What every healthcare facility should do NOW to reduce the potential for workplace violence

Thomas A. Smith, CHPA, CPP

The increase in workplace violence in healthcare facilities is now recognized by OSHA and other regulatory bodies as well as IAHSS, major nursing organizations,and the Joint Commission according to the author. In this article he reports on the causes and effects of such violence and presents security guidelines for taking action to reduce it as well as how COOs can be convinced to support such action.

(Thomas A. Smith, CHPA, CPP is President & Principal Consultant of Healthcare Security Consultants, Chapel Hill, NC. He is a former Director of Hospitals Police and Transportation at the University of North Carolina Hospitals, and a past president of IAHSS.)

RECOGNIZING THE INCEASE IN WORKPLACE VIOLENCE IN HOSPITALS

Contrary to the national trend of reduced crime, healthcare facilities have experienced increasing numbers of workplace violence incidents. According to a 2014 crime survey conducted by IAHSS the rate of violent crime in American healthcare facilities rose by 25 percent from 2012 to 2013, and the rate of disorderly conduct jumped by 40 percent. Increasing workplace violence has also been recognized by major regulatory bodies including The Joint Commission (TJC) and the Occupational Safety and Health Administration (OSHA). In 201604, OSHA published updated Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers, OSHA Publication 3148. In 2010

TJC published Sentinel Event Alert, Issue 45: Preventing violence in the health care setting. This was followed up in April 2017 with Sentinel Even Alert 59 --Physical and Verbal Violence Against Healthcare Workers. This year, TJC developed a Workplace Violence Prevention Resources portal. This portal provides a valuable source of information from The Joint Commission enterprise and other healthcare organizations related to the topic of Workplace Violence.

IAHSS has also updated the workplace violence related guidelines working cooperatively with the Emergency Nurses Association (ENA), and the American Organization of Nurse Executives (AONE). Three guidelines targeting violence in healthcare facilities include Violent Patient/ Patient Visitor Management; Gang Awareness and Activities; and Threat Management.

OSHA published a new Field Directive CPL 02-01-052 in September 2011. In this directive OSHA establishes general policy guidance and procedures for field offices to apply when conducting inspections in response to incidents of workplace violence. This document also identifies healthcare and late night retail establishments as the two industries with high incidents of workplace violence.

Healthcare workers in general, and ED and mental health staff, face a greater risk of violence than most other occupations. In 2004, OSHA reported that healthcare and social service workers account for nearly half (48%) of all nonfatal injuries reported in the U.S. from workplace violence and assaults. Healthcare worker deaths seem relatively rare--the Bureau of Labor reports 154 nursing, psychiatric, and home health aide fatal injuries from work-related incidents from 1995 to 2004. But International Council of Nurses (ICN) noted in 2009 that "healthcare workers are more likely to be attacked at work than prison guards and police officers."

Professional associations such as IAHSS, Emergency Nurses Association (ENA), American College of Emergency Physicians (ACEP), and others have all developed position statements and guidelines for assisting HCFs in mitigating violence.

In addition to this regulatory

backdrop and push by professional organizations, every day there are incidents of workplace violence reported in the local news media. In a ten-year study on fire- arm discharges in hospitals by Tom Aumack, there were 416 weapons discharges reported by media outlets.

A SAMPLING OF INCIDENTS

Here are a few incidents from HCFs across the country that have been reported.

On January 20, 2015 a cardiac surgeon was shot at his clinic at Brigham and Women's Hospital in Boston. The shooter, who also took his own life, was the son of 78-year-old patient, who had died shortly after a procedure Dr. Davidson had performed in November.

In July 2014, a patient shot and killed his case worker and wounded a physician at Mercy Wellness Center in Darby, PA. The wounded physician then pulled a gun and shot the gun wielding patient who was then subdued by other staff members in the clinic.

In July 2014, video was released from an incident that had occurred May 16, 2014, in an Emergency Department in North Logan Utah. In this incident, a patient entered the ED waiting room, pulled two guns and demanded to see his doctor saying that "someone is going to die today." This patient was shot four times by law enforcement staff that happened to be on site for something unrelated.

