

HAS HEALING BECOME DEADLY?



Health-care workers are more susceptible to workplace violence than you probably realize. Here's what you need to know to protect yourself and your employees.

WORKPLACE VIOLENCE

By Lester A. Picker

with Lucille Maistros, Research Associate

PLASTIC SURGEON SELWYN COHEN had it all. A flourishing practice in Bellevue, Washington, a spectacular country home, a wonderful marriage, and solid relationships with his children. All that ended on a chilly April evening when Beryl Challis, a patient of Cohen's, entered his office for the second time that day. She pulled out a .38-caliber handgun, shot and killed Cohen, and later killed herself.

Unfortunately, Selwyn Cohen's tragedy is repeated all too regularly in medical practices, hospitals, and home health-care settings throughout the country. According to the National Institute for Occupational Safety and Health (NIOSH), homicide has become the second leading cause of occupational death, exceeded only by motor-vehicle-related deaths. And health-care workers are at greatly increased risk for nonfatal assaults. *Continued*

Tips for defusing a potentially violent situation: Ten Do's and Don'ts

DO:

1. Watch for signs of escalation in the angry person. Red flags include excessively close physical proximity, body tension, loudness and/or cursing. Take threats from anyone seriously, whether co-workers or patients.
2. Take control of the immediate environment. "Clear the area of patients and non-essential staff," advises James Knoll, MD, a forensic psychiatrist with the Northcoast Behavioral Healthcare System in Cleveland, Ohio. If possible, move the angry person to a less-distracting, more neutral environment. If you are both standing, try to sit down with the patient.
3. Project calmness. Speak quietly and move slowly. If standing, maintain a relaxed, non-threatening posture, at right angles, not directly in front of the person. Besides being non-threatening, this stance also allows for a quick escape, if that becomes necessary. Keep three to six feet between you and the angry person.
4. Use empathetic listening skills. Allow the person to vent their feelings without interruption or argument. Validate their emotions and agree with them when you honestly can. Repeat back to the angry person what they say they want. If you find yourself becoming frightened,

let the person know, suggests Knoll. "I saw a slightly-built female doctor calm an angry patient in the emergency room by telling him that his behavior was frightening her and the other patients, and that she really wanted to help him. It worked."

5. Manage the aftermath of a critical incident by debriefing with all staff members who were involved to discuss the incident, critique the action taken, and plan for future occurrences. Now is also a good time to assess existing protocols and procedures. And be sure to report all critical incidents to appropriate parties, such as police, courts, or parents.

DON'T:

1. Ignore warning signs or your "gut" feelings. "If you think something might happen, it probably will," says Judy Jacobs.
2. Corner the person or allow yourself to be cornered. Don't invade their personal space.
3. Interrupt, argue, or speak condescendingly. Never tell an angry person to "calm down."
4. Touch the person or allow them to touch you.
5. Try to be a hero if the person has a weapon. A weapon immediately makes the incident a police issue. Quickly clear the area and notify police. ■

—By Lucille Maistros

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James Knoll, MD, a forensic psychiatrist for the Northcoast Behavioral Healthcare System of Cleveland, Ohio, recommends not touching an agitated person, getting too close to his or her personal space, or standing between the person and the only exit from a room.

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Assessing the Patient for Violence

As part of an ongoing plan for Workplace Violence Prevention, assessments and thorough documentation must be made on a continual basis by *all* employees and team members and for *all* patients. Unfortunately, if you have just met the patient, you may not have any information about this person or his or her family to know if they have the potential for being dangerous or not. It is extremely important always to stay alert. Violence assessment should begin at admission and continue with carefully assessing the patient and the environment on each and every visit or interaction thereafter.

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The majority of nonfatal assaults occur in the service industry (64 percent), according to the Bureau of Labor Statistics. Of those assaults, 27 percent occurred in nursing homes, 13 percent in social service agencies and 11 percent in hospitals. In 45 percent of these cases, the patient was responsible for the assault, and in 6 percent of the cases, a co-worker or former co-worker was responsible.

Selwyn Cohen and his office staff never realized just how prevalent health-care vi-

olence has become. "For many years, health-care and social-service workers have faced a significant risk of job-related violence," OSHA advises in its published guidelines on workplace violence.

