Institute *for* Healthcare Improvement

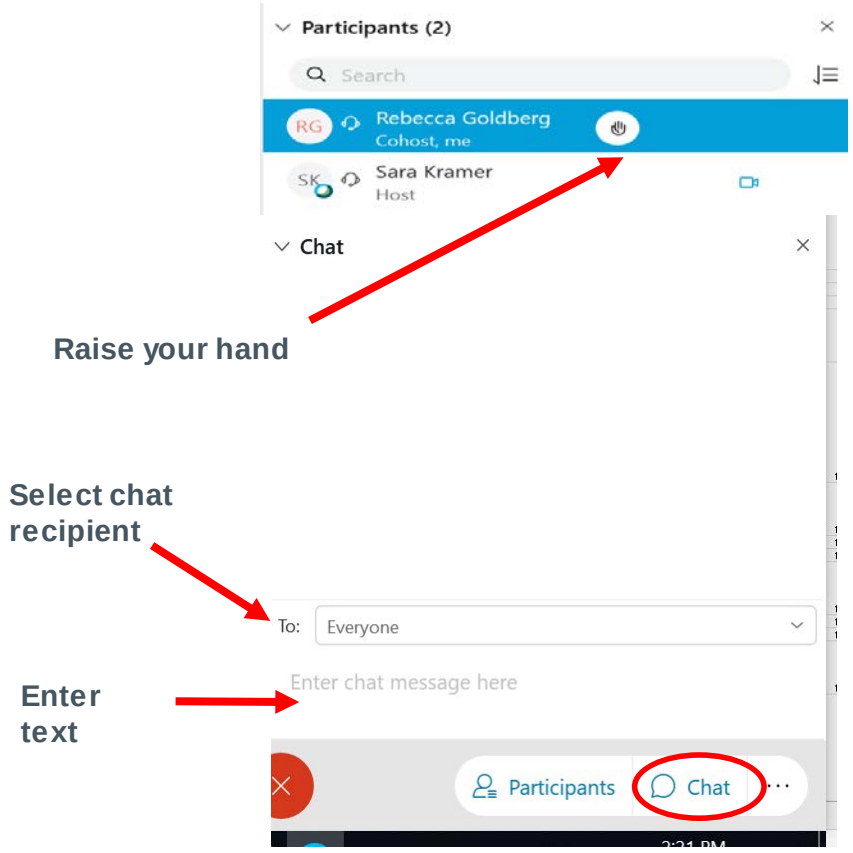
Workplace Violence: Protecting Health Care Workers

PSAW Virtual Learning Hour

3/16/2021

Participate in the Chat

- Please use chat to **“Everyone”** for discussion & questions
- For technology issues only, please chat to **“Host”**



Continuing Education Credits

This educational activity offers **1.00** contact hours for the following:

Physicians and Nurses

In support of improving patient care, the Institute for Healthcare Improvement is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME) and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team. This continuing education activity carries 1 Contact Hour for nurses and physicians. The Institute for Healthcare Improvements designates this live activity for a maximum of 1 AMA PRA Category 1 Credit™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Certified Professional in Patient Safety Recertification

A total of **1.00** contact hours is available toward the fulfillment of the requirements of **CPPS (Certified Professional in Patient Safety) recertification**.

Healthcare Executive

This program has been approved for **1** hour of education credit toward advancement or recertification by the American College of Healthcare Executives.

You will be able to claim credits on the educational platform after the event and must be completed within 30 days. Instructions will be shared via email.

Disclosure

Acknowledgement of Commercial Support

No commercial support was received for this activity.

Faculty & Staff Disclosure

Mary Beth Kingston, PhD, RN, NEA-BC, FAAN has declared no relevant financial relationships.

Stephen Muething, MD has declared no relevant financial relationships.

Amar Shah, MD has declared no relevant financial relationships.

Jeffrey Brady, MD, MPH has declared no relevant financial relationships.

Patricia McGaffigan, RN, MS, CPPS has declared no relevant financial relationships.

Sara Kramer has declared no relevant financial relationships.

Criteria for Completion

- Register for the event
- Login to the event
- **Attend 100% of the event**
- Complete the online evaluation survey

Learning Objectives

- Identify risk factors that are associated with workplace violence
- Describe successful practices and interventions for addressing workplace violence
- Consider resources that may be integrated into your organization’s workplace violence prevention program

Faculty Bio

Patricia A. McGaffigan, RN, MS, CPPS, Vice President, Safety Programs, Institute for Healthcare Improvement (IHI), previously served as COO and Senior VP of Programs at the National Patient Safety Foundation until 2017, when the Foundation merged with IHI. Her prior experience includes clinical practice, academia, and leadership roles in education and marketing positions for several start-up and established medical device companies focused on improving patient safety. Ms. McGaffigan is a Certified Professional in Patient Safety, a graduate of the AHA-NPSF Patient Safety Leadership Fellowship Program, and a member of the American Society for Professionals in Patient Safety. She was awarded the distinguished Lifetime Member Award from the American Association of Critical Care Nurses. She serves on a wide range of national committees related to safety and is a Board of Director for Medically Induced Trauma Support Services. She received her BS with a major in Nursing from Boston College, and her MS with a major in Nursing from Boston University.

Faculty Bio

Jeffrey Brady, MD, MPH, has served as the Director of AHRQ's Center for Quality Improvement and Patient Safety since 2014. He is as a member of the AHRQ Senior Leadership Team and manages a part of the Agency that conducts several AHRQ programs. Dr. Brady led the AHRQ Patient Safety Research Program from 2009 to 2014, and in a prior position, he led the team that produces the National Healthcare Quality and Disparities Report, an annual report to Congress on the status of health care quality in the United States. Before moving to AHRQ in 2006, Dr. Brady served as a medical officer for the Food and Drug Administration's Office of Vaccines. Additionally, he has held positions as a medical epidemiologist for the Department of Defense and primary care physician aboard the U.S.S. Coronado while serving in the U.S. Navy. Rear Admiral Brady retired from active duty in the Commissioned Corps of the U.S. Public Health Service in 2019. He attended the Medical College of Georgia, completed internship training in Internal Medicine at the Naval Medical Center, San Diego, California, and earned a Master's degree in public health from the Uniformed Services University of the Health Sciences (USUHS) in Bethesda, Maryland. Dr. Brady completed the Navy's General Preventive Medicine Residency, also at USUHS, and is board-certified in Public Health and General Preventive Medicine.

Faculty Bio

Amar Shah, MD is Consultant forensic psychiatrist & Chief Quality Officer at East London NHS Foundation Trust (ELFT). He leads at executive and Board level at ELFT on quality, performance, strategy, planning and business intelligence. He is the national improvement lead for mental health at the Royal College of Psychiatrists, leading a number of large-scale improvement collaboratives on the topics of suicide prevention, restrictive practice and sexual safety. Amar is also chair of the quality improvement faculty at the Royal College of Psychiatrists. Amar is an improvement advisor and faculty member for the Institute for Healthcare Improvement, teaching and guiding improvers and healthcare systems across the world. He is honorary visiting professor at the University of Leicester. Amar has completed an executive MBA in healthcare management, a masters in mental health law and a postgraduate certificate in medical education. Amar is a regular national and international keynote speaker at healthcare improvement conferences and has published over 40 peer-review articles in the field of quality management.