ARMING SECURITY OFFICERS? OTHER OPTIONS TO CONSIDER

In February 2015, TJC posted Different Approaches to Mitigate Violence in the Leadership Blog. The post focuses almost exclusively on the question of arming hospital security officers. In my consulting business I find many healthcare facilities are also focused, almost solely, on this question when considering what to do to reduce the potential for workplace violence. Arming security officers or having police officers on staff are certainly options. However, **there are many, many other options to also consider.** Healthcare facilities should carefully assess all the options as they look to implement reasonable measures for reducing the potential for violence on their campuses.

What caused the increase in violence in our HCFs?

The cause of this seeming increased level of violence in our HCFs are many and varied, but here are the generally recognized factors that contribute to violent incidents:

- Increased wait times in our Emergency Departments.
- Unrestricted movement of the public in clinics and hospitals. Many HCFs have moved to "open visitation". This means friends and family may visit anytime of the day or night. Some facilities are taking this to mean no limits on who or when persons may enter their facilities. There is no argument about the need for people to visit, but there must be reasonable checks and balances to limit risks to patients, visitors and staff.
- Reduced inpatient "institutional" mental health beds for high acuity patients. Most if not all states have reduced the number of inpatient beds for mental healthcare. The idea was to place these patients into community mental health outpatient programs. Funding for these programs has continued to be reduced since the 1980s resulting in many mental health patients going without care and ending in the criminal justice system.
- A general increase in patient acuity upon arrival in our EDs and Clinics. Many acute and chronic mentally ill patients are being released from hospitals without follow-up care. These patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others.
- Increasing use of hospitals by police and the criminal justice system for the care of acutely disturbed, violent individuals or as an alternative to already overcrowded jails

AN UNPOPULAR, BUT NECESSARY DISCUSSION

Here are a couple of potentially controversial, and definitely not generally accepted items that I am throwing into this conversation. I am going to upset some of my NRA and Healthcare Administrator colleagues with these, but here goes:

- Ease of access to weapons! There, I said it. I am a gun owner and 2nd Amendment supporter, but the existing laws need to be enforced, and some reasonable

limits need to be in place on gun sales and possession (I did say this was a deep subject).

• A general lack of understanding and support of security and safety by some (not all) hospital leaders! There is immense pressure to contain costs within our healthcare systems. This pressure is felt most by non-revenue producing departments such as security. As a result, some administrators do not want to hear about the need for increased expenses in non-patient care areas.

(Example: I recently had a COO of a major healthcare system ask me, "Tom, why do we need any more security than the local cinema or grocery store chain." It was said with a straight face. I did my best to educate said COO of the above listed reasons why HCFs have more risk, higher incidents of violence etc... but I was not sure it sunk in to any serious degree. As most of you already know, COOs focus time, energy, attention and organizational resources on things that: 1) offer the potential for gain and 2) are causing them pain/risk. It's the allocation of scarce resources issue, and it's a key responsibility of COOs.

Security doesn't provide an opportunity for gain, so a COO will only focus on security when it's causing them pain (risk). When things get bad enough, or the risks are clear enough, they'll provide the necessary resources. In this case, it was probably because I was not doing a good enough job clearly informing him of the risks and evolving standard of care.)

WHAT SHOULD HEALTHCARE FACILITIES DO TO REDUCE THE POTENTIAL FOR VIOLENCE?

So what can and should hospitals do to reduce the potential for these incidents and to effectively respond if they do occur? Many HCFs want to consider initiatives such as arming security staff members, metal detectors, staffing with off duty police, active shooter training and drills etc... Depending on the circumstances, these may all be reasonable and appropriate options. However, before considering any major shift in preventive or reactive measures each HCF should at a minimum take the following actions to assess risk and implement measures to reduce the likelihood

of an adverse incident and provide an effective response if one does occur.

1. **Conduct a comprehensive evaluation of your security program** - Reducing the likelihood of a serious incident involves a layered approach involving many aspects of security including policies, procedures and training as well as physical security, design and other factors. A competent hospital security professional should lead this effort using a multidisciplinary team. Competent means someone with hospital experience and credentials (CHPA and/or CPP). The local PD may have some resources, but you want someone that understands healthcare. An assessment of this nature is not something that can be accomplished through the use of a checklist or online process. These may be helpful, but a combined group including members with knowledge of hospital security and your facility is ideal.