"Assaults represent a serious safety and health hazard for these industries, and violence against their employees continues to increase." In fact, Cohen himself had earlier voiced his concerns about the emotional instability of some of his patients,

The initial assessment should include:

- 1** The patient's mental status, including feelings of loss of control, hopelessness, or suicidal ideations.
- 2** The patient's physical status, including assessment of hypoxia, restlessness, open abrasions, scars, old fractures, and missing teeth, which may indicate aggressive tendencies or abuse.
- 3** The patient's past history of violent behavior (as a result of abuse, medical illness, drug use, alcohol abuse, etc.); patients experiencing drug withdrawal may be delirious, confused and combative.
- 4** Signs and symptoms of current intoxication or use of mind altering drugs.
- 5** The patient's past history of criminal activity.
- 6** The patient's financial history (major source of stress).
- 7** The patient's coping mechanisms for stress and patterns of expressing anger.
- 8** Signs and symptoms of agitation or anger (verbal and non-verbal); threats being made.
- 9** Availability of appropriate and willing caregivers.
- 10** Side effects of prescribed medications and status changes due to co-morbidities or deterioration of disease process.
- 11** Firearms and weapons assessment to include:
 - a) Presence of guns or weapons
 - b) Their location
 - c) Whether guns are loaded
 - d) Who has access to them
 - e) Are they willing to lock them up or remove them from the premises for the duration of care
- 12** History of family violence including: domestic violence, elder abuse, or child abuse.
- 13** Caregiver's perceptions of risk in regard to patient violence.
- 14** Caregiver's fear of being alone with patient.
- 15** Caregiver's feelings of being burdened and resentful toward the patient.
- 16** Identification and assessment of friends and other family members to include:
 - a) Their fears of patient's condition and acting out behavior
 - b) Displays of agitation or anger toward healthcare system or providers or toward the patient
 - c) Whether they are participating in illegal activities on the premises (i.e. drug paraphernalia out in the open, person belongs to same gang as patient, etc.)
 - d) Whether they are carrying or brandishing weapons of any sort
- 17** Assess the environment for:
 - a) Blocked egresses (exits or ways out of the room or building)
 - b) Unhealthy and unsafe environment (i.e. no running water, heat or electricity; vermin present)
 - c) Home in high crime neighborhood

On a continuous basis, the assessment with accompanying documentation should include:

- 1** The patient's physical and mental status, including any changes in mentation (i.e., confusion, feelings of hopelessness, low self esteem, increased frustration, etc.) or cognition, which may be a result of medications or deteriorating disease process.

patient's potential for violence. Any sense of uneasiness or foreboding should not be taken lightly. Your gut feelings could be your safety net in the prevention of becoming a victim."

Documentation of findings of either potential or actual violent behaviors is paramount to the protection of employees. Documenting on the patient's chart the violence assessment findings allows all staff members to take appropriate actions to safeguard themselves and others in the vicinity (i.e., emergency room, psychiatric unit, patient's home, etc.). Additionally, by comprehensively documenting, the staff can benefit from the following:
 - 2** Any variables that could cause increase in stress for patient (i.e., loss of job, refusal of insurance company to pay bills, loss of primary caregiver, breakdown of family, intractable pain, etc.).
 - 3** Any sexual advances or communications directed toward the healthcare worker.
 - 4** Appearance of weapons.
 - 5** Angry or hostile behaviors demonstrated by the patient, caregiver, or other person in the vicinity.

Even though the assessments have been done and the findings documented, the patient's violent behaviors must be brought to the administration's attention so they can be investigated and a plan of action instituted. "Especially important for all healthcare providers is to not dismiss your 'gut feelings' about a situation or the
- 1** The plan of treatment can be re-evaluated and modified by the physician.
 - 2** It provides proof that a real threat exists, which may be required in terminating services to the patient.
 - 3** Appropriate referrals can be made for both patient and employee.
 - 4** Police or safety can be called to provide added security measures.
 - 5** The chart may be used as a legal document during a lawsuit proceedings.

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according to his colleagues.

