Introductions

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NY Times Article Highlights Issue

When the Hospital Fires the Bullet

More and more hospital guards across the country carry weapons. For Alan Pean, seeking help for mental distress, that resulted in a gunshot to the chest.

IAHSS 2014 Survey: Weapons Use Among Hospital Security Personnel
NCQC PSO Database

How Can We Handle This Issue?

- Help clinicians detect patients at high risk
- Assist in identifying appropriate steps to manage risk
- Reduce number of injuries to staff & patients
Getting to the Root Cause(s)

NCHA Behavioral Health Workgroups

• Pre-Hospitalization Crisis Response
• ED Boarding
• Post-Hospitalization Integration into Community-based Care

Safe Table Event Sharing
All Tied Up!
Patient Violence & Aggression

Lisa Terry, CHPA, CPP
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Objectives:

• Review of the severity of violence in healthcare
• Discussion of strategies to reduce violence
• Importance of teamwork between security, police and clinicians
• Low cost, no cost responses
• A look at the future....
Severity of the Problem
(From “Behavioral Health Patient Boarding in the ED” Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

1. In 2007, 12 million Emergency Department visits were related to mental health and substance abuse constituting 12.5 percent of the total Emergency Department visits. 9

2. There was a 42 percent increase in boarding behavioral health patients in Emergency Departments in the US in 2007.

3. American College of Emergency Physicians (ACEP) conducted a survey in 2008 which found that 99 percent of emergency physicians admit psychiatric patients daily. 31

5. In a survey conducted in the state of MA, 100 percent Emergency Department directors reported boarding of psychiatric patients with 85 percent on daily basis. This reflects a clear 50 percent rise since 2007 levels.

6. The conditions are even acute in rural hospitals. Hospitals reported ED stays lasting up to 18 days.
Severity of the Problem
(From “Behavioral Health Patient Boarding in the ED” Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

7. Interviews conducted with ED directors of 15 safety net hospitals around US reported that EDs act as a safety net for psychiatric treatment as access to both inpatient and outpatient psychiatric care is limited.33

8. A study at the Boston Medical Center, Massachusetts reveals that 34 percent of children with severe psychiatric needs are admitted to inpatient pediatric services rather than the inpatient psychiatric services.3

Safety Concerns for Healthcare Workers
(From “Behavioral Health Patient Boarding in the ED” Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

1. Workplace violence affects about 1.7 million U.S. employees each year directly and millions more indirectly.

2. Health care is categorized as a high risk profession constituting 48 percent of all non-fatal assaults in the U.S in 2011.

3. Assaults on health care workers are 4 times higher as compared to other industries which increases to 12 times for nurses and personal care workers.
Safety Concerns for Healthcare Workers
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4. 50 percent of the nurses had been punched at least once in the last two years; 44 percent reported threats of abuse and 25-30 percent were regularly or frequently pinched, scratched, spit on or had their hand or wrist twisted.

5. Workplace violence-related nonfatal occupational injuries and illnesses causing loss of work days for healthcare workers was 16.2 per 10,000 full-time workers in 2014, four times the rate for all other private industries in the US.

Understanding Precipitating Factors / Antecedents / Triggers

- It prevents acting out behavior by helping us recognize a potential crisis and help the patient deal with the situation before escalation.
- In a crisis situation, it helps us recognize that we are not usually the cause of the acting out behavior.
- It helps us avoid becoming a precipitating factor ourselves.
Behavioral Triggers

- Altered perceptions of the world
- Loss (power, support, $, job, etc.)
- Fear
- Displaced Anger and/or feeling misunderstood

Precipitating Factors / Antecedents / Triggers

- Loss of personal power
- Low self-esteem
- Fear of the unknown
- Failure
- Displaced anger
- Being tired
- Being hungry
- Being in pain
- Certain smells
- Holidays
- People in uniform
- Transference

- Mental illness
- Physical illness
- Grief / loss
- Phobias
- Weather
- Addiction
- Being touched
- Loud noises
- Contact with family
- Financial issues
### Characteristics of Disruptive Patients

- Have reckless regard for their own medical needs or the advice of their provider
- Provide distorted or false information
- Engage in abusive or obstructive behaviors that undermine their health and the safety of others
- Are verbally abusive, disrespectful and confrontational
- Interfere with their care by using drugs and alcohol