Faculty Bio

Stephen E. Muething, MD is the Chief Quality Officer and the Co-Director of the James M. Anderson Center for Health Systems Excellence at Cincinnati Children's Hospital Medical Center and Professor of Pediatrics at The University of Cincinnati College of Medicine. Dr. Muething was awarded the Michael and Suzette Fisher Family Chair for Safety at Cincinnati Children's Hospital Medical Center. He focuses on the strategic goals of Cincinnati Children's to improve all aspects of care including safety, outcomes, experience, affordability, and population health. Dr Muething serves as a lead faculty and mentor in the quality improvement development program at the Anderson Center. His research and national impact focuses on high reliability, large scale healthcare safety, lean culture transformation and development of learning networks nationally. He has taught all over the United States and more than a dozen countries. He has led or served on multiple national initiatives including the National Steering Committee for Healthcare Safety. Dr Muething was one of the founders of the Children's Hospital Solution for Patient Safety (SPS) and now serves as the Strategic Advisor. This network of more than 140 children's hospitals across the United States and Canada is collaborating to eliminate all harm for both patients and staff.

Faculty Bio

Mary Beth Kingston, PhD, RN, NEA-BC, FAAN has been in the role of Chief Nursing Officer for Advocate Aurora Health since April, 2018 following the merger of Advocate Health and Aurora Health Care where she serves as a member of the executive leadership team and is responsible for nursing practice and standards, as well as patient experience. She joined Aurora Health Care in 2012. An area of focus in her work is on creating healthy and safe work environments. Mary Beth co-led the workforce safety sub-committee of the IHI National Steering Committee on Patient Safety. Mary Beth is currently serving on the board of the Milwaukee Urban League in Milwaukee and was recently elected to the American Hospital Association board of trustees (2021-2023). She served on the board of the American Organization of Nurse Executives from 2014-2016 and was President in 2019. She is a 2020 recipient of the American Assembly for Men in Nursing's Inclusion and Diversity Award (IDEA), a Robert Wood Johnson Executive Nurse Fellow from 2009-2012 and a 2007 recipient of the Pennsylvania Nightingale Award for Nursing Administration. Mary Beth was inducted as a fellow in the American Academy of Nursing in 2020.

Welcome…

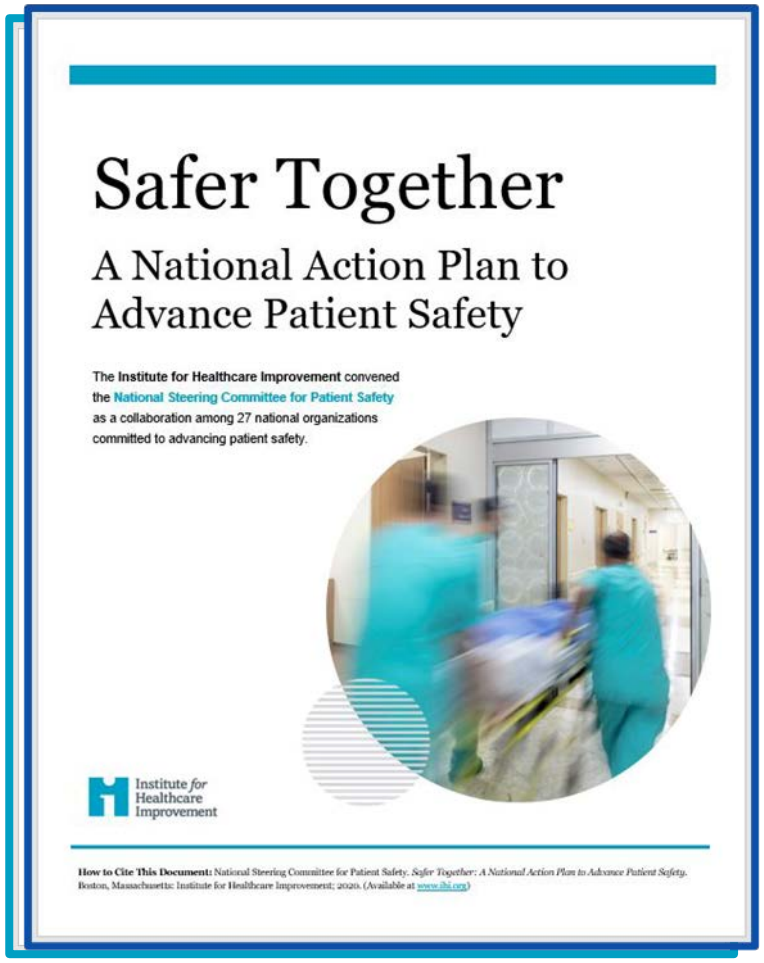
@TheIHI; #PSAW21

Workplace Violence

- Incidents where workers are abused, threatened, or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being, or health.[1]
- An action (verbal, written, or physical) intended to cause or causing death or serious bodily injury to oneself or others, or damage to property. Includes abusive behavior toward authority, intimidating or harassing behavior, and threats.[2]

1. who.int/violence_injury_prevention/violence/activities/workplace/en/.
2. https://www.dol.gov/agencies/oasam/centers-offices/human-resources-center/policies/workplace-violence-program/appendices

Safer Together: A National Action Plan to Advance Patient Safety



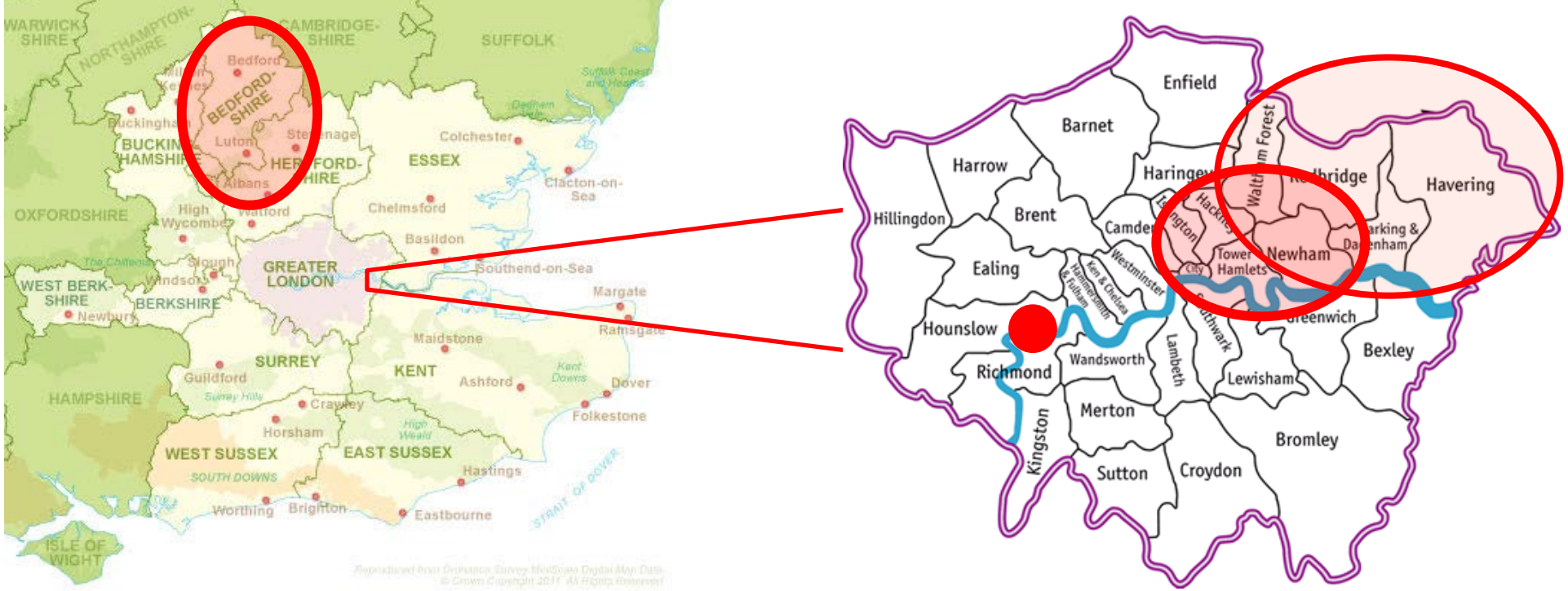
www.ihi.org/SafetyActionPlan

- Illuminates the collective insights of 27 organizations that make up the National Steering Committee for Patient Safety, who are united in their efforts to achieve truly safer care and reduce harm to patients and those who care for them
- Provides clear direction for making significant advances toward safer care and reduced harm across the continuum of care across four foundational areas:
  - Culture, Leadership, Governance
  - Patient and Family Engagement
  - Learning Systems
  - Workforce Safety