If anything, the problem has worsened in recent years due to many social factors, experts say. More assaults occur in the health-care and social-services industries than in any others, including taxi driving and police work. Health-care and social-service workers have the highest incidence of assault injuries, according to the Bureau of Labor Statistics. Between 1980 and 1990, 106 workplace-related deaths occurred among health-care workers, including 27 pharmacists, 26 physicians, 17 nurses' aides, and 18 other health-care employees. Another study showed that between 1983 and 1989, 69 registered nurses were killed at work.

Compounding the problem is that workplace violence is highly underreported, in part due to the fact that too many health-care workers believe that assaults are simply part of the job.

The root of the problem

Workplace safety experts believe that one issue that has prevented many health professionals from tackling the problem head-on is a lack of understanding of what constitutes violence in the workplace. Violence can originate from patients, co-workers, former co-workers, spouses of co-workers, or even from office supervisors and physicians themselves.

Definitions used today for workplace violence are broad and encompassing. They include stalking health-care workers, sexual harassment, spillover from domestic abuse, verbal abuse, threats and intimidation, sabotaging the office environment, and even theft.

Given the magnitude of the problem, many health-care professionals are wondering why the violence is escalating against people who are there to help. The answers are both obvious

and subtle. On the obvious side are that both drugs and money are usually found in health-care facilities. Acute and chronically mentally ill patients today are either de-institutionalized or released early. Couple those factors with the ready availability of guns in America, and you suddenly begin to see how the problem has grown.

"The age of rage has dawned in America," says consultant Judy Jacobs, R.N., M.A., the co-author of the *Workplace Violence in Healthcare Toolkit: A Guide to Establishing a Prevention and Training Program* (McGraw-Hill, 1999). "Patients may act out due to disease processes or they may have an adverse reaction to medication, or they may have mixed their meds with illegal drugs or over-the-counter medications."

Another rage-increasing factor for patients is frustration with the health-care system, which manifests in a bewildering set of requirements, increased costs, and administrative barriers that patients must overcome. "There's also the fact that we're sending very sick patients home to somebody who might not know how to take care of them," Jacobs adds. "These caregivers in the home are becoming very frustrated. So we're having a lot of nurses in home care who are being injured or killed, as well as other health-care workers in the home."

Clinics and hospitals generally do a poor job of restricting patient access, especially in light of cost-cutting measures that have reduced staffing levels. But increasingly, health care is delivered in non-institutional settings, such as private practice offices, homes, and walk-in clinics. These facilities often lack the financial resources for sophisticated detection, monitoring, and prevention systems.

But there is another, insidious factor contributing to the increase in health-

care workplace violence—the staff itself. "Unfortunately, most practices don't have workplace violence prevention programs or policies and procedures in place," cautions Jacobs. "A lot of practices don't recognize the situation as being as serious as it is, so they try to blow it off by ignoring it. Maybe they fire the disgruntled person, if it's an employee, without doing any investigation to determine if that individual has a propensity for violence, or what the risk level for danger is. Our experience is that a lot of people just misjudge the situation."

Recognizing risks

The first step in preventing workplace violence is recognizing risk factors, and then training staff in how to deal with workplace situations that may potentially turn violent. First among the risk factors is a patient or employee who is a substance abuser or, paradoxically, is attempting to withdraw from drug use. "Like it or not, substance abuse is a risk factor for potential violence in a patient," warns James Knoll, MD, a forensic psychiatrist for the Northcoast Behavioral Healthcare System in Cleveland, Ohio.

Another common cause of workplace violence is co-morbidity of illnesses, with its attendant risk of drug interactions. Other common contributors to violence are depression, excessive stress, or a history of psychiatric illness.

Plastic surgeon Selwyn Cohen's patient exhibited two classic predictors of violence: dissatisfaction and anger over her care and intractable pain. Beryl Challis did not like the results of her face-lift, even though her husband and others told her she looked good. She also complained of facial pain and had visited Cohen earlier in the day to seek relief.

Cohen's own caring behavior may

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have helped trigger the tragic event. Challis returned to his office after hours and persuaded the doctor to let her in. The false sense of security that Cohen may have felt is a common occurrence with physicians who have been assaulted in the workplace. Their overconfidence, or even misplaced feelings of omnipotence, may blind them to the real dangers they face.

