De-escalation: Recognizing and Mitigating Potentially Dangerous Encounters in Your Medical Setting

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Presenter Disclosures

No financial relationships to disclose

Learning Objectives

1. Understand the **magnitude** of workplace violence as an occupational hazard in healthcare environments

2. Identify the major known **risk factors** for violence-related events and injuries among healthcare workers

3. Explain the role of the **key elements** in the management and prevention of workplace violence in healthcare settings

Overview: Workplace Violence in Healthcare

- **How big is the problem?**
  - Definition
  - Official statistics and challenges to accurate measurement
- **What are the risk factors?**
  - Types/characterization of workplace violence
  - Workplaces/professional groups at increased risk
- **Consequences of workplace violence**
  - Employee health and safety
  - Quality of patient care
- **Management and prevention strategies**
  - Organizational strategies
  - Individual strategies

Workplace Violence: Definition

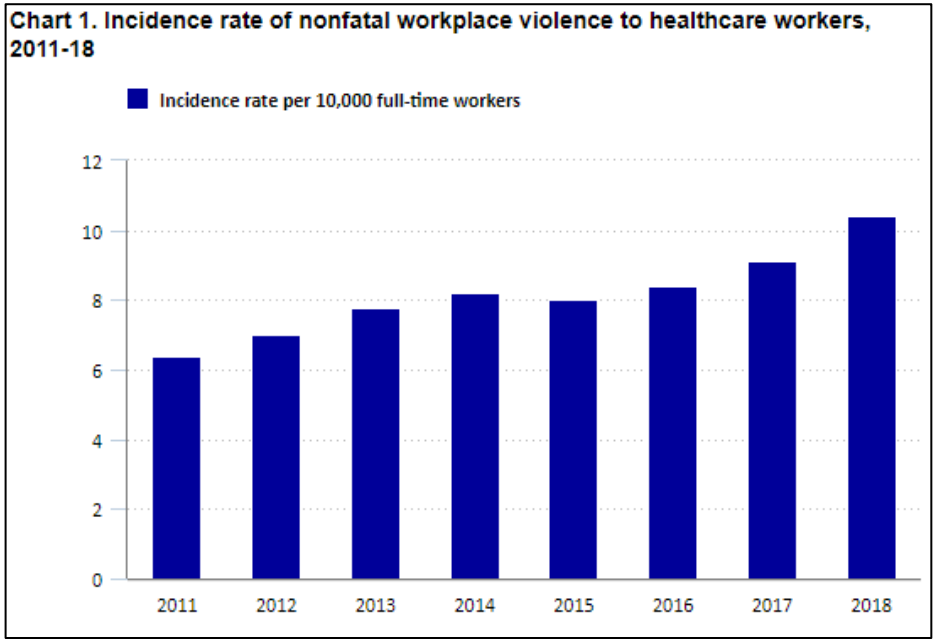
- Any physical assault, threatening behavior or verbal abuse occurring in the work setting (Occupational Safety & Health Administration, 2002)

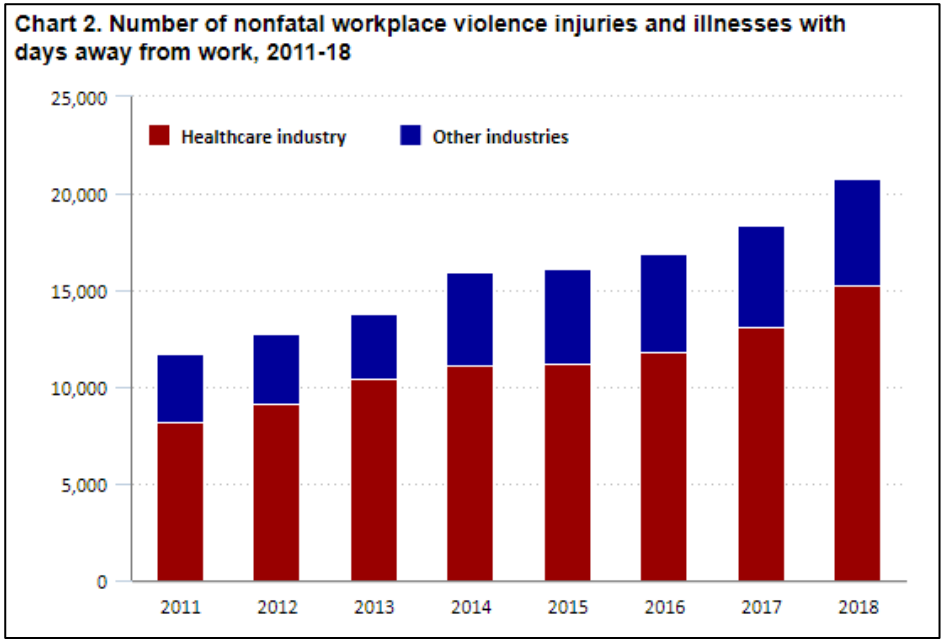
- "An act or threat occurring at the workplace that can include any of the following: verbal, nonverbal, written, or physical aggression; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern involving staff, licensed practitioners, patients, or visitors." (Joint Commission Workplace Violence Prevention Standards, 2022)

