Violence in the Workplace
“One Hospital’s Perspective”

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Awards, Certifications & Accolades

- 2016 Gold Plus
- Top Workplaces 2014
- Top Workplaces 2016
- Top Workplaces 2015
- Accredited Center
- Quality Program
- 2016 Sepsis Hero
- NAPBC
- HomeCare Elite Top Agency
- 2016 HHCAHPS
- ACR
- The Joint Commission
- National Quality Approval
- A Hospital Safety Score
- Best Regional Hospitals
- Best Regional Hospitals
- HFAP
- Recognized Practice
- NCQA
- NICHE Designated Hospital
- Women's Choice Award
- Kennedy Health

Nurses Improving Care for Healthsystem Elders

LEADERSHIP EXCELLENCE

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Objectives

- Define workplace violence
- Describe professional organization’s position on workplace violence
- Define active shooter
- Discuss characteristics of a shooter
- What is workplace violence?
- How to recognize perspective shooter behavior and risk factors
- Video clip: A shooter among us
Objectives

• Describe one hospital’s experience
• Describe the response of hospital staff
• Describe the “aftermath” of a shooting event
• Describe the follow up after the event using a 6 Stage Process
What is Workplace Violence?

• Workplace violence is any act or threat of physical violence, harassment, intimidation or other threatening disruptive behavior that occurs at the work site
• Ranges from threats and verbal abuse to physical assaults to homicide
• Homicide is currently 4th leading cause of fatal occupational injuries
• In 2014, approximately 9% of workplace fatalities was homicide

U.S. Department of Labor-Occupational Health and Safety 2015
What is workplace violence, cont.

"...incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work, involving an explicit or implicit challenge to their safety, well-being or health."

The World Health Organization (WHO) and the International Council of Nurses (ICN)
Regulatory Requirements for Workplace Safety

• **Joint Commission Standard LD.03.01.01** Leaders create and maintain a culture of safety and quality throughout the organization.

A4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

A5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

*(Applicable to ambulatory care, critical access hospital, home care, hospital, laboratory, long term care, Medicare-Medicaid, certification-based long term care, and office-based surgery programs and behavioral health care programs.)*
ANA Position Statement on Workplace Violence, 2015

• Registered Nurses and employers in all settings, including practice, academia, and research, must collaborate to create a culture of respect, free of incivility, bullying, and workplace violence

• Best practice strategies based on evidence must be implemented to prevent and mitigate incivility, bullying, and workplace violence

• Promote the health, safety, and wellness of Registered Nurses; and to ensure optimal outcomes across the health care continuum.
ANA Position Statement on Workplace Violence, cont.

• Also relevant to other health care professionals and stakeholders who collaborate to create and sustain a safe and healthy interprofessional work environment

• Stakeholders who have a relationship with the worksite have a responsibility to address incivility, bullying, and workplace violence
AONE-ENA 8 Guiding Principles
Mitigation Violence in the Workplace, 2014

1. Recognition that violence can and does happen anywhere.
2. Healthy work environments promote positive patient outcomes.
3. All aspects of violence (patient, family and lateral) must be addressed.
4. A multidisciplinary team, including patients and families, is required to address workplace violence.
5. Everyone in the organization is accountable for upholding foundational behavior standards, regardless of position or discipline.
AONE-ENA 8 Guiding Principles

Mitigation Violence in the Workplace, 2014, cont.

6. When members of the health care team identify an issue that contributes to violence in the workplace, they have an obligation to address it.

7. Intention, commitment and collaboration of nurses with other health care professionals at all levels are needed to create a culture shift.

8. Addressing workplace violence may increase the effectiveness of nursing practice and patient care.
ENA Position on Workplace Violence, 2014

1. Emergency nurses are at significant occupational risk for WPV

2. The mitigation of WPV requires a “zero tolerance” environment instituted and supported by hospital leadership

3. Emergency nurses have the right to personal safety in the work environment

4. Emergency nurses have the right to education and training related to the recognition, management, and mitigation of WPV

5. Emergency nurses have the right and responsibility to report incidents of violence and abuse to their employer and law enforcement without reprisal
ENA Position on Work Place Violence, cont.

