Type II Workplace Violence in an Urban Acute Hospital:

How Do We Know If We're Creating a Safer Environment for Patients and Staff?

by M. L. Feodora Jacobsen

About the Author

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"Nurses are three times more likely to be the victims of violence than any other professional group" (Keely, 2002). This is the reason for bringing *Nonviolent Crisis Intervention*® training to California Pacific Medical Center (CPMC). Type II workplace violence (NIOSH, 2006), where the victim is a provider and the patient is the perpetrator, is an issue for all acute hospitals and is increasing (Privitera, 2011) as hospital stays decrease in length and patient acuity increases in strength.

In 2008, CPMC had several different staff training models that focused on de-escalation skills and nonviolent self-defense in the three most at-risk departments: the emergency department, the psychiatry department, and the security department. None of the trainings were open to other departments. It was time to bring a common language for workplace violence prevention to these departments and offer it to all hospital employees.

The first step was to study the different staff training models. The author of this article became certified in several models and selected the *Nonviolent Crisis Intervention*® program from CPI as the gold standard. The *Nonviolent Crisis Intervention*® program was chosen because it had been taught to millions of health care professionals, it exceeded regulatory standards, it had high recognition, and the model was grounded in research. A staff training trial was completed in 2009. Three trainings were offered, and fifty employees attended. The class evaluations were high scoring and the comments from employees indicated that the model was easily understood, provided better structure for learning theory and application than previous trainings, increased staff engagement, increased staff confidence in being able to prevent patients from escalating, and helped staff feel that they could protect themselves.

In 2010, the focus was to secure funding. Initially, a grant for US $30,000 from the CPMC foundation philanthropic board fund with a matching allocation from other departments (risk management, security, environment of care, workers' compensation, engineering, emergency department, psychiatry department, residency training program, and outcomes management) provided the financial means to bring a *Nonviolent Crisis Intervention*® train-the-trainer program to CPMC. Employees from diverse departments and disciplines completed the *Nonviolent Crisis Intervention*® Certified Instructor

training, and the program was officially kicked off. It was mandated for the three high-risk departments and was made available to all CPMC employees.

From 2009 to the present, there have been over 600 participants in training (some employees count more than once, as they completed training more than once). The department of psychiatry and security reached 100% compliance and the emergency room reached a very high level of compliance in the first year.

One of the challenges to keeping the *Nonviolent Crisis Intervention*® program was the cost of training the trainers, the cost of workbooks, and the cost of paying mandated employees. The larger health care network that CPMC is associated with had a free program that took half as long to deliver to employees.

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In spite of this, CPMC leadership supported the CPI model as the gold standard and dedicated annual funding for the program. Other challenges for the program included physician involvement, measuring training effects on individual employee effectiveness, and measuring the overall decrease in type II violence.

Measuring outcomes is very difficult in this area. It is well known that events are underreported. About one in five violent events are reported in psychiatry (Mayhew, 2000). Furthermore, there are no consistent definitions of violence that capture the continuum of severity and consequences (APNA, 2008). Most of the data available comes from workplace injury reports in hospitals. It does not include "incident reports" that go to the risk management department, and it does not include the emotional and psychological impact of violence on the staff victims or staff witnesses, or it comes from journal articles with data from staff surveys. Another factor in the challenge is that organizations often have institutional denial; they ignore the risk of type II violence; they are afraid to acknowledge it because they do not know how to fix it; or they do not want to make the risks known to the employees or the general public. On a larger level, the lack of mandates also contributes to the systemic issues that perpetuate the risks of violence (Privitera, 2011).

Although comprehensive, reliable, and valid measures for workplace violence prevalence are not easily obtained, improvement in other outcomes can indicate a decrease in workplace violence risk. These outcomes can include staff satisfaction scores, patient satisfaction scores, seclusion rates, and restraint rates. Positive changes in these areas can indicate an overall decreased risk for type II violence. Satisfied staff members provide better care for their patients. When the nursing staff builds a culture of structure, calmness, negotiation, and collaboration rather than control, patient aggression decreases (Cahill, Stuart, Laraia, & Arana, 1991) (Delaney, 1994) (Harris & Morrison, 1995) (Johnson &

Table 1: Patient Satisfaction Annual Weighted Rank Percentile Score in the Department of Psychiatry Inpatient Unit

	2009	2010	2011
Completed surveys	169	194	210
Percentage of discharges	29%	34%	36%
Overall score	20th	38th	83rd
Nursing section score	29th	49th	79th
Degree patient felt safe	17.5	28.9	72.4