Workplace violence in healthcare

The magnitude of the problem

Workplace violence to healthcare workers 2011-2018





Bureau of Labor Statistics (BLS) 2020

Workplace violence by industry

Table 1. Incidence rate of nonfatal intentional injury by other person, by selected industries, 2018

Private Industry	NAICS code*	Incidence rate of nonfatal intentional injury by other person, per 10,000 full-time workers
All Industry		2.1
Health care and social assistance	62	10.4
Ambulatory health care services	621	3.1
Hospitals	622	12.8
Psychiatric and substance abuse hospitals	6222	124.9
Nursing and residential care facilities	623	21.1
Social Assistance	624	12.4
Child day care services	6244	7.8

BLS 2020

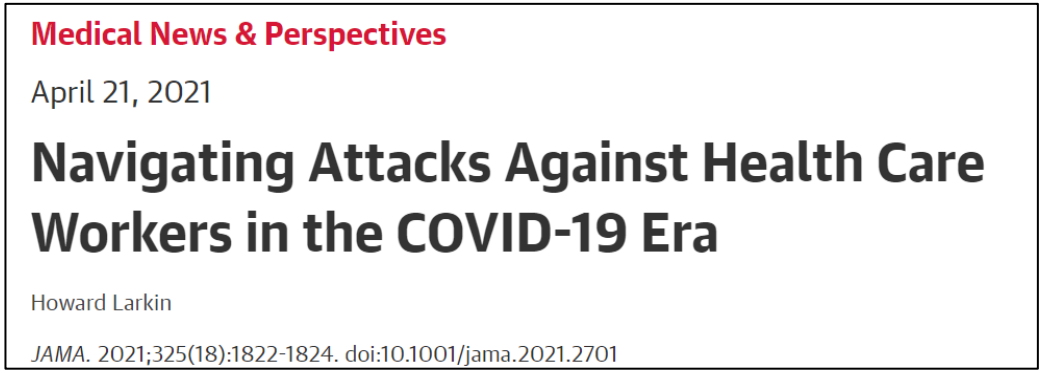
* North American Industry Classification System

Key Points: Magnitude of the problem

- U.S. healthcare workers in private sector 5X more likely to incur violence-related injury compared to workers in all other private industries combined
- 75% of all violence-related injuries/illnesses incurred by healthcare workers
- Injury rates have increased steadily since 2011
- Injury rates highest for workers in psychiatric/substance abuse hospitals

BLS 2020

Workplace violence increased during the COVID-19 pandemic



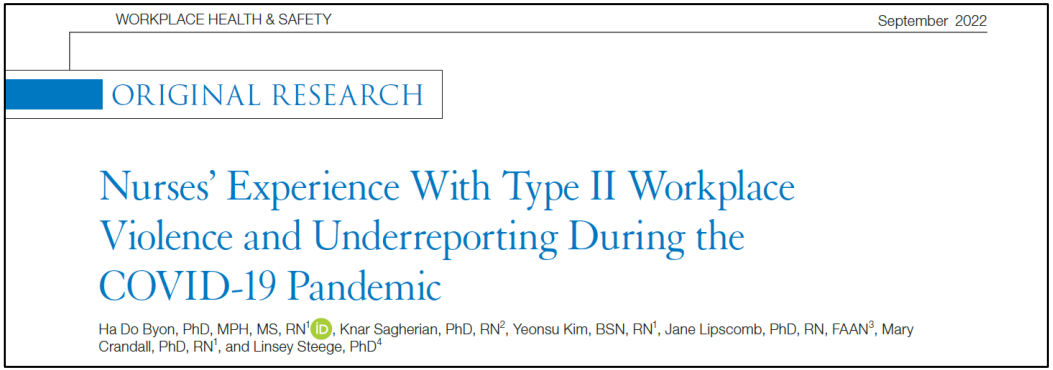
Medical News & Perspectives

April 21, 2021

Navigating Attacks Against Health Care Workers in the COVID-19 Era

Howard Larkin

JAMA. 2021;325(18):1822-1824. doi:10.1001/jama.2021.2701



WORKPLACE HEALTH & SAFETY September 2022

ORIGINAL RESEARCH

Nurses' Experience With Type II Workplace Violence and Underreporting During the COVID-19 Pandemic

Ha Do Byon, PhD, MPH, MS, RN[1], Knar Sagherian, PhD, RN[2], Yeonsu Kim, BSN, RN[1], Jane Lipscomb, PhD, RN, FAAN[3], Mary Crandall, PhD, RN[1], and Linsey Steege, PhD[4]

Nurses who cared for patients with COVID-19 experienced more

- physical violence
- verbal abuse
- Greater difficulty in reporting events

Byon et al, 2022
Workplace Health & Safety

Caveat: Official statistics

- Only encompass events/injuries that result in at least 1 day off of work

Caveat: Underreporting!

