! "#$%#&’($)*(’+’*,$*,$ - *./0123#$4’*1#,3#$

¢

! ! ! "#$%&%’())*)#%+",-+.

Workplace Violence in a Clinical Environment

Workplace violence (WPV) involves violent behavior in a work environment. This includes verbal/emotional abuse, coercive or threatening behavior, self-harm and physical assault. Violence is any event resulting in physical and/or emotional harm that has the potential to introduce or re-introduce trauma. WPV has the potential to culminate in a sentinel event, which is an incident resulting in death, permanent harm, or severe temporary harm. While WPV may lead to incidents of restraint, it can be mitigated by effective crisis intervention.

In 2010, The Joint Commission (TJC) issued a sentinel event alert that emphasized the importance of mitigating violence. With extensive data to support their conclusions, TJC identified healthcare institutions, once considered "safe havens," as being vulnerable to steadily increasing incidents of violence (i.e., crisis) requiring "…vigilant attention and action by safety and security personnel as well as all healthcare staff " (The Joint Commission, 2010).

The safety and frequency of high-risk interventions in clinical environments continues to gain national attention. The occurrence of injuries and sentinel events leads to added scrutiny on day-to-day operations. (Nunno, Holden & Toller, 2006). Complications resulting from the mis-management of crises are far too common. Injuries resulting from physical intervention threaten licensure, accreditation, and may result in criminal investigation. Some insurance companies label complications from physical intervention as "never events" and are denying claims relating to incidents of crisis at an increasing rate.

Beyond the direct financial costs associated with a crisis event, the human cost can be devastating. The acute stress generated by incidents of violence may lead to cognitive dysfunction and/or interruptions that negatively impact focus and performance. Studies have found that 94% of professionals who have experienced violence had some degree of PTSD symptomology (Gillespie, Gates & Berry, 2013). Such symptoms negatively impact work performance and job satisfaction, resulting in regrettable staff turnover. These factors directly impact the general quality of care, operational efficiency, and financial security of any clinical organization.

Economics of WPV

The enormous monetary cost of WPV makes the fiscal benefits of prevention undeniable. "The financial cost of reacting to an incident of violence is 100 times more costly than preventative actions" (Papa & Venella, 2013). Proactive organizations choose to re-allocate resources into violence prevention plans that emphasize effective training.

Cost associated with WPV:

- ✓ Direct cost of staff attention to mitigating an incident: Incidents of violence are resource intensive and often require a large staff commitment. A typical 1-hour incident requires approximately 25 action items and, conservatively, 12 hours of overall staff time expenditure to manage, monitor, and mitigate the process (LeBel & Goldstein, 2005). In a notable case study, staff time expended on crisis incidents have absorbed as much as 40% of a psychiatric in-patient agency's total budget for operations (LeBel & Goldstein, 2005).
- ✓ Staff retention issues: Re-hiring and re-training staff results in costly inefficiency. Studies reveal a strong correlation between increased incidents of violence and staff turnover (Paxton, 200).
- ✓ Decreased job performance and productivity also creates costly inefficiencies as well as quality of care concerns.
- ✓ Subsequent legal expenses: In WPV liability cases, the average jury award was $3.1 million per person, per incident when the employer failed to take proactive, preventative measures under the 1996 OSHA guidelines (Papa & Venella, 2013). The Supreme Court decision in Canton v. Harris: 489-US-378 (1989) provides a further case study supporting the obligation of employers to provide adequate training.

- ✓ Associated medical costs, medical leave, and workers compensation claims.
- ✓ Incidents of violence may negatively affect accreditation, which leads to costly corrective action.
- ✓ Increased insurance premium cost: Complications from crisis incidents may now be considered medical errors. This is significant in that the Federal Government, various State Governments, and private insurers are restructuring their policies on how they compensate for such medical errors. Also, particular incidents (or "Never Events") such as certain sentinel events, may not be compensated under an insurance claim. This increases the exposure for providers.