Reducing physical violence at East London NHS Foundation Trust

Dr Amar Shah
Chief Quality Officer

@DrAmarShah



Mental health services

Newham, Tower Hamlets, City & Hackney, Luton & Bedfordshire

Forensic services

All above & Waltham Forest, Redbridge, Barking, Dagenham, Havering

Child & Adolescent services, including tier 4 inpatient service

Regional Mother & Baby unit

Community health services

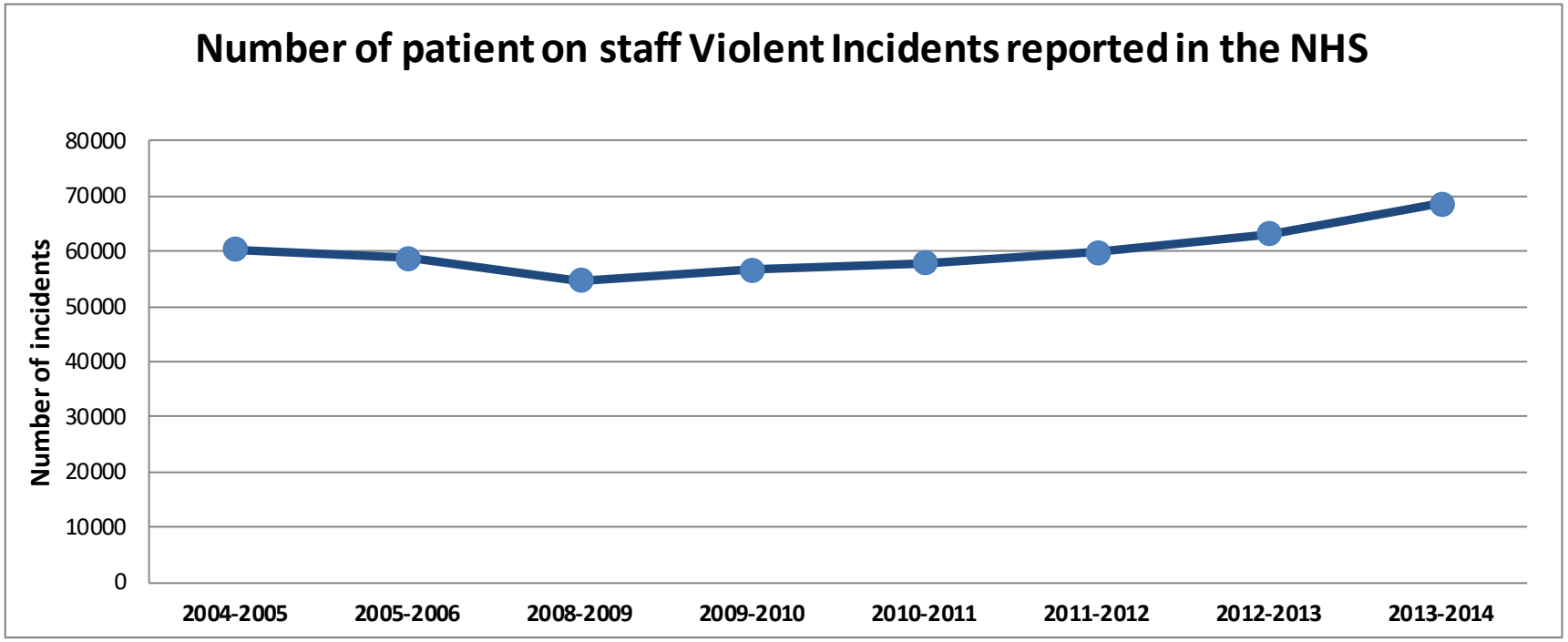
Newham, Tower Hamlets & Bedfordshire

IAPT

Newham, Tower Hamlets, Richmond and Bedfordshire

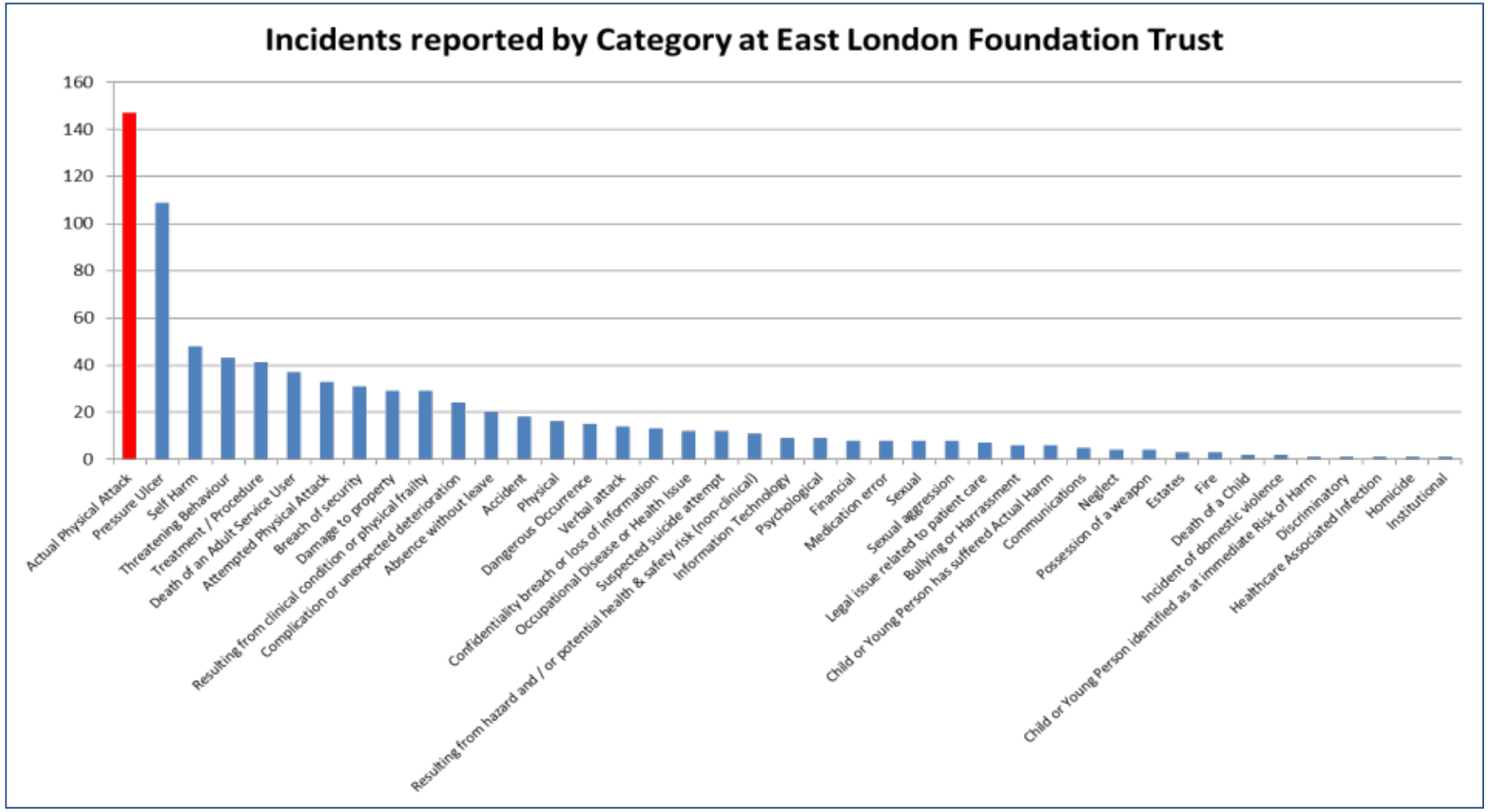
Primary Care

Violence levels over the last few years…



Three times as many violent incidents occur in mental health services than other NHS services

