

Practical Solutions – Difficult Events

Workplace Violence Prevention for Rural Hospitals



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WASHINGTON
HOSPITALS



WORKERS'
COMPENSATION
PROGRAM

Enter the reality of rural
healthcare...



When caring and healing...



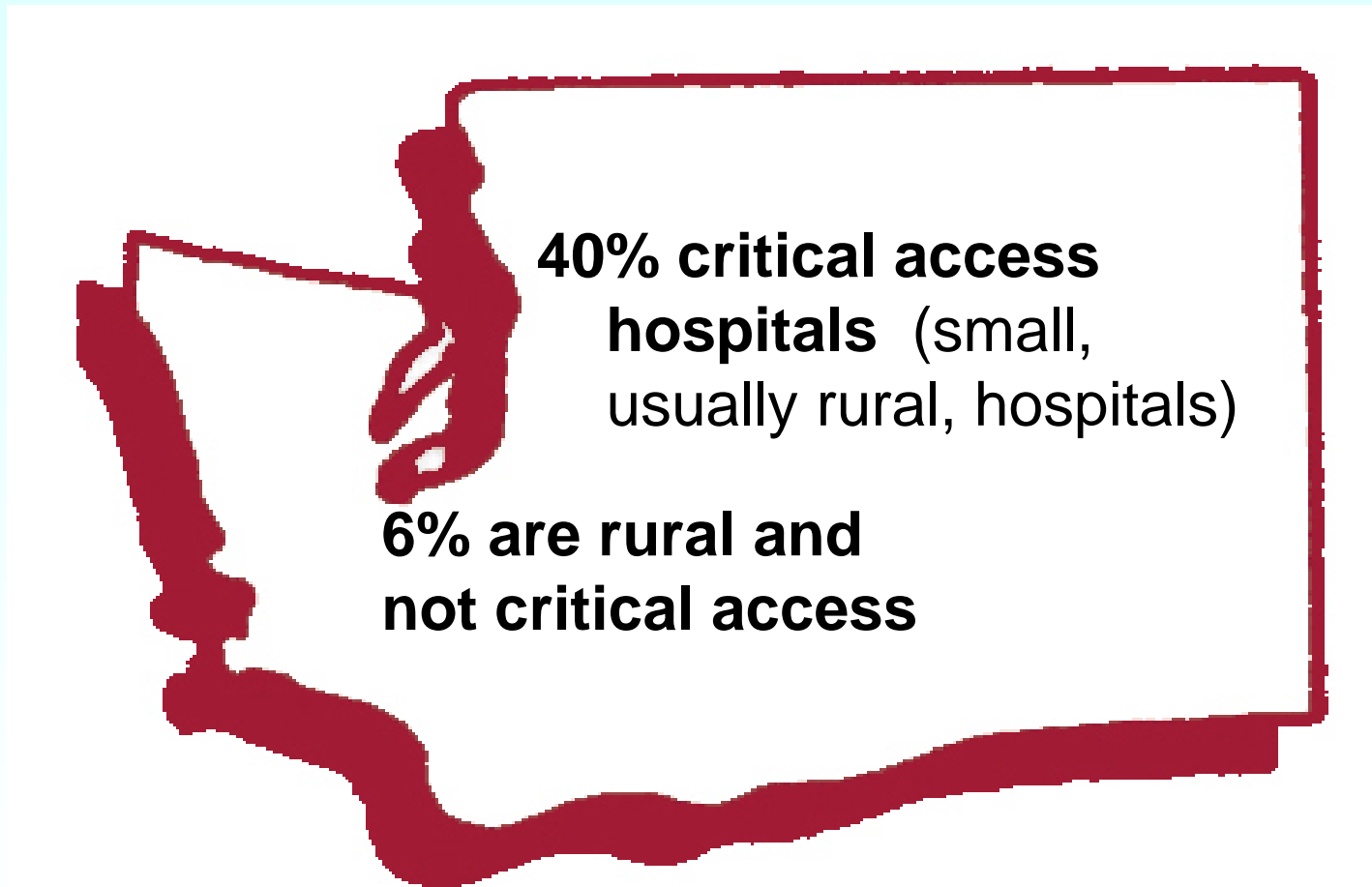
are met with..... abuse and pain



Our objectives during this session:

1. Understand the unique workplace violence risks in rural healthcare – focus on combative patients
2. Scope – including costs/benefits of interventions
3. Create clearly defined plans, goals and systems that are tested for effectiveness
4. Identify 3 best practices and solutions to deal with combative patients
5. Share effective community strategies - action plans and MOU (Memorandums of Understanding)

Risks, rewards & realities in rural Washington communities. In our state -



54% are Urban and not critical access

Reduce risk, reduce incidents:
focus on combative patients

Our #1 Goal:

Change the culture –
Violence will not
happen here!

Combative behavior in rural “healthcare settings”

- Hospitals
- Senior Behavioral Health units
- Home Health
- Hospice
- Evaluation and treatment facilities
- Community programs
- Nursing homes and residential facilities



Costs of handling combative patients...follow the money!

