Violence Prevention Training for Emergency Department Staff

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ABSTRACT

In June 2011, the Pennsylvania Patient Safety Authority surveyed violence protection practices in Pennsylvania acute care hospitals. The survey was based on current best practices, including the guidelines of the International Association for Healthcare Security and Safety and Occupational Safety and Health Administration. Survey results were presented in the December 2011 Pennsylvania Patient Safety Advisory. *Gaps identified through the survey suggest opportunities for improving violence protection practices in the emergency department (ED). ED staff and patients are being exposed to violence, and studies support that violence prevention training is an important component in a comprehensive violence prevention program. Available research supports the need for violence prevention training for staff in the ED as part of a comprehensive violence prevention program. Risk reduction strategies and best practices promoted by professional organizations and accrediting bodies promote patient safety, as well as the safety of visitors and ED staff. (Pa Patient Saf Advis 2012 Mar;9[1]:1-4.)*

INTRODUCTION

Events of violence in the emergency department (ED) are a safety risk for patients and staff. In June 2011, the Pennsylvania Patient Safety Authority surveyed Pennsylvania acute care hospitals about violence protection practices in the ED. The survey was based on current best practices, including the guidelines of the International Association for Healthcare Security and Safety (IAHSS) and Occupational Safety and Health Administration (OSHA). Survey results were presented in the December 2011 *Pennsylvania Patient Safety Advisory*.[1] Gaps in violence protection practices identified through the survey suggest opportunities for improving violence protection practices to increase the safety of both ED staff and patients. Training in violence prevention practices for ED staff was one potential gap and is the focus of this article. Sixty-eight percent of survey respondents reported that their hospitals offered violence prevention training to staff; however, only 36% of all respondents reported mandatory violence prevention training for ED staff.

A comprehensive violence prevention program, which includes violence prevention training for staff, has been recognized as essential to the prevention of violent incidents in the healthcare setting.[2,3] However, violence prevention programs are not mandated under federal law, and currently only nine states have enacted laws requiring violence protection programs in healthcare facilities, better reporting, or additional study of the problem.[4] In Pennsylvania, a new bill has been introduced that would require Pennsylvania hospitals and other healthcare facilities to take steps to protect nurses and other healthcare workers from workplace violence.[5] House Bill 1992, if enacted into law, would require hospitals to establish a violence prevention committee, develop a written violence protection plan, and assess security risks annually to create a safer workplace.

Organizations such as IAHSS and OSHA promote comprehensive violence prevention programs. The Joint Commission's June 2010 issue of *Sentinel Event Alert* emphasized the existence of violence in healthcare; the risk to patients, visitors, and staff; and the need to provide more effective workplace violence education.[6] The Emergency Nurses Association and the American College of Emergency Physicians have issued policy statements recommending that hospitals educate staff on handling violence.[7,8]

Despite recommendations from professional organizations, accrediting bodies, and legislators, ED violence rates continue to rise, exposing patients, staff, and visitors to the risk of harm.[9] There is not a large body of research to quantitatively address which techniques are effective in violence prevention in the ED and none identified as of January 13, 2012, showing whether this training should be mandatory. However, several recent studies support staff training as an important component in any violence prevention program. In addition, events reported to the Authority exemplify instances in which violence prevention training may have resulted in a different outcome. Available studies supporting the need for violence prevention training as part of a comprehensive violence prevention program and related risk reduction strategies will also be discussed.

AUTHORITY EVENT REPORTS

Events of violence in the ED reported to the Authority (384 events of violent acts or verbal abuse reported from 2006 through 2010) are described in a December 2011 *Advisory* article.[1] The need for violence prevention training, particularly violence de-escalation techniques, may have been a contributing factor in the following examples of Authority reports.

Patient was being combative and swinging his fists while staff and a family member were trying to keep him from climbing out of bed. The patient sustained bruises on both hands.

A patient was in a waiting area when another person approached the patient and punched the patient's face several times. Prior to being assaulted, the victim had gone to the registration window to alert staff that a person was verbally assaulting others in the waiting area. Security was called to the ED but had not yet arrived when the assault occurred.