Local Context



Impact…

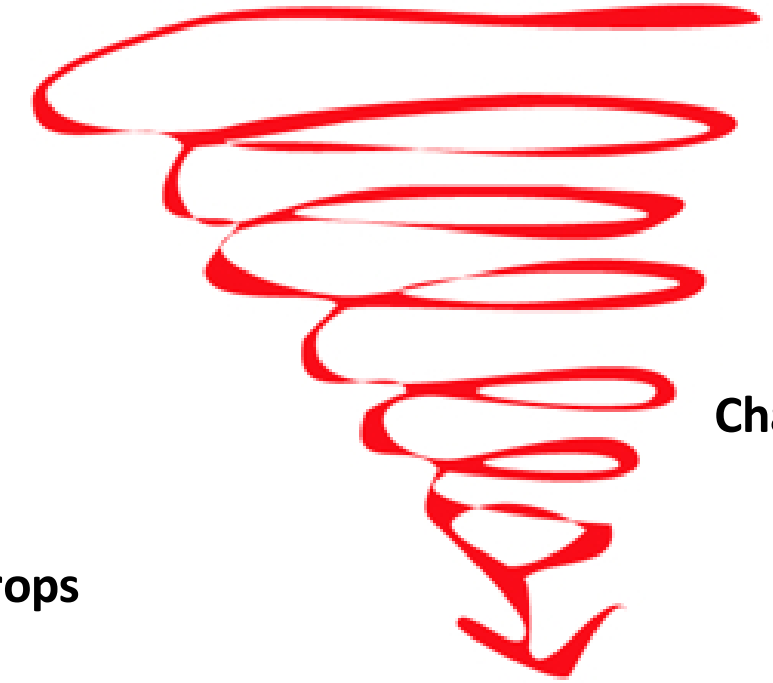
Physical injury

Dread of work

Psychological:
Stress, Fear, Trauma

Service users feeling threatened and fearful

Staff sickness



Ward team depleted

Experience often resonates with histories of abuse

Negative feelings amongst team

Changes service users behaviour (e.g. staying in rooms

Morale drops

Staff leave

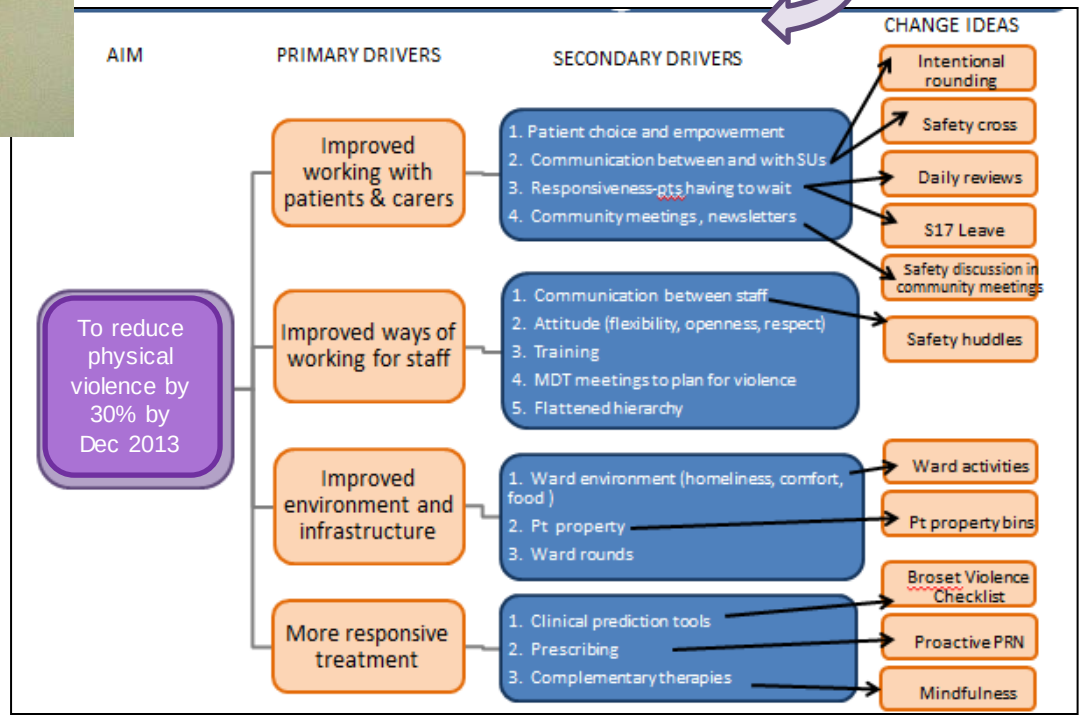
Staff desensitized

Impedes recovery

Bank staff won't take shifts on ward…

Service users spend longer on ward

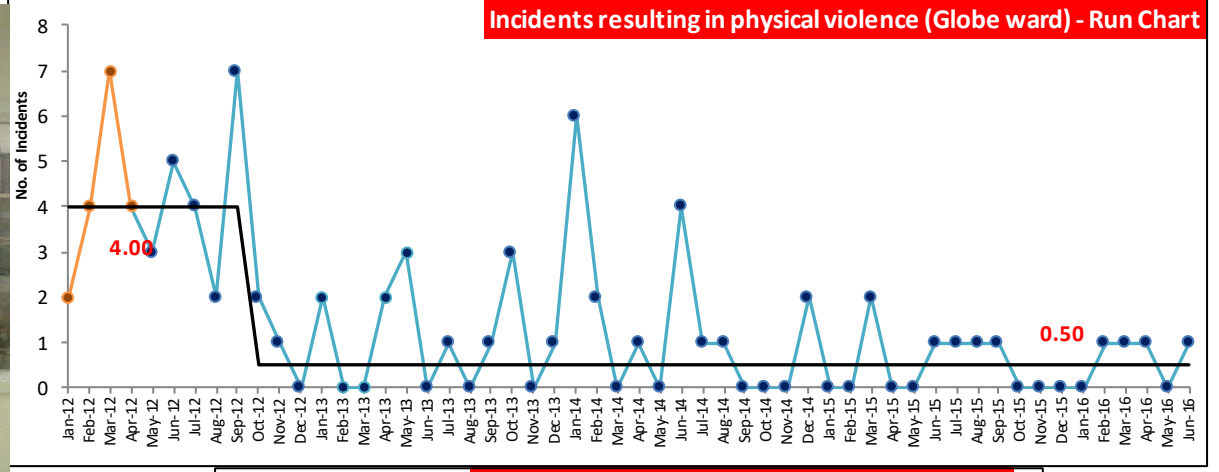
Literature search presented to team as part of developing theory of change

