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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, Robinson, and MacLean 340).
- 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 security officer training with only 2% of ED physician responders having police officers providing ED security and 9% carrying weapons (144).
- 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 the 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 focus for interventions.

	2009	2011	% Change	* Significance
	Mean	Mean		i
Hospital Questions				
Makes Employee Security One of Highest Priorities	2.67	2.97	11.21	***0.018**
Effective Procedures to Maximize Security	2.68	2.99	11.35	***0.007**
Proactive Approaches to Security	2.8	3.04	8.83	***0.027**
Effective Resolution of Employee Security Issues	2.8	2.97	4.84	0.105
Staff Questions				
Consistent Patient Watch Procedures	2.79	3.1	11.26	***0.003**
Follow Behavioral Health Patient Procedures	2.74	3.17	15.76	***0.001**
Use of Effective De-escalation Skills	2.78	2.93	5.42	0.1
Communication of Plan of Care	2.73	2.86	4.77	0.155

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 visitors' 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 seclusion and de-escalation, personal protection and patient detention/takedown 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 though 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.

Reassessment
- Establish staff champions to communicate with colleagues.
- Conduct ongoing situation reviews and debriefings.
- Resurvey to identify next steps.

Conclusions

- Ongoing educational initiatives, policy revision, and clarification of roles responsibilities
- A common language for communication between clerical, 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

Next Steps

- Review security video tapes to identify any educational gaps.
- Support staff champions to communicate changes.
- Develop handoff tool for staff and security.
- Remediate 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.
- Involve staff in state wide legislative activity to promote regulations.

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