CE 1.5 CONTACT HOURS

Workplace violence and safety response

By Tanya Parker, MA, MSN, RN

Healthcare workers, and in particular hospital workers, are at high risk for workplace violence.[1] Yet many hospitals don't have safety protocols in place, and those that do often haven't examined protocol adherence or efficacy. At Mount Sinai Beth Israel (MSBI), an 856-bed, full-service tertiary teaching hospital in New York City, hospital administrators recognized the need to develop a safety protocol. Based on this need, they developed the Safety Team Assessment Response (STAR) code for nursing staff to reduce the incidence and severity of violent situations in the hospital.

However, the initial attempt to educate nursing staff about the new safety protocol failed to achieve the desired level of implementation. The next attempt, a training workshop incorporating simulation and debriefing, showed promise as a means of increasing adherence to the STAR code. This article shares the MSBI STAR code protocol and implementation journey to generate discussion about workplace violence. Specifically, nurse administrators need to ask themselves: What are we doing about violence in our workplace? More important, is it working?

Defining an urgent problem

The Occupational Safety and Health Administration (OSHA) defines workplace violence as "any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site."[2] Acts or threats of violence can:

- focus on employees, patients, and/or visitors.
- be verbal or physical.
- range in severity of harm.[2]

A major contributing factor to the incidence of workplace violence in hospitals is patient history; patients who initiate violence in the hospital setting often have a history of psychiatric problems and/or violence.[3] Particularly in the ED, long wait times and the influence

of drugs and alcohol may provoke patients to commit violent acts against nurses.[3]

The U.S. Bureau of Labor Statistics (BLS) data show that healthcare and social assistance workers were victims of assaults and violent acts approximately 11,370 times in 2010.[4] In 2013 and 2014, rates of workplace violence per 10,000 healthcare and social assistance workers in the private sector, state government, and local government were, respectively, 16.2, 146.0, and 19.3 and 14.4, 135.2, and 19.3.[5,6]

Nurse administrators need to ask themselves: "What are we doing about workplace violence? And, is it working?"

When considering the statistics on workplace violence in healthcare, it's important to recognize two potentially relevant conditions. The first is that the BLS data represent only violent acts that resulted in days away from work. Other violent acts may have occurred in the workplace but may not have been recorded or reported because they didn't result in time away from work. The second is that additional factors, including the type of workplace, the time the incident occurred, and the type of injury, may contribute to underreporting of incidents of workplace violence.[6] Therefore, it's likely that the actual rates of workplace violence in the healthcare setting are higher than indicated. Taken together, these data and additional considerations underscore the urgency to take action against workplace violence in healthcare.

A stellar effort

MSBI is similar to any other large, urban healthcare facility and not exempt from the risk of workplace violence. Early in 2012, MSBI security staff informally reported that nurses didn't react appropriately to incidents of potential or actual violence. It's likely that nurses' inability to recognize the warning signs of violence or previous overreactions to nonthreatening situations may have contributed to these inappropriate responses.

With this insight, hospital administrators established a violence task force committee (VTFC) to address the concerns of increased workplace violence related to both patients and visitors. The VTFC immediately generated the STAR protocol with the purpose of reducing the incidence of violence and mitigating the severity of violent situations in the hospital. The STAR code educates RNs and patient care associates (PCAs) about how to recognize potentially violent patients, visitors, and staff, and how to respond appropriately to crisis situations involving these populations.

All hospital staff members, but not patients or visitors, are qualified to initiate a STAR code, which includes two levels of severity. A Level 1 code is for less severe situations involving patients, staff, or visitors. The four reasons for initiating a Level 1 are a verbally abusive patient who isn't responsive to verbal intervention, invasion of personal space that becomes threatening, a person who exhibits agitated and exaggerated movements, and a person who displays clenched fists or a towering posture. A Level 2 code is for more severe situations involving patients only. The four reasons for initiating a Level 2 code are a patient presents a danger to him- or herself, a patient presents danger to others and/or becomes an acute safety issue (throwing objects, deliberately destroying property), a patient requires pharmaceutical intervention, or the team leader otherwise determines the need to escalate from Level 1.

Initially, the STAR code also included an algorithm to be completed by a supervisor or nurse manager following each incident, indicating the proper procedures for documenting the code event and notifying the patient care service department.

The VTFC introduced the STAR code hospital-wide in mid-2012 with posters and a two-sided, laminated information card that provided an explanation of the STAR acronym and the purpose of the program, the criteria for activating the STAR code, and directions for activation. (To view the information card, visit the *Nursing Management* iPad app.) On the back of the card was an explanation of the two code levels and the personnel responsible for responding to each type of code, as well as the phone number to use to request a psychiatric consult if

necessary. The posters displayed the same information.