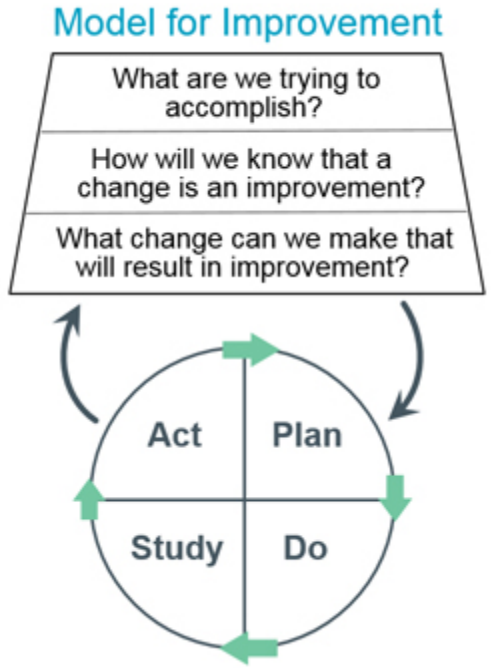


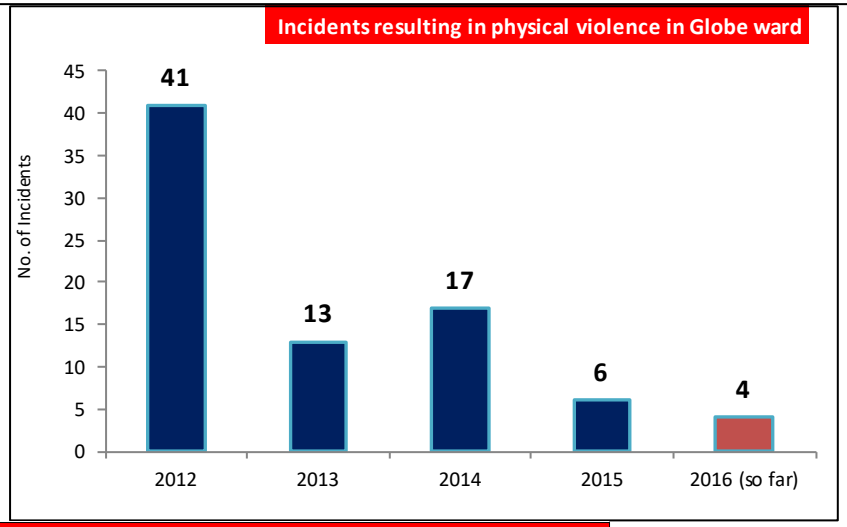
One of our first ever QI projects at East London NHS FT, starting in 2012…

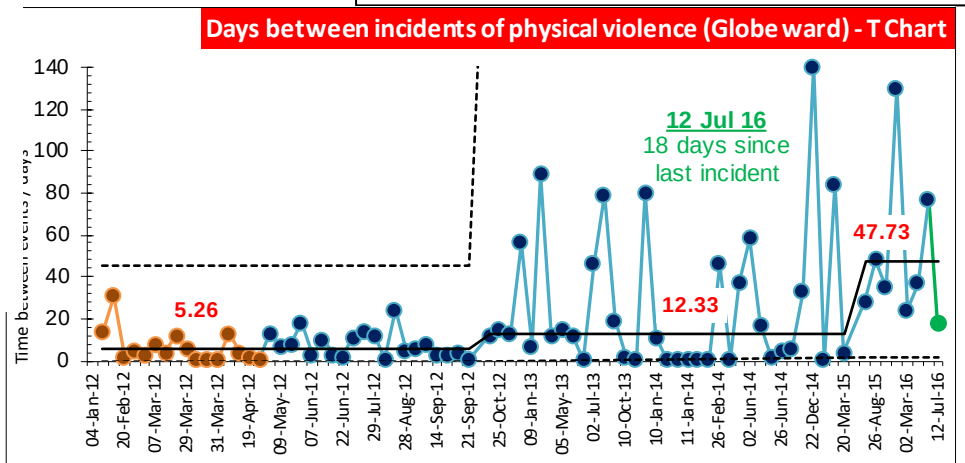
With no real support structure, and before we knew what we were doing!


WELCOME TO GLOBE WARD
NOMINATED FOR TEAM OF THE YEAR AWARD 2013

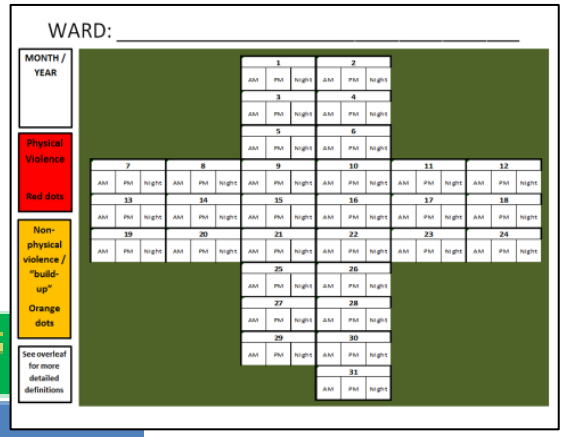

Incidents resulting in physical violence (Globe ward) - Run Chart
No. of Incidents
4.00
0.50


Model for Improvement
What are we trying to accomplish?
How will we know that a change is an improvement?
What change can we make that will result in improvement?
Act
Plan
Study
Do


Incidents resulting in physical violence in Globe ward
No. of Incidents
41
13
17
6
4
2012
2013
2014
2015
2016 (so far)


Days between incidents of physical violence (Globe ward) - T Chart
12 Jul 16
18 days since last incident
5.26
12.33
47.73