IMPORTANCE OF TRAINING

Every published set of guidelines, framework, and conceptualization of violence prevention emphasizes training (i.e. OSHA, The Joint Commission, ENA, AONE, VHA). Staff members who gain increased competency and confidence as a result of training are less likely to be assaulted at work and experience less behavioral escalation in their orbit (Infantino & Musingo, 1985; Gertz, 1980; Paterson, Turnbull & Aitken, 1992). Training is the most accessible, economic, and timely preventative measure to eliminate excessive human and financial cost. Investing in training (education) is the single most important way to prevent and better mitigate violence in a clinical organization.

Effective training produces measurable results through performance-based assessment and utilizes evidence-based practices. "Ensuring that healthcare providers have the appropriate education and training to recognize, defuse and de-escalate violent behaviors is essential" (Papa & Venella, 2013). Training is an essential aspect of The Joint Commission Sentinel Event Alert. TJC and the Emergency Nurses Association (ENA) have identified several factors relevant to a lack of training that could interrupt or negatively impact accreditation. Improving training is a significant way to demonstrate quality improvement and investment in violence prevention (see TJC Element of Care 03.01.01).

Not all training partners are the same. Without *effective* training from the right provider, the benefits of training may not be realized. This is an important consideration, given the costs and risks associated with workplace violence.
Some organizations continue the ineffective practice of maintaining a restraint-heavy workplace environment—which is meant to disincentivize aggressive behavior. However, expert consensus and case studies reveal that such an approach is counterproductive. In fact, such methods usually create negative patterns between clients and staff. Each incident that ends in restraint negatively affects a client's ability to co-regulate with staff in the future (Thompson et al., 2008). Put simply, restraints lead to more aggression. Unfortunately, wide spread use of these ineffective techniques continues. However, recent trends have shown that human service organizations are shifting away from these practices. Leading organizations are moving towards greater investment in (non-physical) de-escalation as part of their physical intervention training. This shift towards de-escalation training has both improved outcomes and staff perception of the use of restraint (Thompson, Huefner, Vollmer, Davis, & Daly, 2008; Carter, Jones, & Stevens, 2008).

Organizations that reallocate their crisis prevention training investment to non-physical techniques see the best outcomes. The most effective preventative approach is to train *all* staff in de-escalation. A focus on de-escalation is a proactive approach versus a reactive approach. Reactivity to crisis has plagued stagnant crisis intervention models for decades. A proactive response to crisis is a vital sign of a healthy organization. The chosen de-escalation model should also align with the organization's values and reinforce the organization's philosophy or therapeutic approach (Suess, 2008).

The research is clear: Investing in a systemic training option has shown to be an effective action for reducing incidents of restraint (Nunno, Holden & Leidy, 2003). Investment in systemic training is well highlighted in case-study as being foundational towards better mitigating and preventing the need for high-risk interventions (Carter et al., 2008; Thompson et al., 2008). Ensuring that an investment in training has a positive impact requires a systemic commitment from the top-down of an organization. (Evans, Faulkner, Hodo, Mahrer, & Bevilacqua, 1992). In this regard, investment in staff, via training, becomes an effective quality assurance measure. (Daly & Dowd, 1992).

ADDRESSING MACRO FACTORS WITH TRAINING

The marketplace for crisis intervention training vendors has become increasingly competitive. This competition directly benefits providers who now have more options than ever before. At the same time, these modern market factors require more diligence when deciding which vendor to engage.