2. **Workplace Violence Policy Assessment** – Evaluate your policy and make sure it has senior leadership support. There are several excellent resources to assist in this process including OSHA's "Guidelines for Preventing Workplace Violence for Health Care and Social Services Workers," and the ASIS Workplace Violence Prevention and Intervention Standard. When surveying HCFs I find many have reasonable policies covering workplace violence, but they are rarely utilized even when incidents occur. The workplace violence policy must be routinely evaluated for effectiveness and measures put in place to educate and inform staff of the policy and their role. Many HCFs have several workplace violence policies that were created by different entities of the organization. These tend to provide different direction as to roles and responsibilities for collection of data, definitions and response to incidents. Ensure some entity (I like to see it in security) be responsible for collecting all data relating to workplace violence whether it is in an occupational health report, risk report, nursing incident report, or employee incident report. If it is a workplace violence incident it must be reported to the security function for investigation, proper categorization, and routine reporting to the appropriate body, often the

Environment of Care Committee.

3. **Threat Management Team** – A threat assessment team will be part of any decent workplace violence program. Establish this team (usually composed of representatives from Legal, Security, Human Resources, Psychiatry, local law enforcement and others depending on the resources readily available in your HCF). Train the team and use them for threats. This group gets better with experiences as with most teams. Most facilities I see *do not* have a Threat Management Team. This is an essential element of the workplace violence policy. There also must be a process to orient and train members of the team regarding the policy and their role. See the IAHSS recently published guideline on Threat Management.

4. **Implement Flag Systems in the Electronic Medical Record** – Develop policies and procedures for identifying threatening patients and family members, and patients with violent criminal records. Patients and family members that have previously threatened and or assaulted staff in the past should be identified and flagged so staff members that encounter them in the future have the benefit of the previous experiences. This then allows staff to take appropriate measures to protect themselves and others. I sometimes get feedback from some HCF leaders that they don't want to stigmatize or create a Pygmalion effect for patients that have previously had threatening behaviors. This can be avoided if there are reasonable and appropriate policies in place to protect patient privacy as well as protecting our staff members. *The best predictor of future behavior is past behavior.*

5. **Design Security into New Construction and Renovation Projects** – In the next decade there will be billions of dollars spent on new construction and renovation projects. This is a major opportunity to build security into each project. The IAHSS has developed *Security Design Guidelines for Healthcare Facilities.* HCFs and healthcare systems should consider these guidelines and develop systems security requirements that each design project implements as a required part of any new project. The IAHSS Security Design Guidelines are intended to provide guidance to healthcare security practitioners, architects, and building owner

representatives involved in the design process in order to ensure that these best practices are considered and integrated, where possible, into each new and renovated HCF space.

6. **Training** – Train staff in security sensitive areas on crisis intervention and security policies and procedures. Evaluate your current crisis training and consider if it meets your needs given this new era of violence toward healthcare and human service workers. Active shooter training and response protocols must be assessed and implemented.

The increase in active shooter scenarios, crime numbers, and the routine threats hospitals face on a day-to-day basis all combine to make security at healthcare facilities more important than ever. Whether it's at a metropolitan hospital, a network of nonprofit healthcare facilities, or a research-based medical center, persons responsible for security programs must employ a combination of training and technology to keep their facilities reasonably secure.

TAKE REASONABLE ACTION. SHED THE 'COWBOY MENTALITY'

In his article, *Risky Business: Working Where Violence Is the Norm,* Nicholas Genes MD, PhD, said, "*Consider the lengths we'll go, as ED physicians, to avoid missing coronary events, or PE, or cord compression, or dissection. Consider the time and expense we take to risk-stratify patients, to reach an appropriate, high threshold for safe disposition. From that perspective, it's puzzling why we don't go to the same lengths to protect ourselves from violence. How did this cowboy mentality--that threats and violence should be tolerated--take hold? However we got here, we've come to accept a situation that wouldn't be tolerated anywhere else in the hospital, let alone in other industries.*"

This is a call to action. It is easy to become complacent and think these things don't happen here. Every healthcare organization should consider the risks and take action to make sure you have reasonable, appropriate, risk based security programs in place.