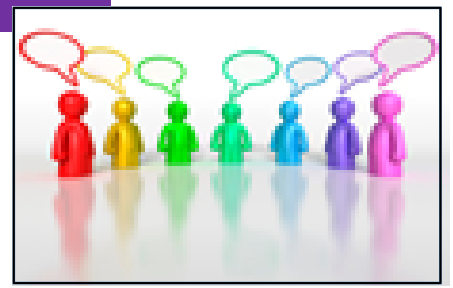
Safety Culture Change Bundle

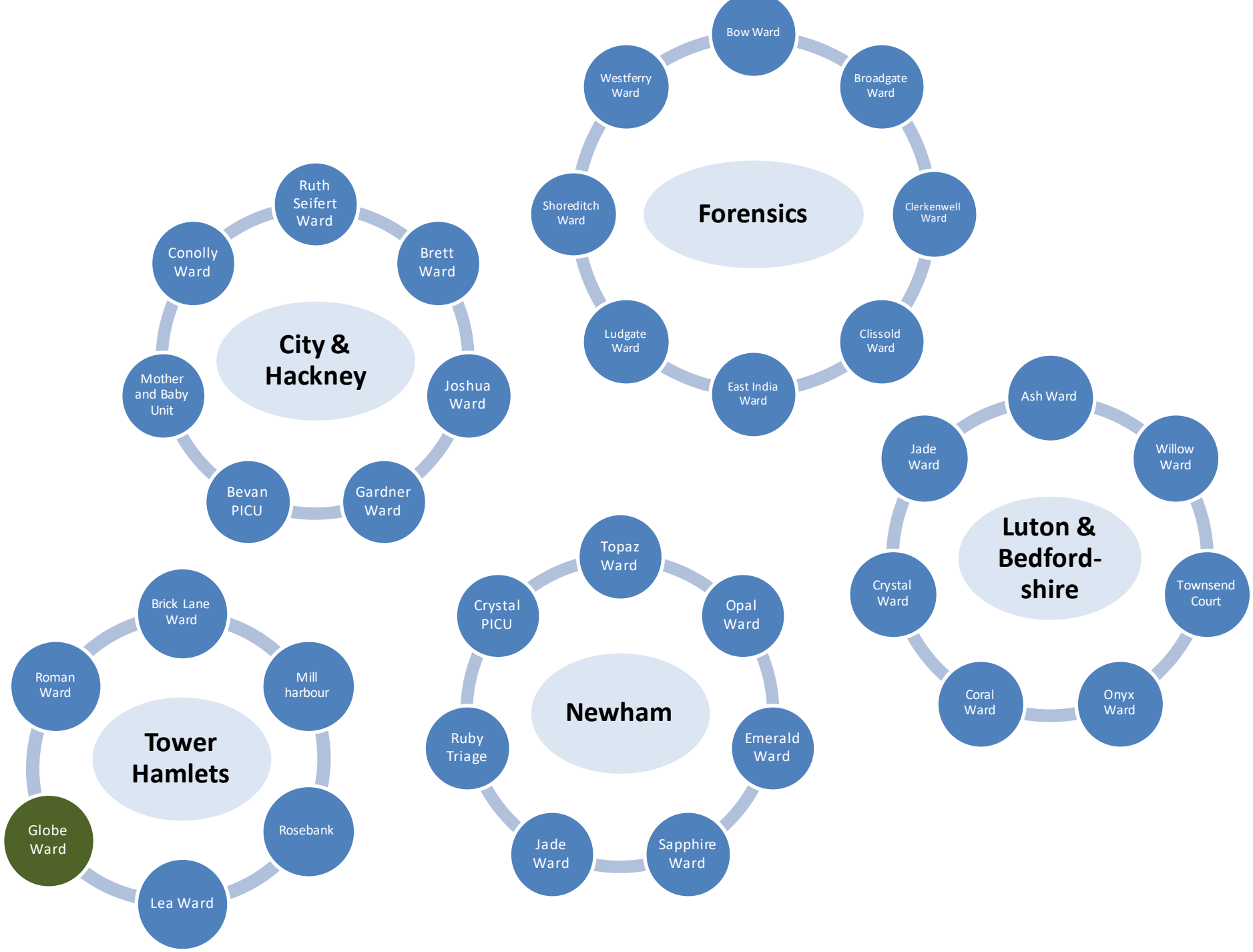


Driver	Change ideas
Increasing prediction and responsiveness	• Safety Huddle • Broset Violence Checklist
Openness, transparency and sharing safety as a priority for our ward community	• Safety Cross • Community Meetings

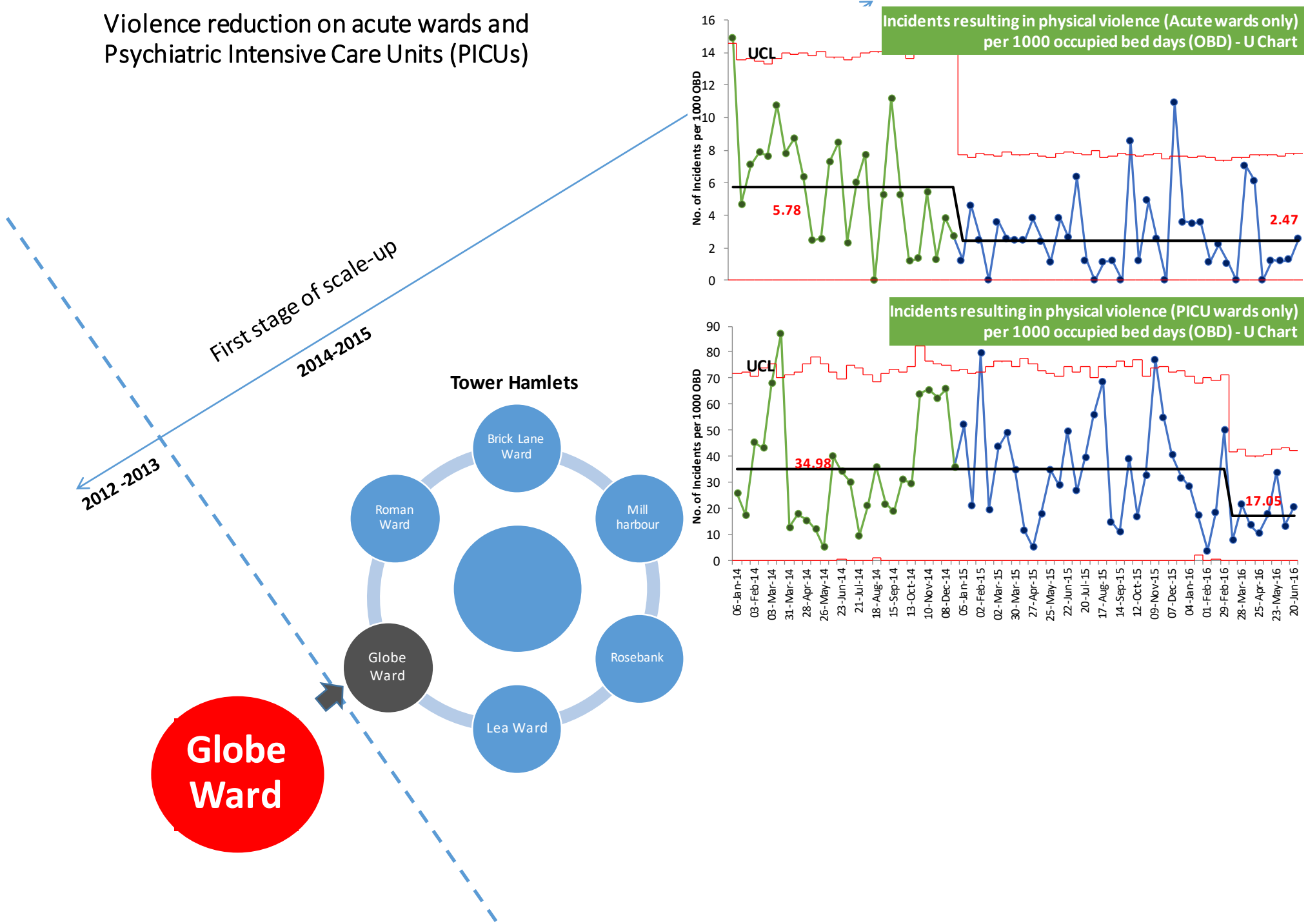
	Monday / /			Tuesday / /		
	Night	Day	Eve	Night	Day	Eve
Confused						
Irritable						
Boisterous						
Verbal threats						
Physical threats						
Attacking objects						
SUM						
INTERVENTIONS						

0 = no interventions	INIT	DATE/TIME	SIGNAT
1 = verbal de-escalation			
2 = diversional activity			
3 = stimulation			