False start

In December 2012, the quality assurance department gave nursing staff a two-item survey to gather feedback on the STAR protocol. The first question was designed to determine how many nurses were aware of the STAR code. The second question was designed to determine whether those nurses who were aware of the STAR code perceived the hospital to be safer as a result of the new protocol.

Of the 100 nurses who responded to the survey, 79 indicated that they were aware of the STAR code. Of that group, 76 (82.9%) perceived the hospital to be safer because of the STAR code. Of the 46 written comments, 4% referenced improved teamwork, 6% referenced the provision of guidelines, 4% referenced faster security response times, and 38% referenced other positive outcomes.

Despite this positive feedback and survey evidence that the majority of nursing staff members were aware of the STAR code, the initial introduction of the protocol clearly wasn't successful. Of the 46 written survey comments, 15% noted the need for additional education regarding the code. Also, during training conducted in the months following survey distribution, nursing staff demonstrated a lack of understanding about the distinction between threat levels and widespread confusion regarding the appropriate conditions to activate the STAR code.

This lack of knowledge among nursing staff was concerning for several reasons. First, when nursing staff fail to call a STAR code in potentially dangerous situations, it increases the risk of injury to patients, staff, and visitors because the appropriate responders aren't notified (such as security and the medical team). Second, if the STAR code is called when it isn't warranted, vital human resources are wasted. Third, if nursing staff members repeatedly make unwarranted calls, it's possible that security staff will react more slowly to their requests over time.

The VTFC and the director of nursing education and research were alerted to the need for additional STAR code activation education. Shortly after, the VTFC revised the program by replacing the nurse manager algorithm with a data collection form. The director of nursing education and research also approved a training workshop for all nonpsychiatric nursing staff.

The single most important thing you can do to prevent workplace violence is to become an advocate for safe working conditions at your facility.

The training workshop

During 26 sessions (July through December 2013), 161 RNs, PCAs, and unit secretary associates from selected nonpsychiatric units participated in the STAR code training workshop, which was presented in four phases.

The training began with a 15-minute slide presentation about the STAR code. Although the information covered in the presentation was conceptually the same as the information provided on the STAR code information card and posters, the presentation was more detailed and thorough. Staff members were then randomly assigned roles in a 20-minute simulation necessitating the activation of a STAR code.

Next, during a 30-minute debriefing, staff members reviewed two handouts: the STAR code tips sheet and the STAR code data collection form. The STAR code tips sheet outlined team and patient debriefing topics that nursing staff members should consider when documenting STAR code incidents in patients' medical records. The STAR code data collection form is required for nurse managers to document STAR code incidents for the patient care service department.

For the final 5 minutes of the workshop, staff members completed both a checklist and an evaluation form. The STAR code checklist reviewed topics covered during the training and the evaluation form collected feedback regarding the quality and effectiveness of the workshop.

On the right path

The training immediately resulted in nursing staff demonstrating increased knowledge of the STAR code. Although no formal data collection or analysis took place regarding changes in the frequency or appropriateness of STAR code initiations, informal feedback from the security staff

in the 6 months following the training workshop suggested that nursing staff initiated more STAR codes and in more appropriate situations. It's likely that this was a result of the training workshop.

Although an increase in the number of STAR codes initiated by nursing staff translates to an increased demand for security staff, when STAR codes are consistently appropriate, security staff members can be more confident about what they'll encounter when they reach the incident location. Under these conditions, security staff members are more likely to respond in a consistent and appropriate manner.

Since the initial protocol implementation, training on the STAR code has been incorporated into new employee orientation. The STAR code protocol is also included in MSBI's annual core competencies manual. It's feasible that a combination of more accurate initiation of the STAR code and consistent responses from security staff will contribute to a decrease in the incidence and severity of violent situations in the hospital over time.

Next steps

According to the American Nurses Association, there's no federal policy in place regarding workplace violence against nurses; however, numerous states have established their own legislation.[7] For example, 32 states are establishing or seeking to increase penalties for assaulting a nurse.[7] Although penalties are important, penal action is reactive rather than proactive. Only seven states require that all employers implement workplace violence programs.[7] This legislation is a step in the right direction, but we can do more. We must do more.

The single most important thing you can do to prevent workplace violence is to become an advocate for safe working conditions at your facility. Start a discussion. Ask that your institution adopt a zero-tolerance policy against workplace violence. If your institution doesn't have a workplace violence protocol in place, ask for one. Refer to OSHA's *2015 Guidelines for Preventing Workplace Violence for Healthcare and Social Services Workers* or use other sources that meet your institution's needs. Guidance for developing a workplace violence prevention program is also available from OSHA.