- **Why don't healthcare workers report incidents of violence?**
  - High thresholds for violence in some settings ("part of the job")
  - No physical injury
  - Patient can't be held responsible
  - Extra paperwork/time
  - Feelings of guilt/shame
  - Accusatory workplace culture
  - Who cares?

Quantifying underreporting

- Linked self-report with documented incidents (7 hospitals)
  - 88% underreporting (central electronic reporting system)
  - 55% underreporting to supervisor (verbal)

Arnetz et al 2015


WORKPLACE HEALTH & SAFETY May 2015

ARTICLE

Underreporting of Workplace Violence

Comparison of Self-Report and Actual Documentation of Hospital Incidents

Judith E. Arnetz, PhD, MPH, PT[1,2], Lydia Hamblin, MA[1,3], Joel Ager, PhD[1], Mark Luborsky, PhD[3,4], Mark J. Upfal, MD, MPH[4,5], Jim Russell, BSN[6], and Lynnette Essenmacher, MPH[6]

- Self-report survey (6 hospitals)
  - 81% underreporting into official reporting systems

Pompeii et al, Am J Ind Med 2015

Physical Assault, Physical Threat, and Verbal Abuse Perpetrated Against Hospital Workers by Patients or Visitors in Six U.S. Hospitals

Lisa A. Pompeii, PhD,[1]* Ashley L. Schoenfisch, PhD,[2] Hester J. Lipscomb, PhD,[2] John M. Dement, PhD,[2] Claudia D. Smith, PhD, RN, NE-BC,[3] and Mudita Upadhyaya, MPH[4]

Underreporting hinders violence prevention efforts

1. **Underestimation** of the true extent of the problem
   - indicating less of a need for prevention than may actually be the case

2. **Incomplete picture** of the full spectrum of violent events
   - prevention efforts may only be addressing limited aspects of the problem

Workplace violence in healthcare

Risk factors for violence

Types of workplace violence based on perpetrators

Type of violence	Perpetrator
I: Criminal intent	I: No association with workplace
II: Customer/client	II: Patient/customer of workplace
III: Worker-on-worker	III: Current/former employee
IV: Personal relationship	IV: Personal relationship with employee(s), not workplace

Perpetrators in healthcare settings

- All 4 types occur in healthcare settings
- Types II and III are most prevalent

  - **Patients and patient visitors (Type II)** are often perpetrators of *physical* violence
    - Ranges from scratching/biting to physical assault

  - **Other employees (Type III)** often responsible for acts of *non-physical* violence
    - Ranges from verbal abuse to systematic bullying

Risk factors: hospital units at increased risk

- Psychiatric/mental health facilities
- Emergency departments
- Geriatric/dementia care units
- Intensive care units

Arnetz et al, Am J Ind Med, 2011

Pompeii et al, Am J Ind Med, 2015

Risk factors: non-hospital environments

- Ambulance/EMS workers
- Nursing homes
- Outpatient mental health facilities
- Home health care
  - Working alone in an uncontrolled environment
  - Neighborhoods with high crime rates

Professional groups at greatest risk

- Mental health technicians (Rate ratio=13.82, 95% CI 11.13-17.29)
- Security personnel (Rate ratio=2.25, 95% CI 1.68-3.00)
- Nurses/nursing aides (Rate ratio=1.32, 95% CI 1.19-1.48)

AMERICAN JOURNAL OF INDUSTRIAL MEDICINE 54:925–934 (2011)

Development and Application of a Population-Based System for Workplace Violence Surveillance in Hospitals

Judith E. Arnetz, PhD, MPH, PT,[1,2]
Deanna Aranyos,[3] Joel Ager, PhD,[1] and Mark J. Upfal, MD, MPH
[3,4]

Arnetz et al, Am J Ind Med 2011

Violence against physicians?

AMERICAN JOURNAL OF INDUSTRIAL MEDICINE 54:925–934 (2011)

Development and Application of a Population-Based System for Workplace Violence Surveillance in Hospitals

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Arnetz et al, Am J Ind Med 2011

The Journal of Reproductive Medicine®

Workplace Violence in Obstetrics and Gynecology

Results of a National Survey

Jean C. Hostage, M.D., Judith E. Arnetz, Ph.D., Angelina Cartin,
Jay Schulkin, Ph.D., and Joseph R. Wax, M.D.

