**CPI *Unrestrained* Transcription**

Episode 53: Anna Dermenchyan

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Host: Terry Vittone

Terry: Hello and welcome to *Unrestrained*, a CPI podcast series. This is your host, Terry Vittone, and today, I'm joined by Anna Dermenchyan. Hello and welcome, Anna.

Anna: Thank you for having me.

Terry: You're welcome. Let me tell you a little bit about our guest. Anna Dermenchyan is a senior clinical quality specialist in the Department of Medicine at UCLA Health and a PhD student in the UCLA School of Nursing. She started her nursing career in the cardiothoracic ICU at the Ronald Reagan UCLA Medical Center, where she cared for the transplant and surgical patient population for five years. In her current role, Anna leads, facilitates, and implements improvement initiatives in the area of hospital readmissions, mortality reduction, and population health management.

Her professional interests include leadership, health care ethics and policy, quality and patient safety, critical care, work environments, and global health. Her passion for the profession and networking skills led her to establish the first hospital-based AACN—that's the American Association of Critical Care Nurses—chapter at UCLA in 2010 and she currently serves as the program chair. Today's interview will focus on a session Anna is giving at the upcoming AACN National Teaching Institute conference that's being held in Boston this May 21st to the 24th.

All right, Anna, let's begin. You're about to give a presentation on individual strategies to recognize and prevent workplace violence at the upcoming AACN nurses' NIT conference in Boston. And in your recent *Critical Care Nurse* article, "Addressing Workplace Violence," you cite some surprising statistics about the prevalence of patient-to-nurse violence. Could you share those with our listeners?

Anna: Unfortunately, workplace violence is all too common in health care settings. According to the Bureau of Labor Statistics, workers in health care and social assistant settings are five times more likely to be targets of non-fatal assault or violent acts than average workers and all other occupants. For example, there's 11,000 health care and social system workers that were victims of assault by another person in 2010. Now, when we look at nurses, American Nurses Association has surveyed nurses and found that 43% of registered nurses and nursing students have been verbally or physically threatened by a patient or a family member of a patient. Additionally, 24% have been physically assaulted by a patient or a family member of a patient while at work.

Other associations, like the American Nurses Association, surveys critical care nurses and again, their numbers are about the same. They find 50% to 60% have been verbally abused and 20% to 30% have been physically abused. There's a lot of hostility—and we will get into this later, about why this happens in health care settings. Certain environments like critical care units or emergency departments, psychiatric units, are at a higher risk of the nurses experiencing violence. In an emergency department, some nurses report that up to 55% of them have experienced some kind of physical or verbal violence—or both—which is very unfortunate. But this is the reality in many of the health care settings today.

Terry: So, patient-to-nurse violence is remarkably common. That seems to be the message.

Anna: Correct.

Terry: Surprising, indeed. The "Code of Ethics for Nurses" states that the primary commitment of the nurse is to the patient, and this is demonstrated by protecting the health, safety, and rights of the patient. But nurses also owe that same obligation to self. So, in light of those statistics, what are some practical strategies nurses can use to ensure personal safety, while also ensuring that patient care isn't compromised?

Anna: Thank you for bringing up the "Code of Ethics for Nurses," because it is in our code that it's an obligation to take care of patients in their time of need. Provision 1, actually, in the Code says, "The nurse practices a compassion and respect for the inherent dignity, worth and unique attributes of every patient," which means we have respect for their human dignity and build relationship with the patient. Provision 2 says, "The nurse's primary commitment is to the patient, whether an individual, family, group, community or population." So, it could be in an ambulatory setting, a nurse practices and takes care of the community. It's

about really meeting the needs of the patient and promoting and advocating for their rights and their health.

Unfortunately, when a workplace violence situation arises, the nurse's safety is compromised. Therefore, the nurse is not able to give appropriate safe care to the patient and in that situation, the nurse has to step back and assess the situation. Going back to "Code of Ethics," Provision 5 says, "The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence and continued personal and professional growth." And in this case, I would say the nurse is responsible for learning all the things they need to do to prevent workplace violence.

