UPMC/WPIC Report

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Background:

Violence towards staff, visitors and patients in the mental health care setting is of epidemic proportion, despite a century of attention to the problem from the mental health and psychiatry professions, as well as two decades of attention by public health research and professional occupational health and regulatory entities. There continues to be a strong reluctance to recognize the problem of workplace violence for fear of stigmatizing the potential perpetrators of the violence, in particular the mentally ill and developmentally disabled. This denial carries with it huge costs in terms of patient well being and care. We must begin to recognize that policies and practices directed towards preventing staff assaults benefits patients.

Workplace violence is one of the most complex and dangerous occupational hazards facing health care and social service workers today. The complexities arise, in part, from a society oblivious to workers' risk of patient-related violence combined with the attitude that violence for those working with mental health patients "is part of the job." The dangers arise from the exposure to violent individuals in combination with a lack of strong violence prevention programs and protective regulations. These factors, together with organizational realities such as staffing shortages and more acutely ill patients, create substantial barriers to eliminating violence in today's health care and social service workplaces. In addition, government, certifying and/or licensing bodies, managers, and community organizations frequently prioritize patient safety over worker safety, without recognizing that patient and staff safety are inextricably linked.

In 2009, the U.S. Department of Justice (DOJ) estimated that 572,000 "violent victimizations" (e.g. simple and aggravated assaults, rape, sexual assault, robbery) per year occurred at work against persons age 16 or older. In addition, roughly 500-600 annually are victims of homicides. The health care sector leads all other industries in

the number of nonfatal assaults resulting in lost workdays in the United States; this sector contributes 45% of all such assaults. Within this sector, the rate of nonfatal assaults to workers in the "nursing and personal care facilities" industry was 31.1 per 10,000 compared to 2.8 per 10,000 in the private sector as a whole. DOJ, in their most recent National Crime Victimization Survey (NCVS) report, estimated an overall average annual rate for non-fatal violent crimes at work of 5.1 per 1000 workers. Among those within the occupational classification of "mental health" the rates for professionals, custodial care and other mental health occupations were 17.0, 37.6, 20.3/1,000 workers respectively.

Evidence of Workplace Violence Hazard at WPIC

A review of OSHA 300 log of patient related staff injuries (including restraint related injuries) for 2007 – April 2012 indicate a large number of injuries requiring more than first aid or lost time as follows:

- *2007 - 63*
- *2008 - 60*
- *2009 - 53*
- *2010 - 48*
- *2011- 75*
- *2012 (1st 4 months) – 39 (x 3 = 117)*

The increase in the number of injuries in 2011-2012 is cause for concern. It is unclear what impact the closing of the State Hospital in 2010 may have on these injuries. In depth tracking and review of the circumstances surrounding these injuries is essential to reverse this trend.

When the number of incident reports (including those that did not meet the threshold of an OSHA recordable injury) input into "RiskMaster" were review for the year 2011, approximately 180 incidents were noted with some units reporting nearly 50 incidents.

Existence of industry recognition of the hazard of violence in the mental health treatment setting is evident by 1996 OSHA Guidelines, the vast literature on the hazard, and UPMC incidents, policies and procedures.

Violence Prevention Program:

In 1996, the U.S. Occupational Safety & Health Administration published "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers" (U. S. Department of Labor & OSHA, 1996). These federal guidelines describe a comprehensive violence prevention program and provide a framework for addressing the hazard via the basic elements of a health and safety program. What follows is a) a description of each OSHA program elements, b) examples of where WPIC is addressing the hazard, and c) areas in which WPIC is deficient in violence prevention.

Management Commitment and Employee Involvement. - *Management commitment must be evident in the form of high-level management involvement and support for a written workplace violence prevention policy and its implementation. Meaningful employee involvement in policy development, risk assessment, joint management-worker violence prevention committees, post-assault counseling and critical incidence debriefing, and follow-up are all important program components. This should include front-line workers and, where a union exists, union representatives. Without both management commitment and employee involvement, it is unlikely that an effective program will be developed.*

b) WPIC's workplace violence prevention efforts are completely overshadowed by patient safety considerations. A number of initiative designed to protect patients also infer staff safety.

c) WPIC's management commitment to violence prevention is obscured by their nearly singular focus on patient safety. UPMC's Workplace Violence Policy is generic to all hospitals and clinics within the system and focuses on the risk of violence from domestic partners and other employees. Example of this include that security incidents

reported to PUH do not include patient on staff assaults and that EC-200 safety, security is an overarching philosophical statement about interest in protecting patient, visitors with no mention of staff safety.

There is no WPIC policy or procedure that specifically addresses the risk of patient on staff violence. The Behavior Management Policy has as its primary focus patient clinical care and behavior. As such it is not equipped to address staff perspectives and injuries that may be associated with organizational and/or unit level (as opposed to individual patient) factors.