Hostage et al., 2019

- MDs not always employed by hospitals
- Not included in human resource database
- Studies of specific groups
- Systematic review: no U.S. studies!

International Journal of
Environmental Research and Public Health
MDPI

Review

Workplace Violence in Outpatient Physician Clinics: A Systematic Review

Lisa Pompeii [1,*], Elisa Benavides [1], Oana Pop [2], Yuliana Rojas [3], Robert Emery [2], George Delclos [2], Christine Markham [2], Abiodun Oluyomi [1], Karim Vellani [4] and Ned Levine [5]

Pompeii et al 2020

Violence against physicians?

Research Letter

FREE

January 4, 2021

Prevalence of Personal Attacks and Sexual Harassment of Physicians on Social Media

Tricia R. Pendergrast, BA[1]; Shikha Jain, MD[2]; N. Seth Trueger, MD, MPH[3,4]; et al

» Author Affiliations | Article Information

JAMA Intern Med. 2021;181(4):550-552. doi:10.1001/jamainternmed.2020.7235

N=464 (42% response rate)

N=108 (23%) personally attacked on social media

Attacks related to:

- Social/political issues (guns, vaccines, abortion)
- Race
- Religion
- Patient care

N= 47 (10%) online sexual harassment

Research on risk factors for Type II violence

- Quantitative- literature review


Journal of Safety Research 44 (2013) 57–64

Contents lists available at SciVerse ScienceDirect

Journal of Safety Research

journal homepage: www.elsevier.com/locate/jsr

Perpetrator, worker and workplace characteristics associated with patient and visitor perpetrated violence (Type II) on hospital workers: A review of the literature and existing occupational injury data☆

Lisa Pompeii *, John Dement, Ashley Schoenfisch, Amy Lavery, Megan Souder, Claudia Smith, Hester Lipscomb

The University of Texas, School of Public Health, 1200 Herman Pressler, RAS E617, Houston, Texas 77030, USA

Pompeii et al, Journal of Safety Research, 2013

- Qualitative-content analysis


JAN

Informing Practice and Policy Worldwide through Research and Scholarship

ORIGINAL RESEARCH: EMPIRICAL RESEARCH – QUALITATIVE

Understanding patient-to-worker violence in hospitals: a qualitative analysis of documented incident reports

Judith E. Arnetz, Lydia Hamblin, Lynnette Essenmacher, Mark J. Upfal, Joel Ager & Mark Luborsky

Accepted for publication 5 July 2014

Arnetz et al, Journal of Advanced Nursing, 2015

Risk factors: Perpetrators of Type II violence

- Patients with altered mental status/behavioral issues
  - Intoxication, substance abuse
  - Delirium
  - Psychosis
  - Cognitive decline/dementia
- Angry, upset, worried/dissatisfaction with care
  - Patients, patient visitors, parents
- Patients in pain/medication withdrawal
- Patients with history of violent behavior

Risk factors for Type II violence

- Patient behavior
  - Cognitive impairment
  - Demanding to leave
- Patient care
  - Needles
  - Pain/discomfort
  - Patient transfers
- Situational events
  - Transitions in care
  - Patients in police custody

Qualitative analysis of 214 staff-reported incidents

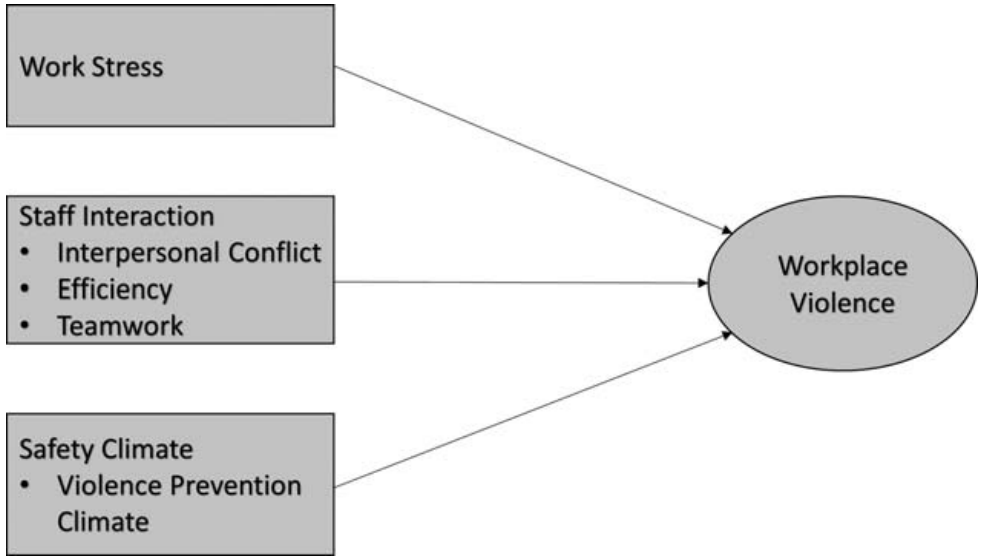
Environmental risk factors

- Poor environmental design
  - No means of escape from a violent event
  - Blocked vision
  - Open access/lack of protective barriers
- Lack of means of emergency communication
- Poor lighting (indoor and outdoor)
- Lack of metal detectors?