The chosen training program should be thought of as collaboration between the training provider and the organization, and should take into account all relevant macro factors (atmospherics, data-driven approach, applied framework, relevant policy & procedure, etc.) pertaining to crisis prevention and de-escalation. A collaborative approach requires a consultative type of client engagement. An important macro factor to consider when engaging a training program is the use of prone restraints. Aegis takes a strong stance against prone (face down) position use and believes that prone floor restraints do not have a place in any clinical environment. The Aegis team has concluded that these types of physical interventions have a much greater risk of injury and death from restraint associated or positional asphyxia. Aegis also takes the position that floor restraints are less legally defensible than other types of physical interventions. The Aegis team believes that those who disagree with this position are not only on shaky legal ground, but their attempts to maintain their outdated models put their client organizations at great risk. The Aegis team has drawn this conclusion from:

1) Exhaustive review of available literature

The following references (see below) are representative of the literature reviewed. The Aegis team is committed to an annual review of available literature.

2) Policy scan / trends in legislative best practices

A recent policy scan conducted by the National Council of State Legislatures affirms this view. For example, prone restraint is essentially prohibited in New England. Maine, Massachusetts, New York, Rhode Island all prohibit the use of prone restraint. Just weeks after the April 2020 incident at Lakeside Academy in Michigan, which resulted in the death of a child, the state signed into law the prohibition of prone restraint and other emergency rules. The death of Cornelius Fredericks was determined to be “sequelae (consequence of) of restraint asphyxia.”

Many other states (CO, CT, FL, IA, MD, MN, NM, OH, PA, TN, VT, WA, WI) now use language that directly, or by way of interpretation, prohibits or guidelines against prone restraint use. Ohio Department of Developmental Disabilities, and many other similar agencies, prohibits the use of prone restraint. The Aegis team has encountered many individual licensing agents or oversight authorities that, even if not specified by state legislature, will not approve individual safety plans/behavioral interventions using prone restraint.

3) Direct experience / review of incidents

Aegis is accustomed to new client integrations where injuries or “near misses” have occurred with other (non-Aegis) techniques. In this context, the verbal disclosure/incident report narratives/video evidence reviewed typically revolves around complications from floor restraints. While legislative language in California on the use of restraint is subject to broad interpretation (see Education Code 49005.8**)**, many referral sources in California will not send at-risk youth to programs using prone restraint. This is a significant factor for many residential treatment centers in the western region of the United States.

Reasonable misapplication of each specific physical intervention technique, under duress, must be factored. The Aegis team does not believe there is any prone restraint technique available to support a claim that an airway or breathing concern will not be introduced under duress by way of staff applying pressure or bodyweight to a person’s breathing apparatus. From past experience, the Aegis team also knows that prone restraint techniques have no way of preventing a person in crisis from using the floor as a weapon against themselves (mainly head thrashing) thus introducing greater

risk of injury. The tertiary design of The Aegis System™ mitigates the risk of injury associated with physical intervention starting with the breathing apparatus and then from the head down.
Beyond research, legislation and best practice trends, the Aegis position is further strengthened by a combination of outside kinesics review (by a team of MD's factoring static and dynamic loading) and considerable inside experience with physical interventions.

References:

Barnett, R., Stirling, C., & Pandyan, A.D. (2012). A review of the scientific literature related to the adverse impact of physical restraint: Gaining a clearer understanding of the physiological factors involved in cases of restraint-related death. *Medicine, Science and the Law, 52*(3),137-142. doi: 10.1258/msl.2011.011101

Barnett, R., Hanson, P., Stirling, C., & Pandyan, A.D. (2013).
The physiological impact of upper limb position in prone restraint. *Medicine, Science and the Law, 53*(1). doi: 10.1258/msl.2012.012044

Barnett, R., Stirling, C., Hall, J., Davies, A., & Orme, P. (2016). Perceptions of supported and unsupported prone-restraint positions. *Journal of Psychiatric and Mental Health Nursing, 23*(3-4), 172-178.

Independent Advisor Panel on Deaths in Custody. (2012). *IAP E-Bulletin.* March, Issue 7.