6. Emergency nurses have the right to expectations of privacy, appropriate injury care, and the option for debriefing and professional counseling

7. Protection against acts of violence include effective administrative, environmental, and security components

8. State legislation in support of emergency nurses who have experienced WPV may lead to more effective WPV programs

9. Emergency nurses have a vested interest in and a responsibility to conduct and participate in research and quality improvement initiatives aimed at preventing, mitigating, and reporting WPV
Facts

• Emergency Nurses Association’s latest annual Violence Surveillance Study survey, which polled more than 3,200 nurses across the United States in 2011, found patients who were drunk accounted for 54.7% of the assaults, while 45.9% were under the influence of drugs and 43.1% were psychiatric patients.

• In 2014, 3 in 4 nurses experienced verbal or physical abuse, such as yelling, cursing, grabbing, scratching or kicking, from patients and visitors.

• Elderly have high violence to healthcare workers: dementia, polypharmacy, aggressive behaviors.
Facts, continued

- Nurse report: 36.4% have experienced physical violence, 66.9% reported nonphysical violence, 39.7% reported bullying, and 25% reported sexual harassment, with 32.7% of nurses reporting having been physically injured in an assault.
- Between 2000-2001: 154 hospital-related shootings with 161 lives lost includes. This includes 70 innocent victims and 90 perpetrators
- 2.5% active shooter incidents occurred in healthcare facilities
Definition of an Active Shooter vs. other Gun-related Incidents (e.g., a single shot fired)

- An individual actively engaged in killing or attempting to kill or attempting to kill people in a confined and populated area

  U.S. Department of Homeland Security

- FBI identified 160 active shooter events from 2000-2013
- 45.6 percent took place in a commercial environment (73 incidents)
- 24.3 percent that took place in an educational environment (39 incidents).
- 30.1 percent open spaces, military and other government properties, residential properties, houses of worship, and health care facilities
Characteristics of a Healthcare Shooting

- 91 (59%) inside the hospital and 63 (41%) outside on hospital grounds
- 235 injured or dead victims
- The Emergency Department environs were the most common site (29%), followed by the parking lot (23%), and patient rooms (19%)
- Most events involved a determined shooter with a strong motive defined by a grudge (27%), suicide (21%) "euthanizing" an ill relative (14%), and prisoner escape (11%)
- Ambient society violence (9%) and mentally unstable patients (4%) were comparatively infrequent
Characteristics of a shooting, cont.

- The most common victim was the perpetrator (45%).
- Hospital employees composed of 20% of victims.
- Physicians (3%) and nurses (5%) victims were relatively infrequent.
- [Link](http://dx.doi.org/10.1016/i.annemergmed.2012.08.012)

International Association of Emergency Medical Services Chiefs (IAEMSC)
Categories of Workplace Violence:

• TYPE 1: Violent acts by criminals who have no other connection with the workplace, but enter to commit robbery or another crime.

• TYPE 2: Violence directed at employees by customers, clients, patients, students, inmates, or any others for whom an organization provides services.

• TYPE 3: Violence against coworkers, supervisors, or managers by a present or former employee.

• TYPE 4: Violence committed in the workplace by someone who doesn’t work there, but has a personal relationship with an employee—an abusive spouse or domestic partner.
Behavior Alerts

• Pathway warning behavior – any behavior that is part of research, planning, preparation, or implementation of an attack

• Fixation warning behavior – any behavior that indicates an increasingly pathological preoccupation with a person. It is measured by:
  
  Increasing perseveration (repetition) on the person or cause
  Increasingly strident opinion
  Increasingly negative characterization of the object of fixation
  Impact on the family or other associates of the object of fixation, if present and aware
  Angry emotional undertone – typically accompanied by social or occupational deterioration
Behavior Alerts, cont.