Situational risk factors

- Long waiting times
- Misunderstanding
- Unmet patient needs/frustration
- Short staffing
- Working alone

Organizational risk factors



Organizational Determinants of Workplace Violence Against Hospital Workers

Judith Arnetz, PhD, MPH, PT, Lydia E. Hamblin, PhD, Sukhesh Sudan, MPH, and Bengt Arnetz, MD, PhD, MScEpi

JOEM • Volume 60, Number 8, August 2018

Workplace violence in healthcare

Consequences

Consequences of workplace violence

Aggression and Violent Behavior 19 (2014) 492–501

Contents lists available at ScienceDirect

Aggression and Violent Behavior

The aftermath of workplace violence among healthcare workers: A systematic literature review of the consequences

Nathalie Lanctôt *, Stéphane Guay [1]

Université de Montréal, Criminology, Institut Universitaire en Santé Mentale de Montréal, Centre d'étude sur le Trauma, 7401 Hochelaga, Montreal, Quebec H1N 3M5, Canada

- **Individual health**
  - Physical injury
  - Psychological effects
    - fear, anger, depression/anxiety, PTSD, burnout
- **Individual performance**
  - Decreased work satisfaction, motivation, ability to concentrate/focus
  - Increased absenteeism/presenteeism
- **Organizational performance**
  - Increased sickness absence, turnover
  - Increased costs: recruitment, medical and legal expenses, etc.

Impact on quality of care

PERGAMON

Social Science and Medicine 52 (2001) 417–427

SOCIAL SCIENCE & MEDICINE

www.elsevier.com/locate/socscimed

Violence towards health care staff and possible effects on the quality of patient care

Judith E. Arnetz*, Bengt B. Arnetz

Department of Public Health and Caring Sciences, Section for Social Medicine, Uppsala University, Uppsala Science Park, 751 85 Uppsala, Sweden

- Hospital units with higher rates of staff-reported violence had lower patient ratings of the quality of care

Impact on patient safety

Nurse-Reported Bullying and Documented Adverse Patient Events

An Exploratory Study in a US Hospital

Judith E. Arnetz, PhD; Leo Neufcourt, PhD; Sukhesh Sudan, MPH; Bengt B. Arnetz, MD; Tapabrata Maiti, PhD; Frederi Viens, PhD

Nurse-reported bullying was significantly associated with the incidence of central line-associated bloodstream infections (CLABSI) on a unit level

Journal of Nursing Care Quality, 2020;35(3):206-212

Mechanisms linking violence with patient care quality?

Violence (stressor) → **cognitive failure** → **patient care**

- difficulty concentrating
- forgetful/distracted
- poor communication with colleagues
- poor communication with patients

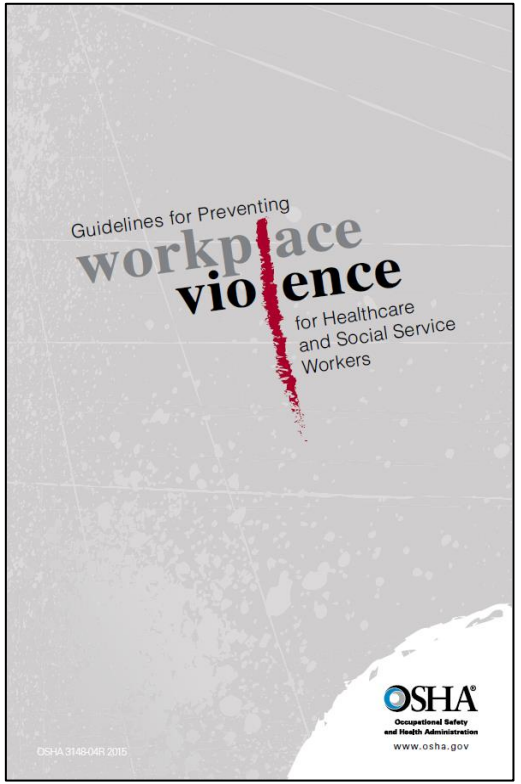
Workplace violence in healthcare

Management & Prevention Strategies

Prevention strategies

3 general approaches:

- Environmental
- Organizational/Administrative
- Behavioral/Interpersonal



2016

Environmental strategies

- Measures to create a positive and safe physical work environment
- Engineering controls to discourage would-be assailants
  - Control of entry/exits
  - Lighting
  - Alarm systems
  - Physical separation workers/customers
  - Cashless transactions

Administrative strategies

- Programs, policies and work practices aimed at maintaining a safe working environment
- Examples:
  - Flagging charts (Drummond et al,1989; Kling et al 2006; Ferron et al 2022)
  - Zero tolerance policies
  - Continuous assessment of risk situations: incident reports

Behavioral/training strategies

- Training employees to better manage/cope with violence

- Examples:
  - Educational programs
  - Conflict resolution training
  - Self-defense techniques
  - Post-incident support (de-briefing)
  - Stress management training

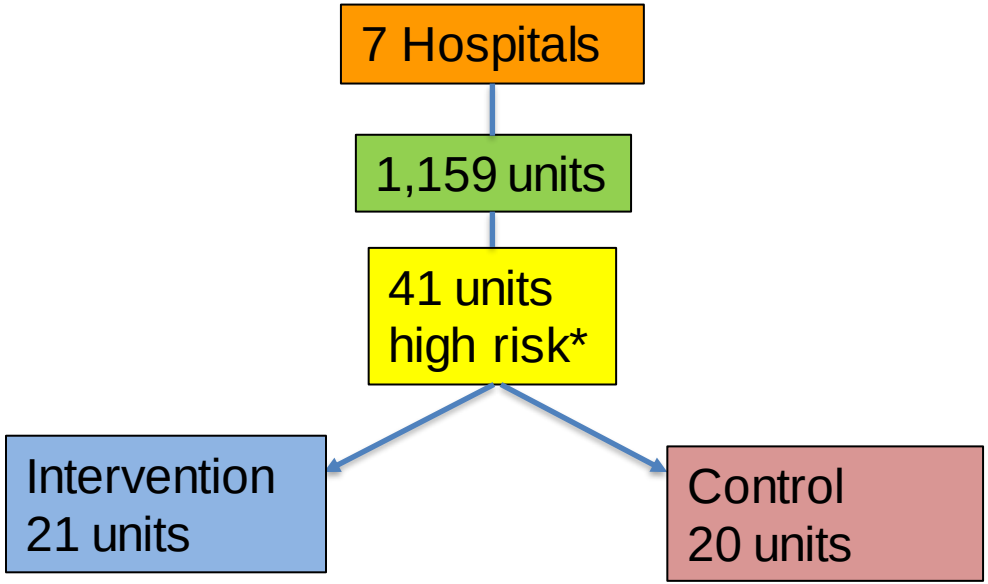
Organizational strategies

- Unit-based interventions
- Predicting violent patient behavior
- Specialized response teams

Unit-based violence prevention

- Research grant from CDC/NIOSH
  - Grant nr. R01 OH009948 (2011-2016)
  - Partnered with the Detroit Medical Center (DMC)
- Overall aim: to develop standardized methodology for workplace violence
  - Surveillance
  - Risk assessment
  - Prevention

Cluster randomized intervention (randomized by unit)



* Hazard Risk Matrix (Arnetz et al., 2014)

Workplace violence intervention

21 intervention units received a **worksite visit/walkthrough**:

- Each supervisor was presented with a summary report of workplace violence data for their unit
- Unit data were compared to corresponding data for **the entire hospital system**
- Based on the data, each unit developed an **Action Plan** for violence prevention

Worksite walkthrough
Data-driven improvement on a unit level

High-risk units identified by **Hazard Risk Matrix**

Worksite Walkthrough: 45 min. WPV Task Force present unit-level data to unit supervisor/staff

Review of risk factors and **Intervention strategies** Modified OSHA checklist

Action Plan Supervisor + staff

Follow-up

ACTION PLAN:

What:

Who:

When (Time Plan):

Contact Person: **Email:**

Checklist of suggested prevention strategies for workplace violence on hospital units (Hamblin et al., 2017)

Available at https//www.jointcommission.org

ENVIRONMENTAL

ENTRIES/EXITS

- ☐ Are there enough exits and adequate routes of escape?
- ☐ Can exit doors be opened only from the inside to prevent unauthorized entry?
- ☐ Is access to work areas only through a reception area?
- ☐ Are reception and work areas designed to prevent unauthorized entry?
- ☐ Are there security guards at the entrances and/or exits of the unit?
- ☐ Are there metal detectors at the entrances of the unit?

WORK AREA HAZARDS

- ☐ Are waiting and work areas free of objects that could be used as weapons?
- ☐ Are chairs and furniture secured to prevent use as weapons?
- ☐ Is furniture in waiting and work areas arranged to prevent employees from becoming trapped?
- ☐ Are hallways and work areas clear of obstacles that block pathways?