The patient came to the ED complaining of back pain and was also diagnosed with a behavioral problem. The patient became extremely combative and uncooperative in the ED. The patient was physically and verbally abusive to staff. The patient scratched two employees. The police were called by hospital security.

The physician was informing the patient of the need for intravenous antibiotics for cellulitis of the foot. The patient became agitated and punched the physician in the eye. When asked why he hit the physician, the patient would not answer. Police and hospital security were notified.

The patient attempted to run out of the ED. The nurse confronted the patient and asked where the patient was going. The patient raised both hands and attempted to hit the nurse. The nurse defensively took hold of both of the patient's hands. Other staff members moved in to assist the patient in walking back to the room. The patient continued to yell at staff and attempt to get free. Staff attempted to assist the patient to lie down on the litter. The patient's hand became free and grabbed a hold of a nurse's throat . . . Staff and security took control of the patient.

VIOLENCE PREVENTION TRAINING IN THE LITERATURE

Although only 18% of states currently mandate violence prevention training for ED staff,[4] the need for a comprehensive violence prevention training program has been demonstrated in several studies. In 2007, Peek-Asa et al. compared workplace violence prevention programs in a randomly selected and representative sample of EDs in California and New Jersey.[10] California was the first state to enact legislation requiring that acute care and psychiatric hospitals implement comprehensive workplace violence prevention programs.[11] California was also the first state to release specific guidelines for the establishment of such a program.[12] In comparison, New Jersey follows only federal OSHA guidelines.

The goal of the study was to determine the most commonly implemented violence prevention program elements and identify gaps in existing programs.[10] With regard to workplace violence training, over 91% of California hospital EDs provided workplace violence prevention training as required by California law. New Jersey has no training requirements, and 72% of New Jersey hospitals provided workplace violence protection training. Mandatory training for staff regularly assigned to the ED was reported by 7.5% of California hospitals and 5.6% of New Jersey hospitals. The study showed that while the majority of hospitals offered violence protection training, few ED staff are actually trained. The study identified that it was common for hospitals to offer existing packaged programs that did not include hospital-specific policies and procedures and potential risk factors. Peek-Asa et al. note that states interested in enacting security legislation should take into account the variance in hospital environments and require that hospitals design programs that are specific to their needs.

Blando et al. also studied hospital workplace violence protection programs and examined how security features varied by size of the hospital and by the hospitals' background community crime rate.[13] During the 10-year study period, the rate of assaults against ED staff was highest in small hospitals in areas with high rates of violent crime. Small hospitals located in communities with low violent crime rates had the second-highest rate of serious assaults against ED staff among all hospital categories. These results were thought to be related to the variance in hospital security programs due in part to the perception of risk for violence. Staff in all hospitals reported incidents of violence among all types of patients and visitors due to the high stress and emotionally challenging experience of an ED visit. The authors cite that the variability in hospital security programs found in this study argues for the need to ensure consistency and implementation of security programs with features such as those in the OSHA guidelines and that a comprehensive security program is needed in all hospital EDs.

Benham et al. addressed the issue of violence protection programs and the rate of violent acts experienced by ED residents and attending physicians. In a prospective, cross-sectional online survey of emergency medicine residents and attending physicians in 65 emergency medicine residency programs, Benham et al. demonstrated that at least one workplace violence act in the previous 12 months was reported by 78% of respondents, with 21% reporting more than one type of violent act.[14] The most common type of workplace violence was verbal threats (75%), followed by physical assaults (21%), confrontations outside the workplace (5%), and stalking (2%). Security was available full-time in most settings (98%) but was least likely to be physically present in patient care areas. The majority of respondent EDs did not screen for weapons (60%) or have metal detectors (62%). Notably, only 16% of programs provided violence workshops and less than 10% offered self-defense training. Self-defense training was not associated with a reduction in violence,

but respondents who reported attending a violence prevention workshop were less likely to report experiencing verbal abuse, suggesting that communication techniques can be used to de-escalate a situation before it erupts into physical violence. The authors also suggest that more research is needed to determine the impact of violence prevention training on violence in the ED.