Table 2: Seclusion and Restraint Rates in Hours per Thousand Patient Days

	2009	2010	2011
Seclusion	10.4	3.9	3.4
Restraints	2	2	0.85

Table 3: Type II Assault Rates in Hours per Thousand Patient Days

	2009	2010	2011
Type II assaults	2.4	1.5	1.9

Morrison, 1993) (Whittington & Patterson, 1996). When aggression decreases, use of restraint and seclusion decreases and incidents of assault decrease. Restraints and seclusion are safety interventions, but generally are not therapeutic interventions. Forced containment can re-traumatize patients who are highly likely to have a trauma history (Wale, Belkin, & Moon, 2011). Ironically, using restraints and seclusion for safety sharply increases the risk of injury to the patient and the staff member during the initial physical contact between them (Wale, Belkin, & Moon, 2011). Reducing seclusion or restraints creates a more therapeutic milieu and decreases workplace violence for nurses in two ways. First, the patient is calmer and less aggressive, and second, the nurse will not have to apply restrictive hands-on measures.

CPMC uses the Press Ganey survey to measure patient satisfaction. The survey contains 48 questions, including questions about the patient's perception of safety, being treated with dignity, and being treated with respect. Patient satisfaction in the department of psychiatry inpatient unit since 2009, listed in Table 1, shows dramatic improvement since the CPI model was instituted. The percentile rank scores are the comparison to 959 other psychiatric units nationwide.

The use of seclusion and restraints has also decreased during the same time period, as summarized in Table 2.

The rate for assaults is harder to capture due to lack of a severity index, underreporting, and changes in reporting. Sometimes an increase in incidence is due to better reporting. We only recently started to track staff injuries due to physical contact between a staff member and a patient when the act of a patient is assumed to be unintentional. This is consistent with the suggested subtypes outlined by Copeland in an unpublished 2007 manuscript (as cited by APNA, 2008) and listed as "unwanted physical contact by a patient whether or not there is intent to harm." It is better to include all such contacts in rate measurement because assessing "intent" is highly subjective, and it is better to have all the incidents captured. It is still important to ask the victims about their subjective perceptions of patient intent because this does affect victims' responses; if nurses feel patients' behavior is due to psychosis or dementia, they tend to do better than if they feel that the patients have specific intent to harm. The rates in Table 3 are in one thousand patient days due to convenience; a better rate would be per employee full time equivalent (FTE).

In 2009, the inpatient psychiatric unit had several incidents with a patient grabbing or hitting a staff member with mild to moderate force, resulting in pain that resolved

quickly. The staff did not seek medical assessment and did not require treatment. However, there were several incidents that included high levels of force from patients who knew right from wrong—incidents that resulted in injuries (e.g., a broken nose). During these incidents, the patients were taken into police custody and then taken to a psychiatric jail unit. In 2010, there was a similar pattern of assaults but a decrease in the number of patients who know right from wrong, and only one patient went into police custody. In 2011, all the incidents were of mild to moderate force, and the staff did not seek treatment. It seems that the severity is decreasing, but the nature of the data has changed over the time it was collected. We now encourage staff to seek medical assessment even if they feel that contact resulting in a mild injury is "not a big deal." We are also collecting more information, including:

1. Details of the physical contact.
2. Pain scale and duration.
3. Whether the employee sought injury assessment and treatment.
4. Physical injury type and duration.
5. Emotional/psychological/spiritual impact.
6. Time off work.
7. Patient factors: severity of illness, patient symptoms, perception of patient's intention, patient's insight and judgment, Precipitating Factors, does patient know right from wrong.

8. Patient's treatment: what level of containment was needed for patient de-escalation: distraction, discussion, medication, seclusion/restraint, security assist.
9. Legal consequences for the patient.
10. Risk management involvement.
11. Impact on other patients, visitors, and staff.
12. Any other factors that indicate the severity of the event.

Introducing the *Nonviolent Crisis Intervention*® program as the staff training model was not the only measure we took to increase patient and staff safety. In late 2008, we closed one of two units which were staffed with RNs, LPTs, LVNs, and CNAs. Many studies support that the ratio of RNs to other ancillary staff is directly related to patient outcomes (APNA 2008); in light of this, we replaced the LPTs and LVNs with RNs. We increased our observation levels of the patients by adding CCTV equipment that includes a display monitor in the nursing station as well as in the security department. The CCTV monitors the common patient areas. We increased rounding on all patients and the unit to every 15 minutes at all times. We also replaced our inadequate "screecher" personal alarms (which just made a lot of noise) with voice-operated badges that are linked to security and have an emergency broadcast function to summon all staff for assistance.