If your institution has a workplace violence program or protocol in place, evaluate its implementation and effectiveness. Consider training that includes simulation to improve outcomes. Workplace scenarios and simulations provide learners with the opportunity to learn and practice skills in a safe and realistic environment.[6,8-13] Although nursing staff in the ED and on CCUs are at greater risk for violence than nursing staff on other units, all nursing staff should receive this training.[14]

No one-size-fits-all policy can protect every facility from workplace violence. What's important is that you determine what protocol works for your facility and you work to implement and maintain it. There's a mindset in the healthcare industry that workplace violence is part of the job.[3] Refuse to perpetuate that culture. If not now, then when? If not you, then who? NM

REFERENCES

1. Preventing violence in the health care setting. *Jt Comm Perspect*. 2010;30(7):7-9.
2. Occupational Safety and Health Administration. Healthcare: workplace violence. www.osha.gov/SLTC/healthcarefacilities/violence.html.
3. Wolf LA, Delao AM, Perhats C. Nothing changes, nobody cares: understanding the experience of emergency nurses physically or verbally assaulted while providing care. *J Emerg Nurs*. 2014;40(4):305-310.
4. U.S. Bureau of Labor Statistics. Number of nonfatal occupational injuries and illnesses involving days away from work(1) by industry and selected events or exposures leading to injury or illness, private industry, 2010. www.bls.gov/iif/oshwc/osh/case/ostb2828.txt.
5. U.S. Bureau of Labor Statistics. Nonfatal occupational injuries and illnesses requiring days away from work, 2013. www.bls.gov/news.release/archives/osh2_12162014.pdf.
6. U.S. Bureau of Labor Statistics. Nonfatal occupational injuries and illnesses requiring days away from work, 2014. www.bls.gov/news.release/archives/osh2_11192015.pdf.
7. American Nurses Association. Workplace violence. http://nursingworld.org/MainMenuCategories/Policy-Advocacy/State/Legislative-Agenda-Reports/State-WorkplaceViolence.
8. Brooks K. Teaching the teachers: Maryland's nurse educators get high-tech at Hopkins. http://magazine.nursing.jhu.edu/2012/04/teaching-the-teachers-3/.
9. Najjar RH, Lyman B, Miehl N. Nursing students' experiences with high-fidelity simulation. *Int J Nurs Educ Scholarsh*. 2015;12.
10. Chan ZC. Exploring creativity and critical thinking in traditional and innovative problem-based learning groups. *J Clin Nurs*. 2013;22(15-16):2298-2307.
11. Smith N, Prybylo S, Conner-Kerr T. Using simulation and patient role play to teach electrocardiographic rhythms to physical therapy students. *Cardiopulm Phys Ther J*. 2012;23(1):36-42.
12. Fay-Hillier TM, Regan RV, Gallagher Gordon M. Communication and patient safety in simulation for mental health nursing education. *Issues Ment Health Nurs*. 2012;33(11):718-726.
13. Menzel N, Willson LH, Doolen J. Effectiveness of a poverty simulation in Second Life®: changing nursing student attitudes toward poor people. *Int J Nurs Educ Scholarsh*. 2014;11.
14. The Joint Commission. Preventing violence in the health care setting. www.jointcommission.org/assets/1/18/sea_45.pdf.

At the time this article was written, Tanya Parker was a nurse education manager at Mount Sinai Beth Israel, Mount Sinai Health System, in New York, N.Y.

The author and planners have disclosed no potential conflicts of interest, financial or otherwise.

DOI-10.1097/01.NUMA.0000482526.08119.76

CE CONNECTION

Earn CE credit online:
Go to ceconnection.com/NM and receive a certificate *within minutes*.

INSTRUCTIONS

Workplace violence and safety response

TEST INSTRUCTIONS

- Read the article. The test for this CE activity is to be taken online at ceconnection.com/NM.
- You'll need to create (it's free!) and login to your personal CE Planner account before taking online tests. Your planner will keep track of all your Lippincott Williams & Wilkins online CE activities for you.
- There's only one correct answer for each question. A passing score for this test is 13 correct answers. If you pass, you can print your certificate of earned contact hours and access the answer key. If you fail, you have the option of taking the test again at no additional cost.
- For questions, contact Lippincott Williams & Wilkins: 1-800-787-8985.
- Registration deadline is May 31, 2018.

PROVIDER ACCREDITATION

Lippincott Williams & Wilkins, publisher of *Nursing Management,* will award 1.5 contact hours for this continuing nursing education activity.

LWW is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity is also provider approved by the California Board of Registered Nursing, Provider Number CEP 11749 for 1.5 contact hours, the District of Columbia, Georgia, and Florida CE Broker #50-1223. Your certificate is valid in all states.

Payment: The registration fee for this test is $17.95.