ED VIOLENCE PREVENTION PROGRAMS

More research is needed to study the impact of violence protection programs on violence in the ED. However, gaps in violence protection programs were noted in the above studies and in the Authority's ED violence protection practices survey, suggesting the need for a comprehensive violence protection program that includes training ED staff. A recent project has identified implementation strategies most likely to be successful in violence prevention efforts. In 2006, a multidisciplinary team at the University of Wisconsin Hospitals and Clinics (UWHC) developed a comprehensive ED security program in response to concerns about violence voiced by ED nursing staff.[15] The program components include the following:

Stages of escalation grid. A staged escalation grid (i.e., green, yellow, and red levels) addresses security status changes and creates awareness of changing conditions in the ED.

Staff cues. Green, yellow, and red lights are placed strategically around the ED to represent the security status of the ED. A change in status is cued by a three-second audible alarm. Green represents business as usual, yellow heightened tension levels, and red a threat to safety and security (e.g., behavioral problems, surge capacity issues, gang-related activities, police involvement).

Huddle. A huddle between the ED team leader, a security supervisor, the ED attending physician, and the nursing coordinator is required before the decision is made to change the color status.

Access control/security presence. The number of visitors and amount of security presence is determined by the stage the ED is experiencing. Difficult parties are separated as necessary to de-escalate potentially dangerous situations. Difficult parties may be moved from one side of the waiting room to the other or completely outside the ED waiting room.

Staff training. Engagement and training of all staff is a critical component of the program. Staff are trained to recognize environmental changes that can escalate into violent disruptions if not handled quickly and effectively. Training is mandatory and conducted when members of all disciplines are present. Training includes presentations, videos, and interactive team exercises.

In the two years before implementation of the UWHC program, staff reported a number of injuries from being punched, hit, and bitten. After implementation, there has been one reported injury and no injury-related absences. Staff reported the belief that the program has not decreased day-to-day risk, but has helped them identify the stages of escalation and take appropriate, prompt action. The authors report that the UWHC ED security program outlines strategies to meet the needs of the patient and their support network, and that the process has allowed the nursing staff to focus on the primary nursing care needs of their patients.

In addition to considering the program components above, facilities may consider incorporating the training components of an ED violence prevention program identified by Peek-Asa et al.[9] As previously discussed, the authors compared elements of the California state guidelines and the New Jersey approach based on federal OSHA guidelines. Recommending that workplace violence training be required for all employees regularly assigned to the ED, the authors highlighted the following training topics to be covered in ED violence prevention programs:

- Hospital safety policies and procedures
- Aggression and violence predicting factors
- Characteristics of aggressive and violent patients
- Verbal methods to diffuse or avoid aggressive behavior
- Obtaining a history from a patient with violent behavior
- Techniques for restraining violent patients
- Self-defense if preventive action does not work
- Appropriate use of medications to subdue aggressive patients
- Resources available for victims of workplace violence
- How to report a violent event

Training specific to the hospital's policies, procedures, and potential risk factors has been recommended.[10] Before training interventions are implemented, a thorough needs assessment will help identify weaknesses from material, systematic, environmental, or cultural sources.[16] OSHA provides a workplace violence protection checklist that can assist in the development of a needs assessment at http://www.osha.gov/Publications/OSHA3148/osha3148.html.[3] The National Institute for Occupational Safety and Health (NIOSH) has also published strategies for workplace violence prevention training applicable to the ED setting.[17] The strategies emphasize management and worker commitment to workplace violence prevention and a multidisciplinary approach. NIOSH recommends the presence of management at training sessions to demonstrate the organization's top-down support of the program. Training (initially and on a recurring basis) can be provided on the

hazards specific to the organization, with emphasis on reporting requirements. A train-the-trainer approach may be used, with supervisors responsible for training and evaluating training for their own staff.

CONCLUSION

Those who work in and visit the ED are increasingly being exposed to violence. A comprehensive violence prevention program is necessary to promote a safe environment for patient care in the ED. Mandatory training for ED staff is one gap in violence protection practices identified by the Authority's survey of violence protection practices. Staff training in violence prevention strategies as part of a comprehensive violence prevention program can promote the safety of patients, staff, and visitors.

NOTES

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