So, learning the safety rules of their hospital, being aware of what are the situations that they can then escalate, if the violence arises. But when a nurse is placed in this situation, they need to get help, especially if it's in a situation where the patient is acting out, physically or verbally abusing the nurse. This means getting others to help the nurse—either security or other interdisciplinary team members—being aware of what's going on and if the situation becomes really bad, where the nurse might, [if] their life is threatened, stepping out of that situation and getting security or police to be involved.

I think later on in this show, we'll talk about specific things that a nurse can do. But it's really important to not abandon the patient in their time of need. But if there's any kind of a life-threatening situation where the nurse is threatened, then stepping out of that situation and quickly as possible, getting help and getting others involved in the care of that patient.

Terry: I see in your article, you've written, specifically, "Nurses do not abandon their patients if they leave the room to call for help when they feel threatened." So that reinforces your point.

Anna: Let me just say one thing, that it's important, when we look at the law too, the law says that we shouldn't be omitting or failing to act in a prudent manner if we—for example, if a patient is in danger and we need to get them help, we have to follow process and procedure and get them the help they need. But in a space where it is very violent or abusive, then the nurse needs to step out and get help and they shouldn't put themselves into harm's way.

Terry: Okay! So, you spoke briefly in that answer about prevention. And I wanted to ask how you would rate the importance of de-escalation skills in managing potential or actual patient aggression. Speak to maybe why prevention is important overall, and then, talk about some techniques that nurses can use to de-escalate agitated patients before physical or chemical restraints become necessary.

Anna: Prevention is key, because in these situations, the most important thing to do is to prevent it from happening in the first place. And to be able to prevent it, the nurse needs to know the skills and the resources available to him or herself before the situation happens. A lot of times, human behavior is unpredictable. And in healthcare specifically, since there are so many stressors for our patients and their families, it becomes even more of a problem and additional risk factors end up contributing to more of a stressful situation.

So, for example, our patients are on different medications. They end up having surgeries and have delirious or other co-morbid conditions that we might not have known come out while they're a patient in the hospital. And if we don't understand the history of that patient, if we haven't taken a good assessment, then sometimes, we're caught off-guard. So, I think a comprehensive patient assessment is important, taking patient history, current medication conditions, looking to see if the patient has demonstrated past aggressive behavior, if there's anything documented before. And communicating with other team members that this might be a concern and an issue, where then, we could proactively manage that patient and have things in place to then manage, if something like that comes up.

There are five signs of escalating behavior that the nurse can pick up on, if they're taking care of the patient. If the patient is confused—his behavior is characterized by the patient being distracted, they're unsure of what's going on—the nurse can respond by showing concern, asking clarifying questions, and kind of provide assistance and actual information for that patient, or even if it's a family member feeling confused. Then, if the patient is frustrated, if they're showing signs of frustration, they could seem impatient. They might have feelings of a sense of defeat or try to get the nurse to get into an argument.

And from this side, the nurse needs to just listen, show concern, ask clarifying questions and provide assistance, and try to relocate the patient to a quiet location and just reassure them and make a sincere attempt to clarify their concern. Another sign of potential behavior leading to violence could include blaming, when we notice the patients or families are blaming or acting in a way of accusing or directing blame to the team members. Sometimes, this happens when it's an unexpected death in the family and the patient is not—or that

person ends up in the hospital, or a code situation or just something that wasn't expected for that family member, so they are blaming the team.

It's important to respond by disengaging them, bringing them to a place of calm and discussing it calmly, getting the team involved, having not just one person there, but a few team members, asking questions, trying to create a space—a safe space—for them, just to share and to get whatever they have out, because they're struggling. Then, another sign could be anger. This could be that they're starting to become very aggressive: pointing fingers, shouting, screaming.

So, if a nurse notices these types of signs, the appropriate thing would be to contact the supervisor or security, get more people involved, and maybe isolate that person if possible. Because then, if we don't control this, it could turn into hostility, where then, there's a physical action or a threat toward the team members or to the nurse. And in this case, it's so important to get security right there, immediately and get help, because by understanding the warning signs that are associated with violent behavior and knowing that security measures are in place, we can reduce the risk of being a target of a workplace violence.

And that's part of, I guess, the escalation. We first have to prevent it: knowing our policies, making sure that if someone is confused or frustrated, that we deal with it right away and don't let it escalate into then anger and hostility where then, it becomes an actual violent situation.