- Identification warning behavior: “warrior” mentality
- Novel aggression warning behavior: “try-out”
- Energy burst warning behavior: increase in any activity related to proposed victim
- Leakage warning behavior: communication to third party
- Last resort warning behavior: increasing desperation or distress
- Directly communicated threat warning behavior: direct communication to target or law enforcement

Workplace Violence attackers

- Most of the perpetrators (90%) planned and prepared their attack beforehand, such as:
  - 30% illegally obtaining a gun
  - 10% constructing explosives or
  - 10% starting surveillance of the residence of the targeted victim
  - 35% displayed final-act behaviors such as ensuring the financial well-being of their families or sending farewell letters to friends – an aspect of last resort
  - Final acts can also occur when people plan to commit suicide
Common background of attackers

- Feel despair
- Suffer from depression or have suicidal thoughts
- History of stalking or harassing
- Suffer main loss or change in life
- Have an obsession with violence
- Development of attack plan
- Approach or visit attack site
- Attempted assault or actual attack
- Approach site visit with weapon

Doherty, (2016)
Violence Risk Factors

• History of and previous convictions for violence, weapons possession, drug use
• Suicidal ideation, homicidal ideation, last resort thinking, high-risk psychotic phenomena, and psychopathy.
• Workplace Assessment of Violence Risk Assessment tool: motives for violence; homicidal ideas, fantasies or preoccupations; violent intentions or expressed threats; weapons skill and access; and pre-attack planning and preparation

(WAVR-21;White & Meloy, 2007) cited: The Role of Warning Behaviors in Threat Assessment: An Exploration and Suggested Typology
Video Clip: A Shooter Among As

- Video clip

- https://www.youtube.com/watch?v=A8syQeFtBKc
Kennedy University Hospital - Stratford, NJ
CBS News:

STRATFORD, NJ — Investigators say a man fatally shot his wife and then wounded himself inside a hospital room in South Jersey Wednesday.

The incident happened inside Kennedy University Hospital on East Laurel Road in Stratford, New Jersey.

In addition, the Camden County Prosecutor’s Office said the couple’s son was later found fatally shot at their home.
August 24, 2014

- What happened?
- Where did it happen?
- What the clinical staff did to respond?
August 24, 2014

- Lockdown
- Incident Command
- Response by hospital staff
August 24, 2014

- Response by hospitalized patients
- Response by visitors
- Response by community
Hospital CEO Joe Devine said this is the first shooting at a Kennedy Health System hospital in 50 years. He also said that hospital security does not use wands or search visitors.

“That's not our protocol," Mr. Devine told The Inquirer: "We have to provide access."
August 30, 2014

Courier-Post Newspaper:

Helene Burns, Kennedy Health’s Chief Nurse Executive, said the day was the most tragic in her 33-year career. It also was her most inspirational.

Burns praised the staff for their quick response, and how they rallied together and checked every patient on the second-floor unit, where the crime occurred.

"One of the things that really struck me was that in the two hours after the event, every nurse had been relieved off that unit," she added. "Other nurses just came in from home and relieved them of their duties."
Post-Event

Stage 1: Avoid the Crisis

• What did we miss?
• Scanning the environment & looking for patterns
• Triggers
• Building safety
Post-Event

Stage 2: Prepare to Manage the Crisis

• Emergency Operation Committee
• Yearly assessment of “possible crisis event”
• Need to include active shooter training
Post-Event

Stage 3: Recognize the Crisis

- Active shooter
- Lock down
- Internal Disaster initiated
- Communication
Post-Event

Stage 4: Contain the Crisis

• Active shooter
• Lock down
• Internal Disaster initiated
• Communication
Post-Event

Stage 5: Resolve the Crisis

- Visibility
- Communication
- Counseling for associates
Post-Event

Stage 6: Learn from the Crisis

• Reporting
• Active shooter training for all associates
• Screening for social service needs
• Building safety and intake process for visitor
References


References, cont.


• ANA Position Paper on Workplace Violence, July 22, 2015

• AONE-ENA Position Paper on Workplace Violence, 2014

• ENA Position on Workplace Violence, 2014

• Joint Commission U.S. Department of Homeland Security

• National Institute for Occupational Health and Safety

Learn How to **SURVIVE** A Shooting Event in a Healthcare Setting
International Association of Emergency Medical Services Chiefs (IAEMSC)
1900 L Street., NW, Suite 705 Washington, D.C. 20036
www.IAEMSC.org

Resource: **Workplace Violence Prevention for Nurses:** CDC Course No.
WB1865 - NIOSH Pub. No. 2013-155
Thank you