Cal/OSHA Advisory Meeting Workplace Violence Prevention in Health Care

September 10, 2014

Jane Lipscomb, RN, PhD
University of Maryland

Overview

- Define workplace violence (WV) and discuss the typologies
- Specific and unique hazards/challenges that healthcare workers face on the job
- Strategies known to work/not work for WV prevention for healthcare workers
- Key components of an effective WV prevention program for healthcare workers

Workplace Violence Definition

- Violent acts (including physical assaults and threats of assault), directed towards person at work or on duty (NIOSH, 1996).
- Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site (OSHA, 2014).

WV Typology (CAL-OSHA, 1993)

- Type I – unknown perpetrator, criminal motive
- Type II – patient, client, customer as perpetrator
- Type III – coworker, supervisor as perpetrator
- Type IV – intimate partner perpetrator

Useful for assessing prevention strategies.

Risk for one type of violence likely to infer risk for other types.

Magnitude of the Problem

- 34 of 62 fatalities in HCSA industry were due to assaults and violent acts (BLS, 2010).
- 572,000 non-fatal assaults /year among all public & private sector workers (DOJ, 2011)
- Between 2003-2010, 59-67% of non-fatal assaults occur in healthcare and social services (BLS, 2013)
- Rate of non-fatal assault among HCSA industry 15.1/10,000 compared with 4.0/10,000 among all private sector workers (BLS, 2013).
- 13% and 39% of RNs experience physical and non-physical violence per year (Gerberich, 2004)

Real faces and personal cost...

Hospital-based surveillance

- Pompeii (2013) – among 17 studies reviewed
  - verbal abuse (22%-90%),
  - physical threats (12%-64%)
  - assaults (2%-32%)
- Arnetz (2011) - Incidence rates per hospital 1.52 - 10.89/100 FTEs (2003-2008)
  - Hospital with outpatient mental health (RR = 7.16)
  - Mental health technicians (RR = 13.82)
  - Security personnel (RR = 2.25)

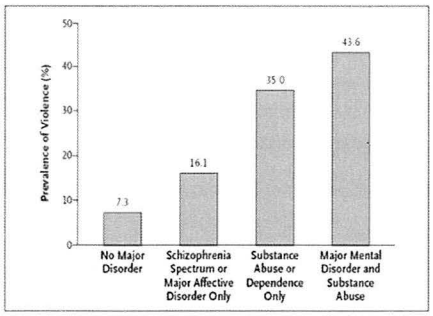
Exposure

Exposure = patient/client/family/visitor/public

- Dynamic and moderated by clinical management, work environment, work organization, worker skills/interactions.
- High potential for confounding of relationship between interventions and outcomes by these factors.

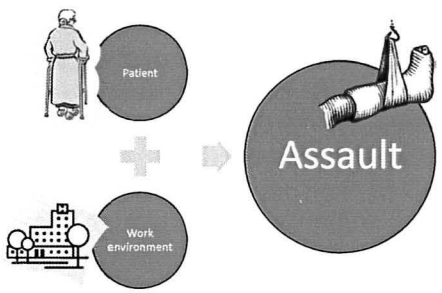
Exposure: Client Characteristics

- Mental illness
  - Untreated psychotic symptoms
  - Risk factors associated with illness (e.g. substance abuse, homelessness, incarceration)
- History of violence (history of trauma)
- Cognitive impairment
  - Elderly, developmentally disabled
- Substance abuse
- Individuals with access to weapons
- Fear/anxiety associated with health care experience



Lifetime Prevalence of Violent Behavior among Persons with or without Major Psychiatric Disorders and Substance Abuse.

Friedman, NEJM 2006



Scope/Setting (OSHA)

- Hospital
- Residential Treatment (e.g. nursing homes, and other long-term care facilities)
- Non-residential Treatment/Service (e.g. neighborhood clinics, mental health centers)
- Community Care (e.g. community-based residential facilities and group homes);
- Field work settings (e.g. home healthcare or social workers who make home visits)

Risk Factors – Job Tasks

1= Hospital, 2= Community Setting, 3= Home Visiting

- Contact with the public (1,2,3)
- Exchange of money
- Delivery of passengers, goods, or services (2)
- Having a mobile workplace (e.g. taxicab, police cruiser)
- Working with unstable or volatile persons in health care, social service, or criminal justice settings (1,2,3)
- Working alone or in small numbers (2,3)
- Working late at night or during early morning hours (1,2)
- Working in high-crime areas (1, 2, 3)
- Guarding valuable property or possessions (1)
- Working in community-based settings (2,3)

(Collins and Cox 1987; Davis 1987; Davis et al. 1987; Kraus 1987; Lynch 1987; NIOSH 1993; Castillo and Jenkins 1994)

Exposure: Setting Characteristics (Nachreiner, 2007)

- Nursing homes/LTC (OR = 2.6)
- Emergency dept (OR = 4.2)
- Psychiatric dept (OR = 2.0)
- Across settings, cases more likely to report:
  - High levels of work stress
  - Expectation that assault is "part of job"
  - No action taken in response to assault
  - Low morale, lack of respect and trust among personnel