Miller, C. (2004). *Restraint asphyxia-Silent killer.* Retrieved from charlydmiller.com/RA/restrasphyx02.html

Mohr WK, Petti TA, Mohr BD. Adverse effects associated with physical restraint. Can J Psychiatry. 2003 Jun;48(5):330-7. doi: 10.1177/070674370304800509. PMID: 12866339

Morrison, L, Duryea, P.B., Moore, C., & Nathanson-Shinn, A. (2002). *The lethal hazard of prone restraint: Positional asphyxiation.* Publication # 7018.01 [Electronic version]. Oakland, CA: Protection and Advocacy, Inc. Retrieved from pai-ca.org/PUBS/701801.pdf

National Institute for Clinical Excellence. (2015). *Violence and aggression: short-term management in mental health, health and community settings.* Retrieved from NICE guideline NG10.nice.org.uk/guidance/ng10

Nunno, M. A., Holden, M. J, & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child andYouth Services Review,* 25(4), 295-315.

O'Halloran, R.L., & Frank, J.G. (2000). Asphyxial death during prone restraint revisited: A report of 21 cases. *American Journal of Forensic Medicine and Pathology, 21*(1), 39-52.

Parkes, J. (2000). Sudden death during restraint: A study to measure the effect of restraint positions on the rate of recovery from exercise. *Medicine, Science and the Law, 40*(1), 39-44.

Reay, D., Howard, J., Fligner, C., Ward, R. (1998). Effects of positional restraint on oxygen saturation and heart rate following exercise. *American Journal of Forensic Medicine and Pathology, 9*(1), 16-18.

United States General Accounting Office. (1999). *Mental Health: Improper restraint or seclusion places people at risk.* (Publication No. GAO/HEHS-99-176). Washington, D.C.: Author.

Addressing Micro Factors With Training

The Aegis System™ emphasizes the importance of addressing macro factors relating to crisis prevention and de-escalation while also recognizing a significant gap in available training solutions that fail to adequately address *micro factors at point of care.* Micro solutions address what occurs between client and staff at point of care to maintain a standard of cooperation and safety. These micro factors are identified and addressed via training. Empowered front line professionals that employ effective solutions at point-of-care is ultimately what prevents the occurrence of violence. These solutions include the ability of each individual staff member to stay calm under duress, to recognize the early stages of crisis, to cultivate rapport with clients, and have an ability to employ tangible de-escalation tools before behaviors escalate (Suess, 2008). These micro solutions help to retain staff by increasing their sense of safety, mitigating potential trauma, and improving performance. Front line professionals that feel competent and satisfied with their job performance have longer tenure. Staff retention is a vital sign of any human service organization.

Training should focus on the early recognition of crisis by encouraging forward thinking, centered on point of care. The ENA has identified factors associated with increased risk of workplace violence including, "lack of *effective* staff training in recognizing and coping with potentially dangerous patients" (American Organization of Nurse Executives, 2014). Violence is never invisible. The early recognition of crisis promotes early intervention. Encouraging early intervention increases the amount of incidents where staff are able to achieve de-escalation and avoid the need for the use of restraint (it's much easier to bring down a fever when treatment begins at 99.4° vs. intervention at 104°). This is best addressed in training using front-track framing to increase staff's level of forensic emotional intelligence (The Aegis System™ Introduction) and acuity in non-verbal communication (Aegis Sections 2.0-2.4).

When considering all of the potential elements present in a crisis, intervening professionals are the most crucial variable in the equation. A positive impact will only be achieved when front line professionals are empowered by an effective crisis intervention model. Staff empowerment includes developing a resourceful and ready state, built on a bedrock of confidence. A major component of this de-escalation training is empowering each individual staff member to manage their own stress levels. The research is clear that the response of staff to stress is a significant factor in the outcome of any crisis. Empowering staff to remain calm under duress is best addressed by stress inoculation training (Aegis Sections 1.0-1.3).