### Strategies to Reduce Violence

(From “Behavioral Health Patient Boarding in the ED” Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

1. Early recognition of potential violence
2. Control of environmental factors provoking violent tendencies by –
   - Verbal or psychological intervention approach
   - Calm and prepared health provider
   - Physical and/or chemical restraints based upon regulatory and legal guidelines
Strategies to Reduce Violence

Control of environmental factors provoking violent tendencies by –

– Evaluate the Physical Environment and Ensure Compliance with the IAHSS Design Guidelines

Strategies to Reduce Violence

(From “Behavioral Health Patient Boarding in the ED” Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

3. Management plans to identify and control potential violent situations at the ED.

The plan should include procedures to:

– Confront and cope with violent situations
– Procedures and methods to alert co-workers and call security and/or law enforcement
– Conflict resolution education for the staff members
– Procedures to cope with and diffuse potentially violent situations
Strategies to Reduce/Respond to Violent Behavioral Health Patients

- Disruptive Patient Policy/Committee
- CIT Training for Police and Security Officers
- Threat Assessment Team
  - Policy
  - Information on Confidential Access of Team

Mitigation Strategies for Violence
(From "Behavioral Health Patient Boarding in the ED" Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

1. Identifying the facility violence risk profile by reviewing the findings of:

   - “Most recent Joint Commission hazard vulnerability analysis (2015 standard: EM.01.01.01) and incident reports,
   - Occupational Safety and Health Administration (OSHA) logs and security reports.
   - The local crime statistics”
Mitigation Strategies for Violence
(From “Behavioral Health Patient Boarding in the ED”
Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

2. Utilizing trained health workers for:

- Reviewing equipment and technology-based security measures
- Forming a response team to enhance the facility capability for dealing with a violent incident
- Improving case management for patients to reduce psychiatric emergencies.
- Expand the outpatient care
- Better management of existing capacity. For example: Use of computerized bed management system – “bed Czars”

Mitigation Strategies for Violence
(From “Behavioral Health Patient Boarding in the ED”
Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

3. Crisis clinic staffed with a social worker and nurse. They will act as an additional resource during the maximum psychiatric ED occupancy.

4. Telehealth services provide a good option for ED without psychiatrists and, during weekend and nights.

32,36
Mitigation Strategies for Violence
(From “Behavioral Health Patient Boarding in the ED” Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

5. A standalone ED completely dedicated to psychiatric patients providing patient evaluation, intensive treatment and observation.

6. OSHA identifies five key elements for an effective program:
   - Management commitment and employee involvement
   - Worksite analysis
   - Hazard prevention and control
   - Safety and health training
   - Record keeping and program evaluation

Mitigation Strategies for Violence
(From “Behavioral Health Patient Boarding in the ED” Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

7. Screening tools can be used for assessing psychiatric hospitalization for suicidal patients.

8. Actual situations can be imitated by role play to teach defensive maneuvers and restrain techniques.
Mitigation Strategies for Violence
(From “Behavioral Health Patient Boarding in the ED”
Evidence Based Healthcare Security Research Series by the IAHSS Foundation – 2015)

10. Hospital administrators should regularly conduct workshops as a source of open ended communication between themselves and staff.

11. Crisis debriefing after a violent event to review and process the event.

Improving Care and Safety
(From “Becker’s Hospital Review December, 2015”)

• De-escalating dangerous behaviors by decreasing unnecessary stimulation can be an important opportunity for improving care and safety.

• A contained area connected to the ED can provide a quieter setting. (See the IAHSS Design Guidelines). After patients are medically cleared, they can be placed in the special area. **However, these patients can and should be treated while in the area, not just housed there.
Improving Care and Safety
(From "Becker’s Hospital Review December, 2015)

• Hospitals might consider weighing the benefits of relieving the problems with the cost of hiring behavioral health staff members that are licensed to assess patients in a timely manner.

Behavioral Response Team

Need for immediate intervention in crisis situation involving a patient, visitor or staff member who is suicidal or homicidal and posing a risk to self or others:
- Suspicion of psychiatric component/driver
- Psychiatric house supervisor records each event

The Behavioral Response Team consists of: Multidisciplinary committee (Nursing, Physicians, Hospital Police, Patient Relations, Risk Management, House Supervisors)
Disruptive Patient/Family/Visitor Committee

For the patient who:
• does not respond well to standard care and limits;
• emotionally manipulates health care provider team; and/or
• requires complex case management.