Terry: So that's a lot of proactive measures that a nurse can take for the patient. In your article, you also write that patients and their families, as well, experience really high levels of stress in the critical care setting and that these proactive and preventative measures can be very effective and sometimes, critical in preventing abusive behavior. Anna, you've just shared some proactive strategy is in techniques that nurses can use for potentially violent patients. How would that extend to the family?

Anna: It's similar to how we deal with patients. We should show the same respect to the family members. And we want to do the things that will minimize destructive behavior or violence, by showing respect, actively listening, showing that we care, and also setting limits and projecting calmness. When we set limits, then we know from the beginning what our expectations are, and they should know what our expectations are. Units should have zero tolerance for violence and that should be in their brochure they give out to patients or [in the] orientations they do.

A lot of times, for example, in my own unit, we will give a folder to the family and patient, if it was a specific type of surgery, with the education about what the patient had and what to expect, and then some of our policies for the unit. And that should be included in the unit information, so when families see it, they know that we do not tolerate any such violent behavior or physical or verbal abuse. So, it's acknowledging the other person's feelings. If they are experiencing some kind of concern or worry, it's acknowledging those feelings, establishing ground rules.

If there's unreasonable behavior that continuously persists, making sure we give them space to calm down. We have one-on-one conversations or bring in the team if it's getting out of hand, [being] reassuring to them, being open. Even if they're criticizing us, being open and just listening and giving positive feedback instead of feeling attacked and starting an argument with the patient or family. Asking for their recommendations. What would they hope to achieve? What is their goal? And maybe it's not being met, or their expectations are not being met.

And then, if it's getting really bad in a situation, making sure that you—the nurse has a way to exit if the conversation's not healthy, if something's becoming—if someone's becoming really aggressive, it's making sure that you can leave the room and get help.

Things to avoid: making sure that you're not getting into this argument or starting a disrespectful conversation, because sometimes that could happen. When they're personally attacking you, you feel like you have to protect yourself. But in that case, it's knowing that you don't want to escalate the situation. So, attempting to bargain is not a good idea, criticizing the person is not a good idea, or minimizing the situation and really invading the person's individual space could get them to get more angry and hostile.

So, it's respecting that person, having space, giving them active listening skills, practicing all that and getting help when the time comes to get help, when you feel like the situation is out of control.

Terry: Excellent. Now, in our pre-interview, you spoke to a case study that concerned an aggressive family member. Did you want to share that with us, Anna?

Anna: Yes, I did. I was in a situation where in the ICU, I had a patient. It was a post-op—so after surgery, cardiac surgery, the patient unfortunately had some

complications during surgery, poor perfusion to his gut. And he ended up having multiple abdominal surgeries, because the gut stopped working, he just hadn't perfused well. So, the family obviously didn't expect that. And it was the wife [who was] physically involved in the care, there 24 hours. Sometimes, we had to really force her to get food or to rest.

But it became out of control, because he just—he chemo-dynamically was unstable. So, a lot of complications happened after surgery—again, multiple surgeries after that surgery—and he just wasn't doing well. And the wife threatened team members, she said she was going to sue, she even went to the C-Suite. We had so many departments involved: our security was involved, our quality as well as risk management. But what was helpful is, we all came to the table and came up with a care plan for this family and specifically how we would deal with the wife.

And whenever I was taking care of the patient—I was in the room—and she had concerns, I would need to have a teammate, like a physician colleague who would be in there with me, discussing her concerns and addressing the problem. We really did it as a team approach, because it was out of hand. It became very distressing for our nurses and other providers to just deal with the situation, because everyone felt that it was an unfortunate situation. But it wasn't something that we caused, it just—it ended up getting out of control sometimes, where she was shouting and very aggressive and we felt that it could get out of hand.

But having a team approach in place, the care plan that we all followed, getting security help when we needed to, and just giving her space to calm down, I think, helped us take care of the patient better. Unfortunately, the patient didn't make it at the end, he did pass away. But I think we had things in place with security and the risk management and other departments, where then it was handled with the wife directly after the patient died and she went home.

Terry: Okay. Well, you mentioned the team approach in other departments and that leads into—thank you for sharing that with us, Anna. My next question is about how all staff from all departments—and I think you spoke to this in your telling of that story—but how staff from all departments can play an integral role in recognizing and preventing workplace violence. Could you speak to the importance of why all staff in all departments need to be speaking the same language and understanding the situation through the same lens?