An exhaustive literature review and expert consensus affirms that client rapport is the greatest preventer and de-escalator of unsafe behavior. "Rapport points" are like currency in crisis. Rapport is a micro solution when it is leveraged to achieve de-escalation at point of care (Bailey, Mrock, & Davis, n.d.; Intersectoral/Interministerial Steering Committee on Behavioral Management Interventions for Children and Youth in Residential and Hospital Settings, 2001; Masker & Steele, 2004; Paterson & Leadbetter, 1999). The data shows that high frequencies of crisis incidents occur when core staff is absent (sick leave, staff changes, etc.) and rapport with staff was not present (Carter et al., 2008). Rapport building strategies are effective because they encourage co-regulation with staff while supporting self-regulation in clients. A rapport-based approach transcends moments of acute crisis and positively impacts day-to-day client interactions. Rapport aligns with the values of any clinical organization and provides a full buffet of micro solutions, or positive responses, that avoid power struggles and enable effective communication (Paterson & Leadbetter, 1999). The Aegis System™ is a rapport based de-escalation model. Aegis training addresses this with The Crisis 2-Step: (1) Achieve client rapport and then (2) utilize that rapport to ensure that de-escalation is achieved (Aegis Section 3.5).

Choosing effective training and being attentive to staff's level of confidence in the chosen crisis intervention model combats the problem of avoidance at point of care. Avoidance is a paramount risk factor in client interactions during crises. In many clinical settings avoiding early signs of agitation or escalation in clients is far too common. This factor is more challenging to measure but consensus on its importance is found across a wide spectrum of varying environments such as hospitals and larger in-patient facilities. If staff are not supported by feeling invested in and empowered by the training they receive, they will be more likely to avoid more challenging client interactions. This becomes a barrier to prevention and de-escalation and places challenges in "someone else's lap." De-escalation is everybody's job as long as there is not an imminent safety threat. This must become a standard competency across the entire organization. Avoidance is best addressed via training in a systemic model that merges non-physical crisis de-escalation with an effective approach to physical intervention. One should not be at the expense of the other and each professional in the organization should have a clear, compartmentalized understanding of both.

Pushing For Positive Workplace Culture

A shift in workplace culture may be necessary to reduce the use of restraint and to increase the overall safety climate of an organization. Training should be viewed as a platform to significantly improve organizational culture. "There is a sizeable body of evidence showing that organizations with the mechanisms in place necessary to promoting individual learning are likely both to perform better, and to be happier and more motivating places for people to work" (Shipton, 2004, p. 4). The collective attitude of professionals within the organization towards the population served, commitment to clinical intentionality, and perception of

the use of restraint are all important considerations in achieving a positive workplace culture (Stanton and Schwartz, 1954; Paterson, Leadbetter, Miller, and Crichton, 2008).

A negative example would be a "culture of acceptance" which serves as a barrier to prevention (Emergency Nurses Association, 2010). This refers to the collective attitude that violence is a common occurrence and "just part of the job." In literature, this may also be referred to as normalization. Normalization suppresses staff's ability to repair after an incident and may serve as a trauma multiplier. This cultural element also leads to under-reporting of incidents, which is far too common in clinical settings. Internal audit reveals that a staggering number of incidents are either un-reported or documented with errors that would make them inadmissible or insignificant under scrutiny. Under-reporting leaves a gap in the data that is typically used to make decisions that impact front line professionals. In high-risk clinical settings across the country, "There is a lack of institutional reporting policies…that is, the employee doesn't know how to report [incidents of violence]" (Emergency Nurses Association, 2010). Once again, under-reporting is best addressed with training. Effective incident documentation should be addressed within the crisis intervention training model. This portion of training should translate into policy and procedure (Aegis Section 4.14).

While there are multiple factors that affect positive outcomes, a simple concept rises to the top: *De-escalation is everybody's job*. Regardless of a person's role within the organization, attempting de-escalation (when safe to do so) is their job. Training must be viewed as a platform to empower staff and inspire their confidence. Implementing this standard across an organization is the single most important way to prevent workplace violence. This must become a common thread from the top-down and bottom-up.