Leaders Care: Mitigating Violence against Emergency Department Staff

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Leaders Care: Mitigating Violence against Emergency Department Staff 2012
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Problem Statement
• Emergency Department (ED) staff felt that support by leaders for mitigation of violence in the ED was lacking and were reluctant to report violent situations in a timely manner. The staff lacked confidence in hospital security systems and security officer skills and abilities.

Introduction
• In a 2009 study by the Emergency Nurses Association, 25% of registered nurse respondents experienced physical violence greater than 20 times in the previous three years (Gacki-Smith, Juarez, Boyett, Homeyer, Homme, and MacLean 346).
• Hospital staff may be fearful to report violent incidents for many reasons including performance critique from their managers (Occupational Safety & Health Administration. 2004).
• The Joint Commission identifies that a causal factor in 62% of hospital violence events is leadership related, specific to policy clarity and implementation (TJC 2010).
• Kowalenko, Walters, Khare, and Compton identified a minimum of 2 of staff security training with only 2% of ED physician responders having police officers providing ED security and 9% carrying weapons (346).
• Our objective was to identify employees’ perceptions regarding environmental security our 29 bed/2 triage-room ED.
• Our findings guided intervention development to maximize environmental security.

Emergency Department Multidisciplinary Violence Committee

Methods
• We used a pre- and post- intervention survey with some open-ended questions to assess staff’s perception about their safety.
• The survey was designed by the Multidisciplinary Committee and administered via Survey Monkey.
• All ED staff, security officers & patient registrars received the survey via email.
• Data was analyzed using Mann-Whitney U tests, due to small sample size, for differences in responses pre- and post-interventions at 0.05 level of significance.
• Initial survey results from 2009 fourth quarter guided interventions from hospital and staff perspectives.
• Repeat survey in 2011 in second quarter to identify significant differences in staff’s perceptions following interventions.

Results
• Significant differences were noted in 5 of the 11 questions from the initial to the second send of the survey.
• Significant differences were noted in 3 of the 4 hospital-related questions, and 2 of the 4 staff-related questions. All questions increased as to percentage of positive responses.
• 3 of the 11 questions on training, identification of patients at risk, and confidence in colleagues were strongly positive on the initial survey and not a second send of the survey.

Table 1: Mean Scores Change

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre 2009</th>
<th>Post 2010</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership Commitment</td>
<td>2.67</td>
<td>2.89</td>
<td>8.83</td>
</tr>
<tr>
<td>Effective Procedures to Maximize Security</td>
<td>2.19</td>
<td>2.99</td>
<td>80.00</td>
</tr>
<tr>
<td>Proactive Approaches to Security</td>
<td>2.8</td>
<td>3.04</td>
<td>8.83</td>
</tr>
<tr>
<td>Effective Response of Employee Security Issues</td>
<td>2.8</td>
<td>4.84</td>
<td>166.67</td>
</tr>
<tr>
<td>Staff Question</td>
<td>2.75</td>
<td>3.11</td>
<td>17.06</td>
</tr>
<tr>
<td>Follow Behavioral Health Patient Procedures</td>
<td>2.75</td>
<td>3.17</td>
<td>14.76</td>
</tr>
<tr>
<td>Use of Effective De-escalation Skills</td>
<td>2.75</td>
<td>2.83</td>
<td>1.93</td>
</tr>
<tr>
<td>Communication of Plan of Care</td>
<td>2.75</td>
<td>2.86</td>
<td>5.71</td>
</tr>
</tbody>
</table>

• Repeat survey in 2011 in second quarter to identify significant differences in staff’s perceptions following interventions.

Interventions
• Mitigation Interventions were identified and clustered into these five categories.

Leadership Commitment
• Leaders committed to creating and supporting culture of staff, patients and keeping patients’ safety, respect, and caring a top priority.

Multidisciplinary ED Violence Committee
• Establish multidisciplinary committee.
• Encourage staff reporting of incidents at earliest opportunity.
• Take immediate actions related to staff concerns.
• Provide education as to metal detection; patient watches and de-escalation, personal protection and patient detention/lockdown techniques
• Provide format for coding of patients with repeated episodes of violence (Code S); and hospital issued restraining orders presented by police (Code R).

Assessments
• Security environmental assessment by security consultant.
• Staff perceptions as to safety and security.

Security Excellence Plan
• Update the security officer’s role.
• Adopt the security officer certification program through the International Association of Healthcare Organizations as a required training program.
• Provide security personal protection equipment.
• Establish environmental controls with video system with control center concept.
• Add security officer FTE support with increased presence in ED.
• Conduct reviews of incidents requiring restraint.

Next Steps
• Review security video tapes to identify any educational gaps.
• Support staff champions to communicate changes.
• Develop handoff tool for staff and security.
• Remodel staff with trended performance concerns with escalating patients.
• Consider security environment enhancements.
• Trend employee injuries related to violence.
• Keep in contact with staff injured on the job.
• Involving staff in state wide legislative activity to promote regulations.

Conclusions
• Ongoing educational initiatives, policy revision, and clarification of roles responsibilities.
• A common language for communication between clinical, clinical, and security staff.
• Timely and thoughtful review of contextual factors contributing to violence.
• Staff reporting of violent incidents.
• Staff role accountability in violent incidents.
• Security Excellence Plan.
• Zero Tolerance Policy.

Bibliography

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