For the family member or visitor who disrupts patient care

Multidisciplinary committee (Nursing, Physicians, Police, Patient Relations, Risk Management, House Supervisors)

Role of Committee
• Assist with evaluation and management strategies
• Determine individualized care plan
• Notify patients, family or visitors of care plans and behavior contracts
• Review and analyze incidents of disruptive behavior
• Identify training needs related to the prevention and management of disruptive behavior
Restraint Devices

• Nursing device? Medical? Forensic? Legal?

• Protective hood, restraint chair, handcuffs, etc.

• Who can apply/remove

• For how long (2 hours, 4 hours etc)

Restraints Defined

• Non-violent (previously medical)
  ▪ For patients who are confused, restless, unable to follow safety instructions, or unwilling to comply with medically necessary treatment that is administered in accordance with law.

• Violent (previously behavioral)
  ▪ For patients who are self destructive or violent and putting themselves or others at risk for harm.

• Forensic
  ▪ The device is applied to persons in the custody of the Department of Justice to meet regulatory requirements, to either prevent elopement and/or control behavior. (not medical or behavioral).

In all cases, restraints are only to be used to ensure the immediate physical safety of the patient or others, and when less restrictive interventions have been determined to be ineffective.
We are All on the Same Team

Defensive Equipment/Weapons for use by Hospital Police and Security Officers

Jeff Strickler, RN-BC, MA, Associate Vice President, Hillsborough Hospital, NC, explains the future of collaboration:

“We need more ‘community’ involvement from Hospital Police and Security similar to the rationale for officers walking a beat. Each clinical area should be assigned a liaison. Officers should round and specifically interact with nurses and physicians. I see no problem with officers interacting with patients and families and not just the [high risk] cases. I envision an officer coming into a room and saying, ‘just checking on you and making sure that everything is alright. Is there anything that I can do for you?’ That’s the future of healthcare security.”
Defensive Equipment/Weapons for use by Hospital Police and Security Officers

The term “weapon” is used to refer to any of the following tools that hospital police or security personnel may use to defend themselves or others in an event or potential event of violence:

- “Protective Shield”
- Spitsock/Net
- Hand cuffs/Flex cuffs
- OC product
- Electronic Control Device (e.g., Taser)
- Baton
- Firearm
- K9 unit
- Other device used to control a violent or potentially violent individual

Evaluating defensive weapons

- Liability
- Benefits
- Risks
- Trends
- Other

The C-Suite must consider the risks and benefits of defensive weapons in the healthcare environment. First and foremost, decision-makers must understand the need, liability, benefits, risks, trends, and other factors surrounding armed security officers. Decisions must be made based on facts, data, and statistics in concert with other mitigating factors. Legal consultation is vital to the decision-making process.
Regulatory agency views

- The Joint Commission (TJC)
- Centers for Medicare & Medicaid (CMS)

Data driven decision-making

- Risk management
- Historical data
- Foreseeability of violent crime
- CAP Index CRIMECAST® reports
Once the decision is made

- Management oversight
- Equipment selection
- Applicant selection process
- Training
- Officer protection
- Continuous program evaluation

Management’s role

- Strong commitment
- Use of Force policy
- Proactive discipline
- Continuous oversight
- Officer evaluation
- Continuous training
- Educate staff
- Educate community
Management’s role

• Continuous Out-of-the Box Searches for Training and Education

  – Example: Meggitt Simulator Training System - delivers judgmental use of force simulation training

Proactive Measures for Dealing with High-Risk Patients & Visitors

Increasing Patient Engagement to Reduce Anxiety

How Officers Can Impact Patient Engagement
  ▪ Be approachable
  ▪ Interact positively
  ▪ Provide sincere greeting
  ▪ Communicate clearly
  ▪ Listen to what is said
  ▪ Understand what is said
  ▪ Watch for behaviors of concern
Proven Strategies for Mitigating Violence and Aggressive Patient Behavior

Free/Low Cost Online Reference Materials and Resources

Access US Dept. of Labor materials (online)
Utilize existing free/low cost materials
Create Workplace Violence drills
Partner with IT on mass notification processes
Work with security to ALL educate staff
Leverage partnerships with law enforcement