WORKPLACE DESIGN

- ☐ Could someone hear a worker call for help?
- ☐ Is there appropriate lighting used in patient areas? (brightly lit, dim during sleeping times)
- ☐ Is there an appropriate noise level in patient areas?
- ☐ Can workers observe patients or clients in waiting areas and rooms from their work stations?
- ☐ Are patient or client areas designed to maximize comfort and minimize

Intervention evaluation

Incident Rates of Violent Events*

- **6 months** post-intervention: *significantly lower* on intervention units vs. Controls

* Type II events

- **Incident Rates of Violence-related Injury**
- **24 months** post-intervention: *significantly lower on intervention units vs. controls*

ORIGINAL ARTICLE

Preventing Patient-to-Worker Violence in Hospitals: Outcome of a Randomized Controlled Intervention

Judith E. Arnetz, PhD, MPH, PT, Lydia Hamblin, MA, Jim Russell, BSN, Mark J. Upfal, MD, MPH, Mark Luborsky, PhD, James Janisse, PhD, and Lynnette Essenmacher, MPH

ORIGINAL ARTICLE

Worksite Walkthrough Intervention

Data-driven Prevention of Workplace Violence on Hospital Units

Lydia E. Hamblin, PhD, Lynnette Essenmacher, MPH, Mark Luborsky, PhD, Jim Russell, BSN, James Janisse, PhD, Mark Upfal, MD, MPH, and Judith Arnetz, PhD, MPH, PT

First prospective, randomized controlled study evaluating effects of a data-driven, unit-based intervention (Arnetz et al, 2017; Hamblin et al, 2017)

Tools to assess risk of patient violence in healthcare settings

- Developed for use in
  - Psychiatry (e.g., **Brøset-Violence-Checklist**, BVC) (Woods & Almvik 2002)
  - General acute care (e.g., **M55**) (Kling et al 2006)
  - Emergency departments(e.g., **STAMP** - Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling and Pacing (Luck et al 2007)

International Journal of Mental Health Nursing

International Journal of Mental Health Nursing (2019) 28, 1248–1267 doi: 10.1111/inm.12645

REVIEW ARTICLE

The validity and utility of violence risk assessment tools to predict patient violence in acute care settings: An integrative literature review

Manonita Ghosh,[1] Di Twigg,[1,2] Yvonne Kutzer,[1] Amanda Towell-Barnard,[1,2] Gideon De Jong[1] and Mary Dodds[2]
[1]School of Nursing and Midwifery, Edith Cowan University, Joondalup, and [2]Centre for Nursing Research, Sir Charles Gairdner Hospital, Nedlands, Western Australia, Australia

Specialized response teams

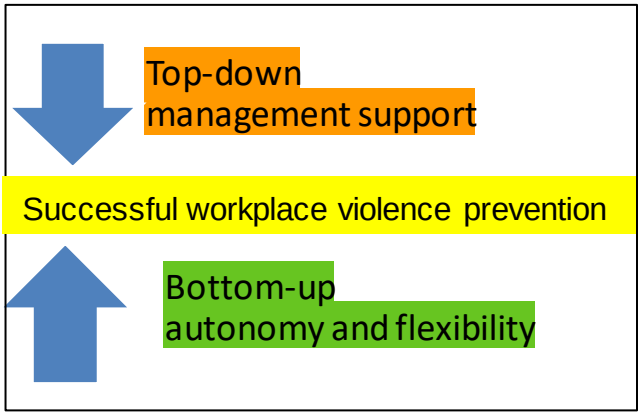
- **Behavioral Emergency Response Teams (BERT)**
  - Consists of staff members (registered nurses, social workers) from behavioral health services who have experience in caring for patients with acute psychiatric disorders as well as competence in management of assaultive behavior

(Loucks et al 2010; Derscheid & Arnetz 2020)

- **Med-Psych Teams**
  - Integrate staff with expertise in treating patients with mental health disorders in situations as needed

Organizational approaches: critical elements

- **Both management and employees play an active role**
  - Enforcing policies:
    - Prohibiting violent behavior
    - Documenting violent events
  - Culture of safety: no retaliation/reprisal for reporting
    - Psychological safety
  - Monitoring incident reports of violence
  - Holding individual worksites accountable
  - Education and training



Individual prevention strategies

- Individual healthcare worker response can mitigate patient violence
- There may be certain basic skills that all healthcare workers can learn to maximize safety and reduce/prevent violent events

Incident victims vs. skilled workers

Applied Nursing Research 63 (2022) 151544

Contents lists available at ScienceDirect

Applied Nursing Research

journal homepage: www.elsevier.com/locate/apnr

Preventing patient violence in hospitals: Applying critical decision method interviews to understand how skilled staff think and act differently