Anna: Yes, and this goes to the policies. If we have policies in place and everyone's trained and knows what's expected, then we have a common language that we can share, and we could speak up. The important thing is speaking up when you notice something's wrong, and this could happen with any team members. Let's say a physical therapist was working with the patient and the patient becomes aggressive. It's sharing this information with the nurse and other team members, where then, we figure out what is going on.

Is it an issue, just a one-time issue, or was it something that has been happening with the patient and we need to deal with it? So, it's different team members assessing the patient and their family members and bringing it to the attention of the whole team. This could be social workers, it could be different providers. But if we have a team approach where hospital security's involved, nursing administration, risk management, even ethics or legal affairs, then we know that we're all on the same page and we're following the policy and we're providing the best care possible to the patient.

So, if it's an issue where the patient is violent, maybe we don't really know if it's a medication issue. Maybe a medication caused the patient to be that way, or a psychiatric issue. Getting psychologists or a psychiatrist to evaluate the patient's decision-making capacity, or other people like security, if we're feeling there's a threatening situation. Security is trained to really investigate incidents and more of their de-escalation process, they're involved in that process. And they could really target verbal or physical abuses and make sure that they're de-escalating the situation.

If there's something even, where security can't control, then they could involve law enforcement and get outside help if we need to, at the hospital. But it's—I think going back to learning what's expected, learning to see if there's a policy in place, what staff has to do to follow that policy and then having a team approach, where if there is a concern—there's a high-risk patient—then we talk about it and have a care plan in place then, to know what each of us has to do to take care of that patient.

One other thing I would say is, we have code situations. We have different codes in the hospital. It's knowing what those codes mean and how to react to them. For example, we have Code Gray, where we know it's a combative or abusive person. If you're in the immediate situation, what would be the thing to do is to call security, remain calm and use some of those de-escalating techniques, engage coworkers, remove patients or visitors if possible. Knowing those kinds of things is helpful. Then when you're in the situation, you don't panic and don't do something that might cause the situation to get worse.

Another code we're supposed to be aware of in the hospital is Code Silver, where [there's] a person with a weapon, or there's a hostage situation. It's knowing, if that's the case, removing yourself from that situation: running, hiding, fighting, whatever it takes and then getting law enforcement involved and making sure the appropriate security, everyone's there to handle that situation. Our personal safety is top priority and we want to make sure we're safe, as well as the people we're taking care of, the patient and their families, they're safe. This really takes a team approach, and coming together as a team is the most important thing we can do to provide quality and safe care.

Terry: Well said. It leads to my next question, which is that if risk for violence is determined when assessing a patient, there are certain practical and preventative measures that can be taken to assist other team members that you talk about in your article. Could you review a couple of those for us?

Anna: Yes, there are a variety of methods for potentially flagging a patient or putting an electronic health record banner that then alerts people. It could be an active flag. For example, if we are dealing with an electronic health record, we can put "Active Flag" in the electronic record, where it pops up each time the file is opened. So anytime a team member goes into the patient records, there could be a reminder of, "This patient is a high risk for physical or verbal abuse or any kind of violent behavior." And it helps the team or that individual to just be more aware. And every time they interact with that patient, then they could assess and see if the patient is exhibiting any of those behaviors.

So, it's the active flag that could then–really, it helps to bring that notification right away, when someone is in the patient chart. Or it could be a passive flag, where it's on a banner or somewhere in the record, where it's a certain color. It still brings attention that this patient's a high-risk and we need to do—like, we just need to be more proactive and use some of our preventative things to make sure the patient doesn't get into trouble. We could do other visual cues, such as wristbands, bedside signage, or patient sign-on boards. There's graphic symbols we could put on, or colored markers.

So, each hospital or unit might come up with a different format that works for them. But the goal is to identify high-risk patients based on a comprehensive assessment of that patient's history. Or it could be some environments, like the psychiatric units or emergency departments, where people some people are high utilizers, they keep coming back in. and if we know that about that patient,

to highlight that they're a high-risk patient and come up with a comprehensive plan on how to deal with it.