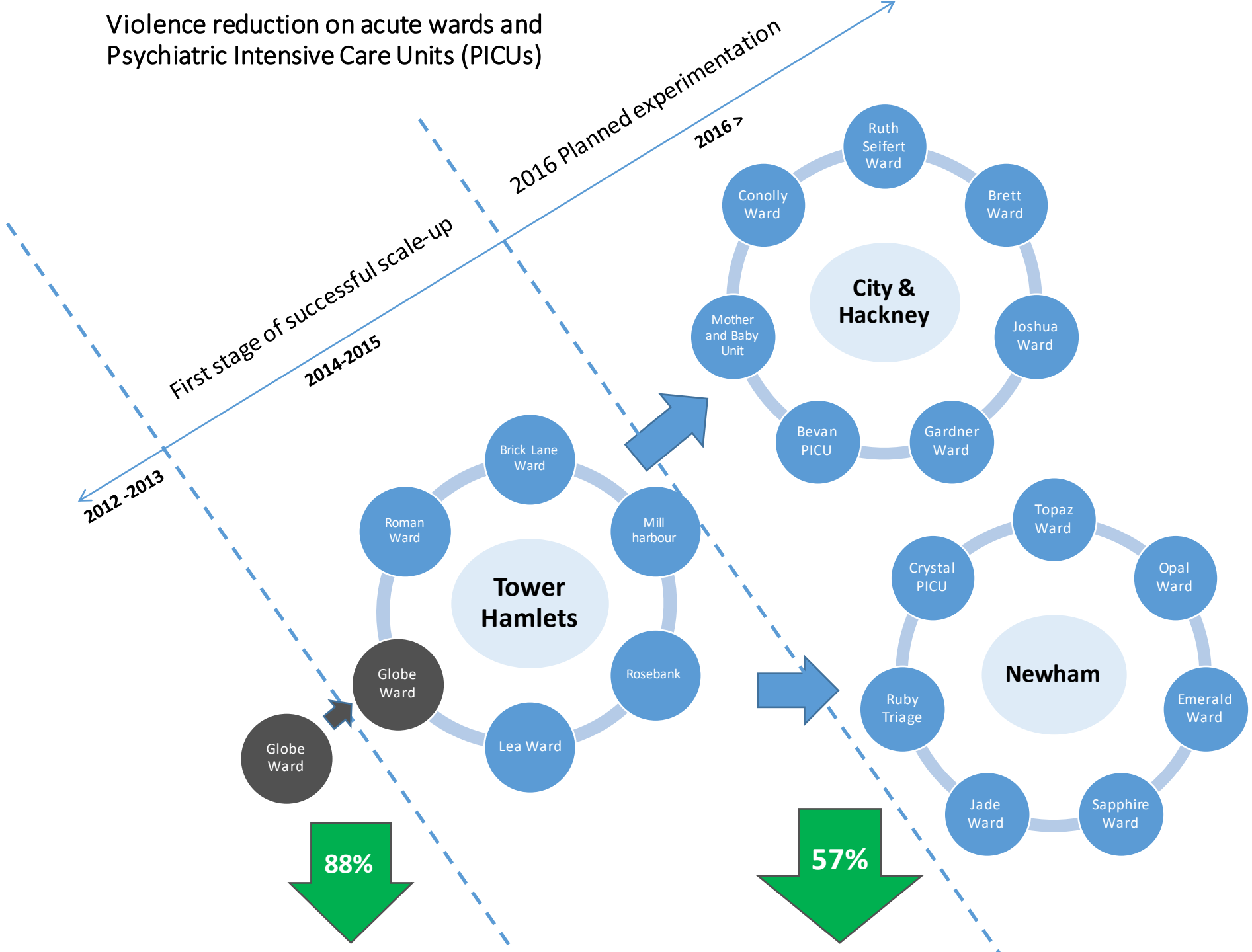



Forensics
Bow Ward
Broadgate Ward
Clerkenwell Ward
Clissold Ward
East India Ward
Ludgate Ward
Shoreditch Ward
Westferry Ward
City & Hackney
Ruth Seifert Ward
Brett Ward
Joshua Ward
Gardner Ward
Bevan PICU
Mother and Baby Unit
Conolly Ward
Luton & Bedford-shire
Ash Ward
Willow Ward
Townsend Court
Onyx Ward
Coral Ward
Crystal Ward
Jade Ward
Newham
Topaz Ward
Opal Ward
Emerald Ward
Sapphire Ward
Jade Ward
Ruby Triage
Crystal PICU
Tower Hamlets
Brick Lane Ward
Mill harbour
Rosebank
Lea Ward
Globe Ward
Roman Ward

Violence reduction on acute wards and Psychiatric Intensive Care Units (PICUs)

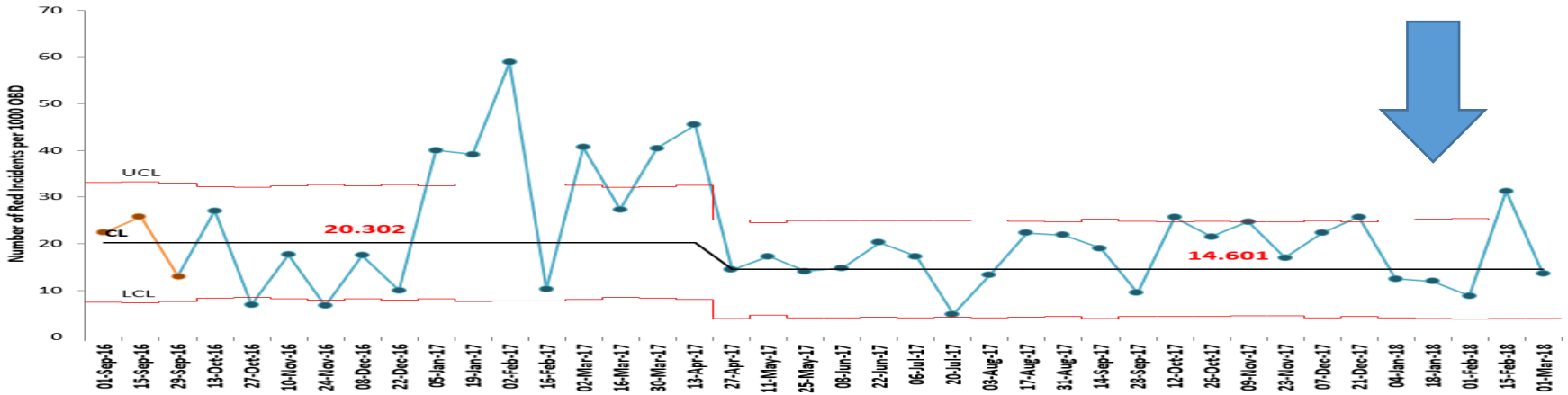


Violence reduction on acute wards and Psychiatric Intensive Care Units (PICUs)