Suzanne Janzen [a], Judith Arnetz [b], Sydney Radcliffe [a], Laurie Fitzpatrick [b], Joyce Eden [c], Melanie C. Wright [d,*]

Incident victims:

- Less tolerance towards patients whose behavior they attributed to mental illness
- Greater sense of urgency to stop the aggression
- More likely to identify challenges

Skilled workers:

- Empathy for patient's situation
- Don't take patient's behavior personally
- Strategies to establish rapport
- Give patients time and space

De-escalation

- *A combination of strategies, techniques, and methods intended to reduce a patient's agitation & aggression**
- Establishing rapport to gain the patient's trust
- Minimizing restriction to protect the patient's self-esteem
- Intuitively identifying creative and flexible interventions that will reduce the need for aggression

**Joint Commission Quick Safety Issue 37, Jan 2019*
Price & Baker 2012

Hallett & Dickens 2017

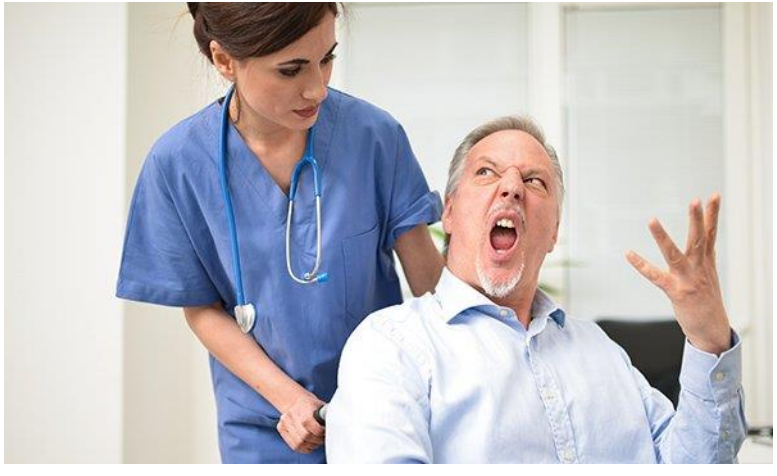
Elements of De-escalation

Communication	Self-regulation	Assessment	Actions	Maintaining safety
Forming a connection	Remaining calm	Assessing the patient's state and immediate situation	Activities to help patient displace anger/frustration	Approach the patient with slow, careful movements
Offering choices/alternatives	Self-control	Assessing the risks with interventions	Redirecting the patient's attention	Avoid vulnerable positions/isolation
Acknowledging the patient's feelings/situation	Avoid taking the aggression personally	Using all 5 senses to assess the situation	Decreasing environmental stimuli	Remain aware of risks
Slowing things down	Avoiding making judgement about the patient	Judging the anticipated trajectory of the situation	Stand if patient is standing, sit if patient is sitting	Allow the patient personal space

CAREER ADVICE

Unexpected lessons from 'difficult' patients

'Difficult' patients can be hard to like, which can in turn affect the care they receive. But make the effort to step into their world and you can transform the relationship



Mandy Day-Calder

Posted 11 July 2017 - 08:37

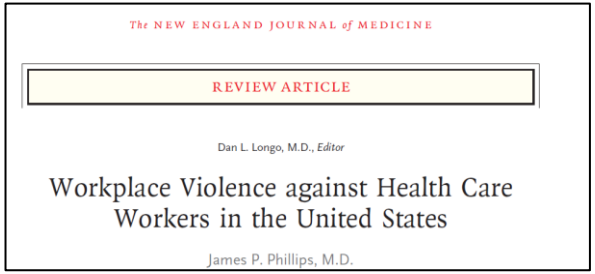
Take home points

- Patient violent behavior is more prevalent in certain environments and in patients with specific risk factors; not always predictable
- Health care worker response can mitigate patient aggression/potential violence
- Key elements of many of the response/de-escalation techniques:
  - Empathy
  - Self-regulation
  - Assessment
  - Calm/slow
  - Maintain safety for self and those around you

Summary: Why is workplace violence so difficult to address?

1. Underreporting/lack of accurate prevalence & incidence data
2. Different
   - **Perpetrators**: may be internal or external to the organization
   - **Types of violent events**: from verbal abuse to physical assault to shootings
   - **Risk factors** for care settings/types of patients
3. Despite some well-known risk factors: some violence is unpredictable

"One-size fits all" approach may not be feasible
(Phillips, 2016)


The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

Dan L. Longo, M.D., *Editor*

Workplace Violence against Health Care Workers in the United States

James P. Phillips, M.D.

The challenge

- How to change the mindset of healthcare managers and employees

  From violence is "part of the job"

  To violence is a problem that needs to be better managed and prevented?

Thank you!

arnetzju@msu.edu