- Rural hospital programs, recommendations and interventions are cost driven
- Assess the data to determine the costs/benefits of interventions for workplace injuries resulting from the handling of combative patients



Data Analysis and the other story...

Numbers don't tell
the entire story



There is the very real
and incalculable cost
of ignoring combative
patient behavior

Hidden Consequences

- Medical Errors



- Overall job dissatisfaction
- Feelings of hopelessness and disempowerment
- Easily frustrated
- Physical and emotional exhaustion

Eroded productivity with excessive amounts of sick leave and...



More injuries
from workers'
compensation
claims

3 Hazards....3 Interventions

1. **Unaware of dangers:** Caregivers are intent on the patient care/transfer
2. **“Hands-on” activity:** Caregivers “get close” and into the danger zone
3. **Volatility:** Combative patients can escalate quickly and sometimes send mixed signals to caregivers

Caregiver Control Competency

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graph TD; A([Caregiver Control Competency]) --> B[De-fuse]; A --> C[Distance]; A --> D[Depart];
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De-fuse

Distance

Depart

Administrative Control

```
graph TD; A([Administrative Control]) --> B[Directions: Clear, Concise]; A --> C[Drills]; A --> D[Debriefing]
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**Directions:
Clear,
Concise**

Drills

Debriefing

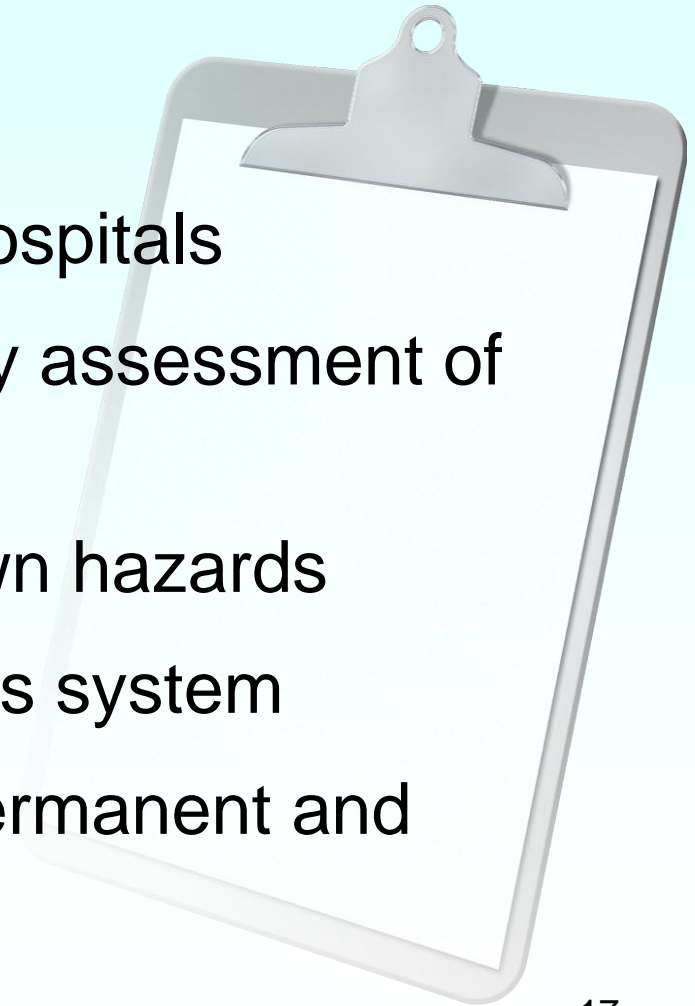
Starting Point: Compliance with Washington State Requirements

- Chapter 49.19 RCW 49.19 was passed in 1999
- This law requires “health care settings” to develop and implement plans “to reasonably protect employees from violence”
- Workplace Safety Plan, training, recordkeeping mandated



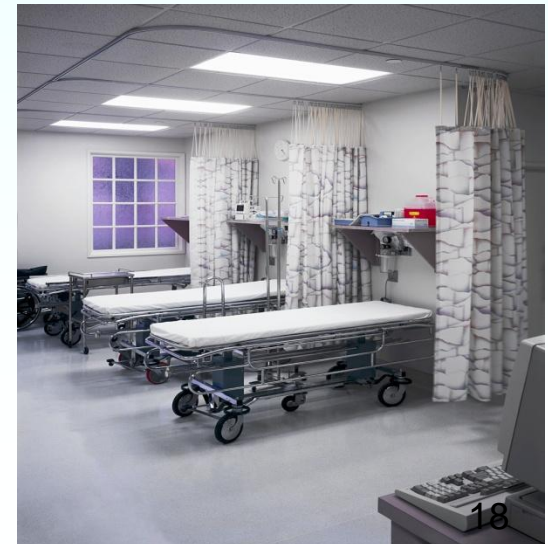
Rural hospitals and RCW 49.19: Violence prevention is **NOT** a choice!

- Plans are mandatory for all hospitals
- Mandatory security and safety assessment of potential violence hazards
- Written Plan addressing known hazards
- Incident reporting and analysis system
- Training for all employees (permanent and temporary)



Start With Goals

- Establish minimum regulatory compliance
- Systems: reporting and investigations
- Find the champions: Safe Patient Handling
- Design and begin interventions



Intervention #1 - Awareness

- What is “violence” or a “violent act”?
- Do we understand the data?
- Where can it happen?
- Who is at risk?
- How can we best train for awareness?
- How to assess the warning signs of violence?



Physical Guarding and Protective Systems

- What can happen during the care of a combative patient?
- How can the hospital systems protect the caregiver?
- How can the caregiver guard against becoming injured?
- How can the caregiver protect the patient from his/her own actions?



Acknowledge the reality and demands placed on caregivers



- ✓ Limited time
- ✓ Staffing – No help
- ✓ Changing priorities
- ✓ No support
- ✓ No time for “hands on training”

MYTH: “Not enough time...”



