not being hit when trying to provide care, and they requested security presence on the floor. When asking the patient what safety looked like, they stated, “Why can’t I be on the floor? Leave my stuff alone and let me eat my food in peace!” Collectively, the team devised a plan to

meet the needs of the patient and the nurses, although it required some additional resources and operated outside of the usual confines of the standard protocols. Safety for the patient first meant having their environment arranged in a certain way. The nurses obtained a floor mattress for the patient, and removed the bed. The psychiatrist evaluated the patient's medications, and made adjustments secondary to the agitation and impulsive behavior that was exhibited. Physical and occupational therapy set their schedules to see the patient during the hour every morning when the patient insisted on organizing the "camp." The patient was incentivized with ice cream outside in the wheelchair after medications were taken. While the new plan was being trialed, security maintained a presence outside of the patient's room, but by the end of the first day, the nurses stated that they did not need security any longer. Although there continued to be challenging moments, after the implementation of the patient-centered plan, there was not another instance in which security had to be called, and there was no further injury.

17.3 Leadership Application

The Joint Commission (TJC) mandates healthcare organizations to both assess for and address violence [8]. Despite regulatory standards, there is a continued lack of attention to facility and department-specific risk assessment and policies [7]. Although TJC specifically requires training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents [8], leaders must diligently strive to develop and provide systems, processes, and resources that prevent workplace violence. Leaders must recognize the significant challenges that clinical staff face in caring for communities in which trauma, untreated mental illness, substance dependence, and violence has become increasingly common. In many locations, healthcare workers are in danger when caring for their patients. It is not reasonable to expect that support for clinicians, including the provision of resources, would look the same as what was required even just five years ago. Leaders must provide for adequate education, specialists, and human and material resources with the understanding that different situations require different experts and interventions. In conducting annual assessments of workplace violence events, leaders must identify areas of high risk of violence, and collaborate with the caregivers in identifying what safety provisions are necessary. It is unlikely that online learning modules are sufficient, and interdisciplinary subject matter experts must be involved in designing structures and processes that account for the patient population, knowledge, and experience of the HCWs, and environmental limitations.

When WPV occurs, leaders must also engage in trauma-informed approaches to address the issue. It is never a HCW's fault that they were assaulted, and any such incident must be viewed as a systems failure. In response to a WPV event, providing for both physical and psychological safety for the victim must be the first priority, as well as implementing immediate measures to prevent further harm. Offer the employee access to psychological and medical support services, as well as time off

from work. Conduct an interdisciplinary briefing with every major incident of WPV, and prioritize providing authentic support for the HCW's who are tasked to navigate providing care to a person that presents a credible risk to their physical safety. Actively empower all members of the team to express concerns, identify problems, identify early warning signs, and collaborate expeditiously to address these issues.

Many incidences of WPV could have been prevented had the appropriate resources been provided and utilized. Too often, leaders engage in addressing workplace violence only after a series of major incidences have occurred. Equitable and proactive attention must be given to all of the NIOSH domains of risk factors for workplace violence, and leaders must move beyond “duck and cover” training for these high-risk staff. Addressing the clinical risk factors requires investing in appropriate screening tools, clinical experts such as psychiatry and chemical dependence specialists, and establishing community resources to implement upstream interventions to prevent acute hospital admissions. Addressing organizational contributors requires repairing staffing models that pervasively leave departments understaffed and unable to meet the needs of the patients, and radically changing the idea and messaging that violence is an expected part of the job. Environmental modifications may be required, including reducing noise and overcrowding, as well as designing safe spaces for HCWs. Lastly, staff training must be robust and appropriate for the specific needs of the work that a HCW is performing. There is WPV prevention training that everyone in healthcare needs; however, a healthcare professional working in a trauma unit will need specialized training in the understanding and treating the behaviors of a patient with a frontal lobe versus occipital lobe injury, whereas a neurology healthcare professional may need additional treatment in post-epileptic safety. The resounding message is that the required tools to prevent WPV are as individualized and complex as the patients themselves. The time, space, and resources must be allotted to create a care delivery environment and processes that meets the needs of the patients and the HCWs doing the work.

17.4 Opportunities for Future Research

Many healthcare institutions have implemented training for HCWs in *response* to workplace violence, but the impact of these training programs on *preventing* workplace violence is unclear. There is little research on the impact of upstream, or preventative interventions on workplace violence in healthcare. The HCW in direct contact with the patient, particularly those in acute care where a patient is likely in crisis, is at the end of a long line of opportunity for intervention and prevention. There is an opportunity to study how community substance abuse and mental health services, housing support, economic equity, and mutual aid impact the rates and severity of violence in the workplace. Until the healthcare system and society addresses structural inequities and the dearth of public and community health resources, the institution is responsible for the provision of enhanced resources to mitigate, prevent, manage, respond to, and recover from violence in the workplace.

References

1. Mento C, Silvestri MC, Bruno A, Muscatello MRA, Cedro C, Pandolfo G, Zoccali RA. Workplace violence against healthcare professionals: a systematic review. *Aggress Violent Behav.* 2020;51:101381. <https://doi.org/10.1016/j.avb.2020.101381>.
2. OSHA. Guidelines to preventing workplace violence for healthcare and social service workers. (OSHA 3148-06R 2016). Washington, DC: Occupational Safety and Health Administration; 2015. <https://www.osha.gov/sites/default/files/publications/osha3148.pdf>.
3. Liu J, Gan Y, Jiang H, Li L, Dwyer R, Kai L, Yan S, Sampson O, Hongbin X, Wang C, Zhu Y, Chang Y, Yang Y, Yang T, Chen Y, Song F, Zuxun L. Prevalence of workplace violence against healthcare workers: a systematic review and meta-analysis. *Occup Environ Med.* 2019;76(12):927–37. <https://doi.org/10.1136/oemed-2019-105849>.
4. Copeland D, Henry M. Workplace violence and perceptions of safety among emergency department staff members: experiences, expectations, tolerance, reporting, and recommendations. *J Trauma Nurs.* 2017;24(2):65–77. https://journals.lww.com/journaloftraumanursing/Fulltext/2017/03000/Workplace_Violence_and_Perceptions_of_Safety_Among.3.aspx.
5. Rosenthal LJ, Byerly A, Taylor AD, Martinovich Z. Impact and prevalence of physical and verbal violence toward healthcare workers. *Psychosomatics.* 2018;59(6):584–90. <https://doi.org/10.1016/j.psych.2018.04.007>.
6. NIOSH. Workplace violence prevention for nurses. Washington, DC: The National Institute for Occupational Safety and Health; 2013.
7. Arbury S, Hodgson M, Zankowski D, Lipscomb J. Workplace violence training programs for health care workers: an analysis of program elements. *Workplace Health Saf.* 2017;65(6):266–72. <https://doi.org/10.1177/2165079916671534>.
8. The Joint Commission. 2021. https://www.jointcommission.org/-/media/tjc/documents/resources/workplace-violence/ts_10_2021_preventing-workplace-violence.pdf.