Our purpose in bringing the *Nonviolent Crisis Intervention*® program to CPMC was to increase safety for nurses and patients. We have a clear and sustained three-year trend in improving patient satisfaction and decreasing seclusion. Both outcomes indicate a safer patient care environment.

Employees also report a subjective sense that the severity of type II assaults has decreased. Going forward, we will continue to pursue an improved understanding of how

to measure type II violence—and, most importantly, how to prevent it. ■

References

American Psychiatric Nurses Association (APNA). (2008). *Workplace violence: APNA 2008 position statement.* Retrieved from apna.org/i4a/pages/index.cfm?pageid=3786

Cahill, C., Stuart, G., Laraia, M., & Arana, G. (1991). Inpatient management of violent behavior: Nursing Prevention and intervention. *Issues in Mental Health Nursing, 12*, 239–252.

Carmel, H., & Hunter, M. (1989). Staff injuries from inpatient violence. *Hospital and Community Psychiatry*, 41–46.

Delaney, K. (1994). Calming an escalated psychiatric milieu. *Journal of Child and Adolescent Psychiatric Nursing, 3*, 5–13.

Farell, G. (1999). Aggression in clinical settings: Nurses' views—a follow-up study. *Journal of Advanced Nursing,* 532–541.

Farrell, G., Bobrowski, C., & Bobrawski, P. (2006). Scoping workplace aggression: Findings from an Australian study. *Journal of Advanced Nursing*, 778–787.

Fernandez, C., Bouthillette, F., Rabound, J., Bullock, L., Moore, C., & Christianson, J. (1999). Violence in the emergency department: A survey of health care workers. *Journal of the Canadian Medical Association,* 1245–1248.

Fossett, B., Badker-Moodie, M., & Thobaben, M. (2004). *Psychiatric Principles and Applications for General Patient Care.* Western Schools.

Harris, D., & Morrison, E. (1995). Managing violence without coercion. *Archives of Psychiatric Nursing, 9,* 203–210.

Johnson, K., & Morrison, E. (1993). Control or negotiation: A health care challenge. *Nursing Administration Quarterly, 17,* 27–33.

Keely, B. R. (2002). Recognition and prevention of hospital violence. *Dimensions of Critical Care Nursing, 27* (1), 34–43.

Mahoney, B. (1991). The intent, nature, and response to victimization of emergency nurses in Pennsylvania. *Journal of Emergency Nursing,* 292–294.

Mayhew, C. (2000). *Preventing client initiated violence: A practical handbook.* Canberra, Australia: Australia Institute of Criminology.

National Institute for Occupational Safety and Health (NIOSH). (2006). *Workplace violence prevention strategies and research needs.* Retrieved from cdc.gov/niosh/2002-101.html

Peek-Asa, C., Allareddy, V., Valiante, D., Blando, J., O'Hagan, E., Bresnitz, E., et al. (1992–2001). *Work place violence and prevention in New Jersey hospitals emergency departments: Summary report on 50 New Jersey hospitals participating in the evaluation of California initiative to reduce violence against healthcare workers study.* Public Health Services Branch, Division of Epidemiology, Environmental and Occupational Health, Occupational Health Surveillance Program, funded by the National Institute for Occupational Safety and Health.

Privitera, M. R. (2011). *Workplace violence in mental and general healthcare settings.* London, United Kingdom: Jones and Bartlett Publishers.

Rippon, T. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing*, 457–460.

Runyan, C. (2001). Moving forward with research on the prevention of violence against workers. *American Journal of Prevention Medicine,* 169–72.

Wale, J. B., Belkin, G. S., & Moon, R. (2011). Reducing the use of seclusion and restraint in psychiatric emergency and adult inpatient services: Improving patient-centered care. *The Permanente Journal, 15*(2), 57–62.

Whittington, R., & Patterson, P. (1996). Verbal and non-verbal behavior immediately prior to aggression by mentally disordered people: Enhancing the assessment of risk. *Journal of Psychiatric and Mental Health Nursing, 3*(1), 47–54.

Whittington, R., & Whykes, J. (1989). Invisible injury. *Nursing Times,* 30–32.