Online tools from U.S. Department of Labor (www.osha.gov) & OSHA 3148
FBI’s Workplace Violence-Issues in Response
CDC / NIOSH Violence-Occupational Hazards in Hospitals
ECRI Healthcare Risk Control System / Violence in Healthcare Facilities
U.S. Postal Service’s Guide on Threat Assessment Teams
Make the Case for a Violence Prevention Program

Recommendations for Policies and Procedures: Strengthen the Security Program

- Healthcare-specific security proprietary training programs
- IAHSS training and certifications (www.iahss.org)
- ASIS International (www.asisonline.org)
- Emergency Nurses’ Association Workplace Violence Toolkit
- Center for Personal Protection and Safety (www.cppssite.com)
- Occupational Safety and Health Administration (www.osha.gov)

Make the Case for a Violence Prevention Program

Have a Plan Before Violence Erupts

- Ensure effective planning
- Maintain persistence in face of adversity
- Protect self and others
- Assume a proactive stance
- Execute post-situation recovery
- Deliver on moral obligation
The Future of Violence in Healthcare

Eight Future Healthcare Security Strategies

1. **Hold Security Practitioners and Officers Accountable**

   - The future of healthcare security is highly dependent on advanced levels of officer training relative to the sensitive hospital environment.

   - ED security officers must be specially trained to that environment.
Eight Future Healthcare Security Strategies

2. Develop leaders

- Directors and other leaders will be expected to achieve and maintain advanced certifications and qualifications.
- Leadership will focus on people versus processes.
- Not only are professionalism, competency, and certification required as part of the leadership role, but leaders must also be equipped to interpret and demonstrate the healthcare facility’s mission, culture, and overall focus on delivering optimal services in a healing environment.

Eight Future Healthcare Security Strategies

3. Impact patient experience

- HCAHPS
- Security professionals have a valuable opportunity to provide a welcoming, inviting, and empathetic greeting to everyone.
- Increased pressure on hospitals to reduce operational costs and improve patient outcomes is supported by the healthcare security professional.
Eight Future Healthcare Security Strategies

4. Deliver high-risk patient management
   - Aware of the behavioral health patients’ impact
   - Officers trained specifically in healthcare security techniques
   - Officers who understand behaviors of concern and the significance of early intervention
   - Aware of the forensic patients impact

Eight Future Healthcare Security Strategies

5. Conduct threat assessments, planning, and surveys
   - The Joint Commission (TJC) and other regulatory agencies require at least annual assessments with carefully documented findings and recommendations.
   - A multidisciplinary team of security, clinical, and management team members must be included as part of this process.
   - The future of healthcare security integrates every discipline within the healthcare organization into the process.
   - Consideration of safety measures, technology, and risk mitigation strategies must be incorporated into these assessment processes.
Eight Future Healthcare Security Strategies

6. Collaborate
   • Collaboration is key to the future of a safer and more secure ED. Strong relationships between Security and the clinical team are vital.

Eight Future Healthcare Security Strategies

7. Deploy technology
   – Technology to provide valuable, detailed data and information for incident reporting, remediation, and auditing events for future improvements.
   – The ACA also drives technology integration. The ACA requires healthcare facilities to deploy integrated security technology as well.
Eight Future Healthcare Security Strategies

8. Manage metrics and data

- You must be able to demonstrate and document what you do, how much you do, and why you do it.

- Service levels, efficiency, and effectiveness will be measured by data to demonstrate the value of de-escalation, RAD, Basic Life Support, nonviolent crisis intervention, and other training to the ED clinical staff. Quantify the costs and benefits.

- Response times, number of patrols, thefts, assaults by type, security violations remediated, number of violent events managed, number of security escorts, potential weapons confiscated, and many other metrics can be used to demonstrate value.

Looking Ahead…..

- Security professionals who accept the accountability and responsibility to protect the lives of others in this volatile environment are to be highly respected and esteemed.

- I still remember the days of sitting in front of that black and white television set as I watched Superman and The Lone Ranger swoop in to save the day.

- I recall the vivid memories of desiring to be a part of something special—and being able to make a difference in the world by protecting others. I am honored to be among the brave men and women who deliver outstanding security and safety for the sick, weak, and vulnerable.
Thank you!

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Thank You for Sharing!

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