Having a worker or patient involved in domestic violence is often likely to spill over to the workplace. Since the victims are usually women and the health care industry employs a high percentage of women, this thorny issue represents real dangers to the abused spouse as well as her co-workers.

When a woman in a domestic violence situation leaves her dangerous home environment, it actually increases her risk of violence in the workplace by 75 percent. "The husband or boyfriend may turn into a stalker," says health workplace safety expert Jacobs. "He may be harassing her in the workplace, perhaps damaging vehicles, and it will include other employees as well as the person that he's trying to get to. If the stalker thinks that someone is getting in his way to get to her, he'll include that person in his retribution plans."

There are few things equivalent to an incident of workplace violence to ruin a medical practice. In 1992, the National Safe Workplace Institute calculated that the average cost of a single incident to an employer could amount to \$250,000, which most experts today consider conservative. Beyond the immediate effects of the violent episode, victims and their co-workers frequently report continuing psychological injury akin to post-traumatic stress disorder, which can show up as sleeplessness, depression and flashbacks—even years later.

UO Readers on Workplace Violence

In the last issue of *UO*, we asked readers to tell us about their experiences with violence in the workplace. Of the 135 of you who responded, most had some experience with violence. It would seem obvious that those who have had these experiences would be more likely to respond than those who had not. Nevertheless, these responses may shed light on the prevalence of the problem

Have you experienced abuse from a patient?

Verbal abuse	103
Threats	67
Physical assault	21
No	23

Has another physician or staff member in your office experienced abuse from a patient?

Verbal abuse	93
Threats	60
Physical assault	20
No	22

Have you or a staff member in your office experienced abuse from a co-worker?

Verbal abuse	53
Threats	22
Physical assault	2
No	30

Most common specialties of the 103 physicians who said they had been verbally abused by a patient:

16	family practice
13	emergency medicine
12	psychiatry
12	internal medicine
10	obstetrics/gynecology
10	pediatrics

Most common specialties of the 21 physicians who reported they had been assaulted by a patient:

7	psychiatry
3	emergency medicine
3	pediatrics

An ounce of prevention

The multitude of risk factors and the difficulty in recognizing some of the symptoms speaks volumes on what needs to be done to prevent workplace violence in the health-care arena.

A low-cost, first line of defense should be staff training, and lots of it. "Proper training should include routine violence assessment of patients throughout the care delivery period," Jacobs reminds her colleagues. "Patients don't have to be psychiatric patients to become enraged and act out in the workplace." Violence assessment protocols are now available for patient intake. (See sidebar, "Assessing the Patient for Violence.")

The proper training can also help your staff be aware of threatening situations, defuse potentially violent scenarios, and manage violent outbursts to a safe and satisfactory conclusion. (See sidebar, "Tips for defusing a potentially

violent situation,") Most hospital education departments offer low-cost training in aggressive patient management. For the private physician's office or clinic, many consulting firms offer similar programs, at somewhat higher cost.

Violence assessment should also be part of every health-care hiring decision. While it may not be possible to ask about a person's past violent episodes, there are ways you can ferret out that information. Check references carefully and probe to see if there are other references they might be willing to supply, especially ones that could fill in gaps in the prospect's background. Ask references how well the prospective employee handled high stress situations. Specifically ask about incidents in which the prospect handled conflict with patients and co-workers.

In conducting patient assessments, psychiatrist Knoll recommends choosing the setting carefully if there is any question about a particular patient's be-

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havior. Leave the office door open or use an open area to conduct interviews with that person.

It's important to monitor your own behavior for body language that may be threatening to someone who is agitated. For example, Knoll recommends not touching an agitated person, getting too close to his or her personal space, or standing between the person and the only exit from a room.

Securing the Environment

Taking the time to assess the office environment with your staff for potentially troublesome areas can pay dividends many times over. Check stairwells, entrances, corridors, rest rooms and parking lots for adequate lighting and potential hiding places for attackers. Many workplace incidents occur immediately outside the office space proper.