MYTH: “It won’t happen here...”



MYTH: “It won’t happen to me”



How to Respond to Threats?

- Talk about them ahead of time
- Conduct a physical and operational risk assessment
- Categorize risk level by job / location
- Develop and implement a plan for possible scenarios



Intervention #2: Annual training, drills and Violence Plan Assessments



Q: Is the plan evaluation a real review or just a pass to the “status quo”?

Intervention #3: Plan for Program Evolution

- Incident reporting
- Incident investigation –Use the tool of “Root Cause Analysis” to find the system errors
- Go beyond record keeping and data analysis with program evaluation



Needs of rural hospitals require programs and approaches that are:

1. Easy to understand
2. Easy to do
3. Easy to measure
4. No cost or “cost neutral”

Step #1:

SUPPORT

Help patients express feelings and channel his/her tension towards appropriate behavior

Step #2:

SET LIMITS

- Clear
- Consistent
- Enforceable
- Continue to offer alternatives
- Confront the behavior, NOT the “CHILD”

Step #3:

PROTECT & RESTRAIN

- Competency
- Drills with real scenarios
- Debriefing

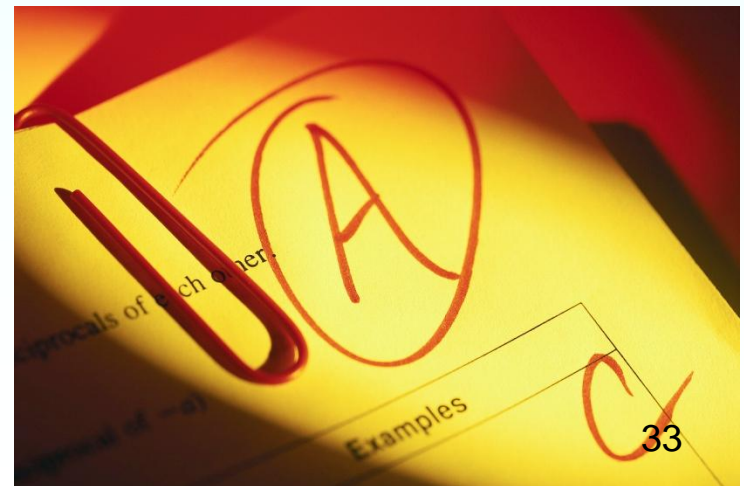
Caregiver Competency needed in Protective Movements

1. Hair pull
2. Garment grab
3. Wrist grab
4. Biting and spitting
5. Hitting



Strategy: Caregiver Competency

- Written quiz
- Demonstrated competency with real scenario
- Review with supervisor or lead



Strategy: Community

- Involve community and leaders
- Work with law enforcement for coverage
- Create Memorandums of Understanding
- Involve the police with drills
- Feed the police!

Why does violence and harm continue to occur in a place of healing?

- Organizational realities; staff shortages
- Increased acuity of mental health disorders
- Few or no resources for mentally ill in rural communities – they end up in the ED
- Increasing population of age-related dementia in rural residential facilities
- Limited internal and external law enforcement resources
- Existing buildings were not designed with security in mind

Three Best Practices

- 1) Caregivers complete a quick “violence assessment” before and during patient care.
- 2) Do a Root Cause Analysis (RCA) for each “combative patient” to understand “why” **and to create the interventions, support and focus for future staff training.**
- 3) Assess the Workplace Violence Prevention Plan, training and processes annually along with the RCA results – **are interventions working? Get staff feedback!**

Post Training Evaluation Feedback

- I have a strategy
- I'm "in control" now
- I feel supported by my supervisor
- I can provide better care to my patients



QUESTIONS?

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Three Case Studies

1. 48-bed general community hospital in Western Washington with well known high risk populations (community mental health, drug and alcohol issues)
2. 25-bed critical access hospital in Central Washington with a 37-bed nursing home
3. 25-bed critical access hospital in Eastern Washington with an ambulance service