WPIC administration's primary focus is on patient safety. Occupational health and safety programs appear to exist only as they related to patient care. WHIP administration repeatedly refer to Joint Commission standards yet did not appear to recognize that they require processes that identifies risk factors in your facility either to patient or the staff (p.40) –

> *In her deposition, Ms. Carol Vanzile (CV). Director of Joint Commission and Regulatory Compliance, states her responsibility is to assure that the organization is meeting compliance with all regulatory agencies overseeing Western Psychiatric, the Joint Commission, the Department of Public Welfare, drug and alcohol program licensing (p.10). When asked directly if she was responsible for OSHA related activities she answered affirmative. Yet she states she is not involved at all in the OSHA 300s and recordkeeping for OSHA (p.38). In discussing JC standards (p. 22) Ms. Vanzile states that the written standards do not cover workplace violence. She goes on to state that if we're meeting patient safety we're also ensuring worker safety.*
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> *Ms Kimberly Owens (KO), VP of inpatient and emergency services and chief nurse officer at Western Psych, when presented with exit 2 "OSHA Guidelines" sated that she was not familiar with it (p.23); flipping through it she stated she recognized some of the language and standards, but did not have this book.*

WPIC is lacking a clear mechanism for direct care workers and clinical staff to review and track patient on staff incidents and develop strategies or improve processes to

prevent future occurrences. Patient on staff injuries/Incident reports are said to be reviewed by patient safety committee but there is no evidence of tracking of incidents by unit, patient, staff, type of incident.

WPIC has numerous committees and meeting where patient on staff violence can be raised but it is not their focus/charge. There is no single policy, procedure or committee whose primary focus is staff safety. Labor and Management meetings (nurse union committee and others) may include a discussion of patient on staff assaults but does not appear to be charged to do so. Numerous committees exist and meet regularly including: monthly professional practice council, trauma informed care committee, (formerly named the violence committee), seclusion and restraint committee, and behavior management meetings. The former Violence Committee appears to have been a venue for staff to bring and deconstruct cases of patient on staff assault but now the focus is trauma informed care.

Worksite Analysis - *A worksite analysis is the foundation on which an effective program exists. This analysis should utilize all available "data" sources and be repeated, at least in part, on a periodic basis. "Data" sources include: OSHA logs, unusual incident logs, and workers compensation data. This information can be invaluable in identifying trends and risk factors. These data are often supplemented by staff surveys and focus groups. Regular walk-through surveys of all areas of the facility should be conducted, and should include staff from each area and from all shifts. Special attention should be paid to those areas where assaults have occurred.*

b) WPIC reported that on admission, staff do extensive review of past violence, include past stays at State Hospitals, as well as talking to current community providers. They report seeking whatever documentation they can access.

Staff are trained to enter incidents of patient on staff violence into Riskmaster. If staff fail to record an incident; management may input the information. In addition, staff are encouraged to record incidents, even in the event of no injury. Incident tracking is conducted by program directors and used to modified individual patient plans (not organization and unit-l level trending).

c) Incidents of patient on staff violence should be tracked by organizational, environmental, unit and staff level factors. A forum (e.g. violence prevention committee) for direct care and management review and analysis of incidents should be established.

Hazard Prevention and Control - *Hazard prevention and control measures should be designed based on the risk factors identified above. The classic industrial hygiene hierarchy of controls should be followed. To the extent possible, exposure to the potential violence should be eliminated. An example is transferring an unstable, violent patient to a different facility, one that is better equipped to provide care to such a high-risk patient. The next priorities for prevention are administrative and/or engineering controls. Measures to be considered include: modifying the layout of admissions areas, nurses' stations, medication rooms, lounges, patient rooms, or offices; limiting access to certain areas; evaluating all furnishings to ensure that they are not used as weapons. Developing and implementing appropriate policies and providing regular training are important administrative controls. Finally, personal protective devices may be warranted, such as issuing cell phones and personal alarm devices to workers.*

Staff involvement is just as important in designing effective controls as it is in conducting a thorough risk assessment. Front-line staff and union representatives can help identify unintended consequences of various prevention measures, and can provide feedback as to whether implemented changes have been effective. Additionally, programs need to be in place to provide support to assault victims and to their co-workers. These can include easy access to medical and mental health services, assistance with the workers' compensation system, and support in accessing the criminal justice system, when appropriate.

b) WPIC had a large and active safety department (15-20 staff). The department is responsible for surveillance of safety events and is reported to work closely with direct care staff to assure patient, visitor and staff safety. Security cameras are placed throughout the building, but not in patient rooms or bathrooms. Some units have cameras in hallways. On individual units, the areas in between the elevator and locked

doors do not have security cameras. Cameras are viewed from safety office on first floor behind reception desk which serves as a hub of safety and security management in the hospital.