So, some techniques might work with some patients and some might not, like certain ways of speaking or acting. There are individuals that could be more proactive in situations where, if they build a relationship with the patient, then they could calm them down easier. So just knowing what works for that person, especially if they have a record with the hospital system or with that organization. Then keeping track of them and knowing the right steps—if we all use the same care plan—and add to that care plan, it helps us then prevent an incident happening to a full-blown threat or a workplace violence, then that endangers staff and other people.

Terry: Well, those sound like some very effective strategies to alert other staff that there's potentially challenging behavior from a particular patient. In your article, you write—and I want to close with this question today, because I think it's a really important one, and will kind of summarize, maybe, for nurses who are wanting more support or recognition of this issue from their hospital—you write, "Having additional training in the areas of prevention policies and procedure will be instrumental in making effective decisions during high-risk situations." You go on to say that, "If no institutional policies exist, nurses are obligated to develop relevant policies for their workplaces." And I'm wondering how nurses can practically and effectively set about that task.

Anna: That's a good question to end on. I would say that just speaking about workplace violence, it is a complicated and multifaceted problem. It's hard to predict sometimes what will happen in situations like this. But having policies in place and having clear expectations helps nurses be prepared in situations like this. And if there isn't a policy that exists, it's important—going back to our Code of Ethics, ANA Code of Ethics says that it's nurses' responsibility to advocate for a safe environment, to come up and really, to develop the policies that are needed.

Because as patient advocates, as people who are with patients and families and communities constantly, we have insight, sometimes that other people—other providers—don't. And it's important, to use that insight then, to put things in place for preventing incidents like this from happening. And that's why I think it's important for nurses to assess their situation. If they go back to their unit and realize that there is no guideline or there is no policy, then [it's their responsibility] to bring it to the concern of their leadership and say that this is something they're passionate about. There's so many national organizations like American Nurses Association that have recommendations.

There are healthy work environment guidelines from American Association of Critical Care Nurses; OSHA and Joint Commission have standards. It's really state-based, a lot of the policies. But the states that mandate things, then the hospitals have to do [those things]. But in the states that don't have those policies, it's still the hospital's responsibility to protect their workers.

And I think what's important, if a nurse has had a personal experience—when we talked about the statistics of how many people experienced workplace violence, verbal or physical abuse, and other types of violence—if you've experienced this, then it is a personal story, using that story to then share with others the importance of preventing something like that from happening again to you and to the others. And if you could use that voice to get that message across, it will be a strong—you will be a strong advocate for this issue.

Going back to your resources: professional organizations, bringing the leadership to the table, sharing stories, statistics and then forming a team—a team that cares about this topic—to draft something. Because it is not one person or one individual that could really get this done. It is, again, back to a team approach: getting the relevant people at the table, having the conversation, and then setting about putting a policy in place.

If anyone's attending that critical care conference in Boston, NTI, there will be a session from a hospital that actually, one about nurses—a nurse experience, a workplace violence situation—and the hospital didn't have a policy. She went about and drafted something that is now a health system policy for their whole organization. It is possible to do this. And I just encourage anyone who's listening, if they have been in a situation where they felt stuck, then to do something about it. It doesn't need to be that way. Additionally, if you're really passionate about this topic, then to make it known in our communities where this is an issue. A lot of people don't realize that this is a big issue in health care. Bringing this to the attention to our legislators, making sure that we put national policies in place to protect our health care workers. I think those are important steps to take as a nurse.

Terry: Well, it sounds like there are some sessions at the conference that nurses can use in tandem, to really get their arms around this topic of addressing workplace violence and then, going about setting up a policy initiative in the place they work.

Anna: Yes. And I would just add that American Nurses Association has an effort to end nurse abuse. They have a hashtag actually, #endnurseabuse, by supporting policies that help end violence against nurses. And anyone who's listening, you can take the pledge to support zero tolerance and sign up to get notifications and information and really be the promoter, be the advocate to end nurse abuse and workplace violence.

Terry: Well, excellent. Thank you, Anna. Well, my guest today has been Anna Dermenchyan. She is a senior clinical quality specialist in the Department of Medicine at UCLA Health. She will be presenting at the American Association of Critical Care Nurses NTI Conference, National Teaching Institute conference, rather, that's being held this May 21st through 24th in Boston. So be sure to look for Anna there. Thank you so much for joining us today, Anna.

Anna: Thank you for having me.

Terry: Thank you. And thank you all for listening.