NIOSH recommends such basic procedures as posting signs to let patients know that only limited amounts of cash are kept on site. Making high-risk areas, such as reception and waiting rooms, visible to more people serves as a deterrent to violence-prone individuals. These are typically low-cost solutions that will markedly increase security and will further boost staff awareness of the problem. In fact, Jacobs and her co-author, Wayne Porter, special agent with the Florida Department of Law Enforcement and an FBI-certified psychological profiler, recommend a team approach to office, clinic, or hospital security involving all levels of staff. Women, especially, should be encouraged to report to management their perceptions of situations, locales, and tasks where they feel unsafe.

Staffing patterns make employees vulnerable to stalkers. Is someone rou-

tinely opening or closing the office alone and at the same time every day? If so, rotate the assignment and opening and closing sequences. Does one staff member routinely transport cash? Is it on a regular schedule?

Take a cue from research that shows that music calms the inner beast. Create a soothing office environment by playing classical or New Age music softly. Decrease external noises and stimuli, which tend to agitate people. This is yet another low-cost solution, available for \$1,500 to \$3,000, including installation.

Doors that offer easy access to employees but that are locked from the outside serve as deterrents. Be sure to install panic bars for all emergency exits. High security doors can cost up to \$2,000 each.

Guns have no place in a medical practice, even if one believes they are there for protection. First, they raise the bar in terms of what prevention measures will be tolerated in the office. Second, they are rarely available at the exact instant they are needed, especially if they are kept locked, as they should be. Third, they open up a practice to lawsuits for use of excessive force, especially when low-cost training to prevent violence is available. Finally, the chances are greatest that a gun will be used against a co-worker.

Install security devices

More elaborate security systems can range from simple to highly complex, depending on the location of the practice, the clientele, and other factors. A simple, discreet alarm button strategically placed under the receptionist's desk can be rigged to notify your local police for under \$300, plus a small monthly monitoring/connection fee.

Total access control systems, with

keyless entry doors, remote alarms, bullet-resistant barriers and two-way mirrors in reception areas, can cost \$5,000 to more than \$10,000, depending on options. Closed-circuit camera systems cost \$1,500-\$2,500 each, and you may need several cameras and recorders to cover a large practice. The highest security costs are associated with personnel such as guards, which are increasingly justified by lowered insurance costs and the peace of mind that they may bring to staff, especially in high-risk clinic settings. Guard costs range from \$35,000 a year for a person hired by the practice, to \$50,000 and up a year for guards hired from security firms. In either case, make sure that guards are trained for the specific circumstances of medical practices.

The human factor

No system designed to minimize workplace violence will work without a good measure of common sense thrown into the mix. Threats must be taken seriously, no matter how absurd they may appear on the surface. Your employee manual should include that caveat, as well as how threats against co-workers will be treated. It should also state that any and all threats from patients must be reported and to whom.

"Don't ignore warning signs," suggests Jacobs. "If you think something might happen, it probably will." Larry Chavez, a workplace violence expert with the Sacramento Police Department agrees. "Experience has taught us that 85 percent of workplace incidents had clear warning signs." People generally have an uncomfortable feeling preceding such incidents. A 1976 study found that in more than half of the cases in which a psychiatrist was attacked by a patient, the psychiatrist later recalled distinct cues which could have predicted the attack. Another study

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found that despite strong indications of possible assault, 39 percent of psychiatrists who were attacked did nothing to minimize their risks.

If you own or administer a practice, make it a consistent practice to investigate any signs of potential violence, such as staff or patients carrying weapons of any type. It is critical to maintain control of the work environment, to ensure the safety of all employees, and to reduce potential legal liabilities. That control should include the use of restraining orders, which is a legal tool that medical practices could employ more to their benefit.

Get started

While each health-care practice is unique, there are enough commonalities so that a body of experience in workplace safety has emerged. The consensus among experts is that the most critical step is simply to get serious and get started. Consultants recommend forming an employee committee that addresses the issue so that workplace safety is "owned" by everyone in the practice. Keeping workplace violence prevention at the top of everyone's mind is the best way to keep your office safe and productive. ■

Les Picker is a regular contributor to Unique Opportunities.