Administration reported incorporating safety concerns into all building renovations. The recently renovated MR/DD unit includes innovative safety architectural design (based on safety concerns); staff had input into renovation.

All WPIC staff are provided body buttons (and trained) to call for assistance from security.

A Bronze alert system was instituted following shooting at Hopkins.

WPIC has made a number of enhancements to WPIC security following the March shooting including adding 5 safety FTEs to the department, an armed guard in lobby of DEC, and locking handicapped entrance on first floor and stationed additional security staff on fifth floor entrance (J lot entrance).

WPIC staffing is determined by an acuity classification scale developed at Western Psych, yet staff report (and administration) report inadequate staffing at times. The high number of patients (30-40 at one time) requiring special constant observation has implications for staffing.

Following a patient on staff incident, staff are encouraged to contact the "Resolve Crisis Center" for therapeutic debriefing. On occasion the Center makes the recommendation that staff not return to the unit where the unit where the incident occurred.

c) Although referral to "Resolve Crisis Center" is an important part of post incident process, it does not take the place a critical incident debriefing where staff can discuss the incident and identify factors which could be modified to prevent further similar incidents. Such a debriefing group may be established ad hoc or on a standing committee basis.

Patient strip searches at time of admission to the unit (following magnometer in DEC) are routinely performed by lone staff; usually of the same gender.

Wanding of visitors outside the unit (without security cameras) is a potential high risk activity. Staff report conducting this activity alone, regularly find and confiscate weapons and may to ask visitors to leave. Staff report receiving training on the procedure at orientation but no refresher training. According to the Metal Detectors Search Committee Guidelines, "staff will have an annual competency for detector as well as use" however staff report only receiving training at orientation.

c) Searches should be conducted in the presence of a second staff person, ideally, a safety officer.

Wanding of visitors should be conducted by safety officers or alternatively in the presence of a second staff member. Camera instillation in the areas where the wanding is performing could provide an additional measure of security/surveillance.

Furniture and other objects that have been and can continue to be used as weapons/thrown at staff should be replaced with objects that will not cause injury or secured to the foundation.

Training and Education - *At the time of hiring and periodically thereafter, worksite- and job-specific training should be provided covering the risk factors, prevention measures, and relevant policies and procedures. This should not be a generic training. For direct care staff, training should include skills in aggressive behavior identification and management.*

b) "Positive Approaches in Crisis Situations" curriculum was developed by the WPIC Crisis Training Institute (2011). The training appears to provide important clinical information with an emphasis on patient assessment and restraint/seclusion reduction. The training is delivered by certified trainers as a 2 day program within six weeks of hire and as an annual refresher. The curriculum is updated and modified as indicated e.g. seated restraint method.

c) Violence prevention training should also include information on the prevalence of violence in mental health work, risk factors for staff assault, a description of the

written violence prevention program, how to report an incidents, and participation in committees addressing patient on staff violence.

Recordkeeping and Program Evaluation - *Recordkeeping and Program Evaluation are inextricably linked and should focus on not only incidents of physical and verbal assaults but also on near misses. Reporting should be something that staff are actively encouraged to do. Reports should be followed up and investigated promptly, with the results reported to the individual who made the report. Obviously, employees should not be retaliated against for filling out an incident report or filing a workers' compensation claim. The reporting and investigation of incidents is a critical means of evaluating the effectiveness of the WVPP and of identifying control measures which need to be modified or implemented.*

b) WPIC appears to encourage the reporting of patient on staff incidents via RiskMaster.

c) Staff should be encouraged to report all incidents, regardless of their severity. The reporting and review of incidents should be a critical aspect of the risk assessment and hazard control process. The number and severity of incidents should be tracked to evaluate the impact of organizational, unit, and staff-level changes such as enhanced security procedures, renovations to units, as well as changes in the patient population.

Summary of Recommendations:

- *In order to reduce patient on staff violence, WPIC "safety" goals as well as policies and procedures must be expanded to include staff safety and wellness, in addition to patient safety and quality of care.*
- *WPIC policies to safeguard the rights of the mentally ill and developmentally disabled, while laudable, must be balanced with the right of workers to return home safely to their family at the end of each workday.*
- *WPIC should establish a joint labor management health and safety committee whose primary focus is the tracking, review and discussion of patient on staff violence. This committee should be charged with identifying and evaluating the impact of strategies designed to reduce organizational and unit level factors associated with incidents.*
- *WPIC should establish a system for written and oral communication of past and recent patient-related violence incidents so that all staff have real time information about risk to staff and patients.*
- *WPIC should re-evaluate policies and procedures for patient strip search and "wanding" of visitors to insure greater staff security.*