Literature Review: Intervention Evaluation (1)

- Training
  - Lehman (1983) VA Hospital +
  - Infantino & Musingo (1985) +
  - Carmel and Hunter (1990) -
  - Parks (1996) -
  - Goodridge et. Al. (1997) +
- Post-incidence debriefing
  - Flannery et.al. (1998) +
  - Matthews (1998) -

Literature Review: Intervention Evaluation (2)

- Other strategies
  - Drummond et. Al. (1989) +
  - Hunter& Love (1996) +
  - Arnetz & Arnetz (2000) -
- Comprehensive Program
  - Lipscomb et al. (2006) +/-
  - Mohr et al. (2012) +/-
- Policy/Regulation
  - Peek-Asa et al. (2007) +/-

Evidence from the Field

- Hospitals that have strong WVPP have experienced reduced staff assaults.
- Background information on patient history of violence could be life saving.
- Staff working along and/or in remote locations must have a means to summons assistance.
- Visits involving involuntary admission, removal of children from home – very high risk

U.S. OSHA Guidelines (1993, 2004, 2014?)

- Management Commitment
- Employee Involvement
- Worksite Analysis
- Hazard Prevention & Control
- Recordkeeping
- Evaluations

18

Home Visiting

- Physical assaults less frequent than in institutional setting
- Risk of injury associated with driving, traveling in high crime areas
- Workers have less control over physical environment (guest in home)
- No support from coworkers
- Risk from firearms, drugs in home

Prevention Strategy Across Settings

- Recognition of link between patient/staff safety as reflected in culture of safety for both
- Comprehensive Violence Prevention Program*
  - Risk assessment and system for identifying high risk patients/encounters (e.g. flagging charts).
  - Enforce strict code of behavior and have consequences for violation of code (including pressing criminal charges)

IH Hierarchy of Controls: Applied to Workplace Violence

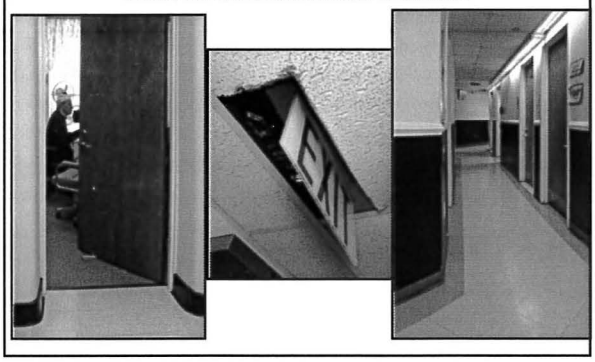
- Elimination/Substitution
- **Engineering Controls**
- **Administrative Controls**
- PPE

Environmental Survey Checklist

(K. Murrett, ARI, NY)

- Lighting, noise, air quality
- Objects/furnishings as weapons
- Sharp edges, hard surfaces
- Access control
- Working in isolation, hidden areas
- Surveillance cameras
- Security hardware, alarm systems

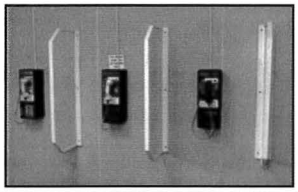
Environmental Risks

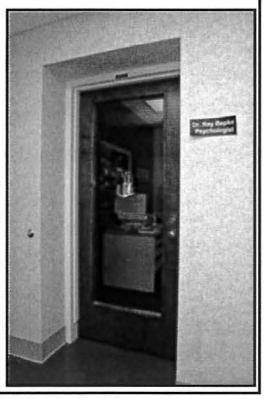


Environmental Controls

- Arrange furniture to prevent entrapment
- Curved mirrors at hallway intersections
- Comfortable waiting areas for clients/visitors
- Adequate lighting
- Opportunity for passive surveillance
- Panic buttons, cell phones, alarms, cameras, etc.
- Assess construction/renovation plans

Hazard Controls





Administrative Controls

- Adequate staffing and staffing mix*
- No solo work in high-risk areas/jobs
- Report/record all incidents
- Availability of patient risk information
- Reduce waiting time for clients/visitors
- Liaison with police

Training: Necessary But Not Sufficient

- Training should include:
  - Elements of a WVPP
  - How to report incidents
  - Risk of particular patient population/setting
  - Early intervention de-escalation techniques
  - Policy for restraint and seclusion
- Physical intervention
  - Last resort
  - When early intervention fails
  - Many questions about simulation, frequency and intensity of practice

What Workers Have Told Us

- Culture that WV is "part of the job"
- Patient rights movement creates a huge challenge to staff protection
- Resistance/reprisal for filing criminal charges against patient/client
- Inadequate staffing - very high risk situation
  - Increases patient agitation
  - Makes staff easy targets
- Lack of regulations results in lack of WVP programming, even in high risk settings

Workplace Violence Prevention: What it Looks Like in Practice

- Labor/management H & S committees/teams
- Ongoing review and synthesis of incident/injury data
- Review, analyze, revision of policies & procedures
- Collect additional data where needed (e.g. focus groups, interviews, staff surveys)
- Evaluate and modify physical work environment
- Teamwork to implement changes

Questions??