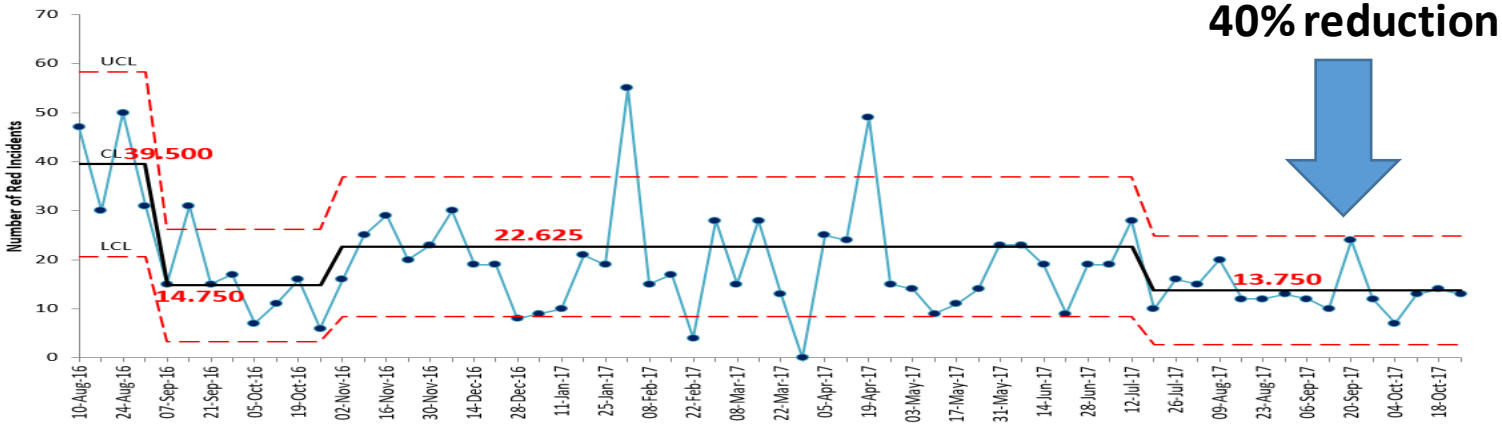
Newham Violence Reduction Collaborative

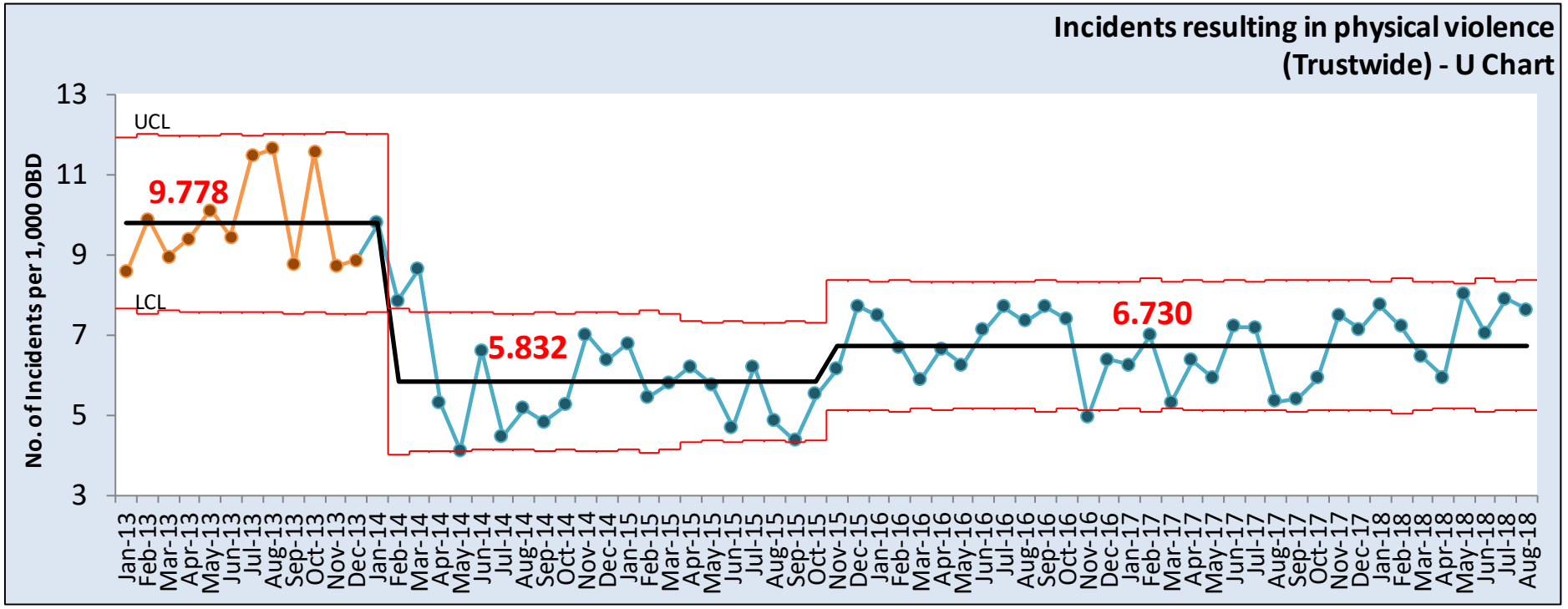
28% reduction

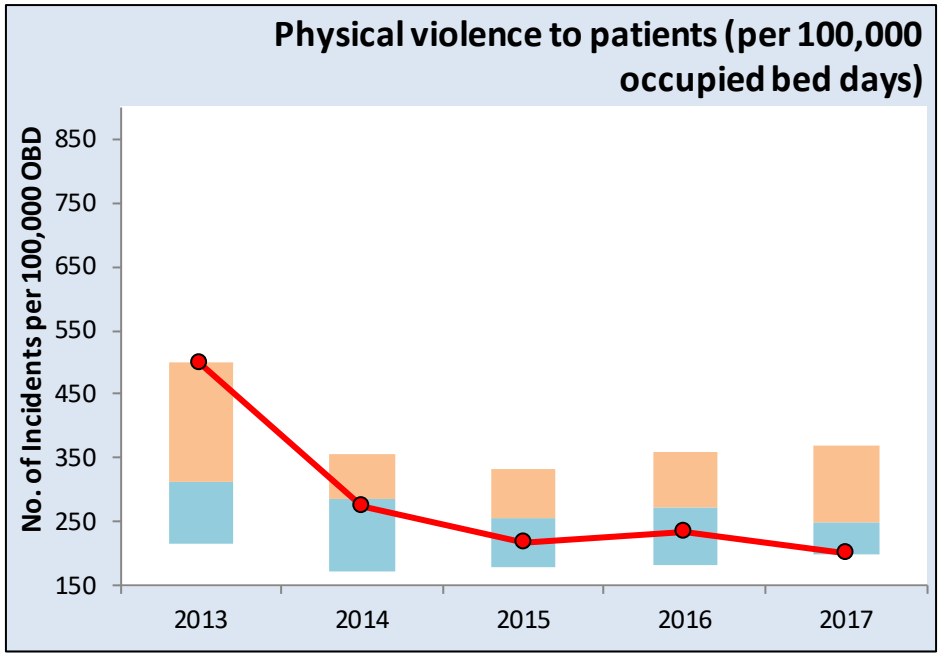


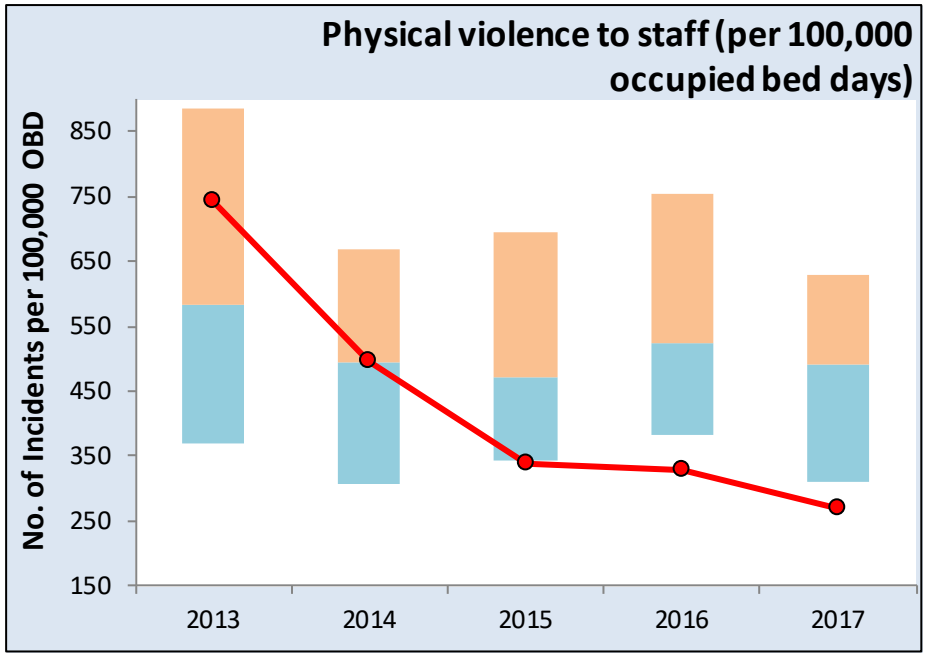
City and Hackney Violence Reduction Collaborative

40% reduction




Incidents resulting in physical violence (Trustwide) - U Chart
No. of Incidents per 1,000 OBD
13
11
9
7
5
3
UCL
LCL
9.778
5.832
6.730
Jan-13 Feb-13 Mar-13 Apr-13 May-13 Jun-13 Jul-13 Aug-13 Sep-13 Oct-13 Nov-13 Dec-13 Jan-14 Feb-14 Mar-14 Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15 Jul-15 Aug-15 Sep-15 Oct-15 Nov-15 Dec-15 Jan-16 Feb-16 Mar-16 Apr-16 May-16 Jun-16 Jul-16 Aug-16 Sep-16 Oct-16 Nov-16 Dec-16 Jan-17 Feb-17 Mar-17 Apr-17 May-17 Jun-17 Jul-17 Aug-17 Sep-17 Oct-17 Nov-17 Dec-17 Jan-18 Feb-18 Mar-18 Apr-18 May-18 Jun-18 Jul-18 Aug-18


Physical violence to patients (per 100,000 occupied bed days)
No. of Incidents per 100,000 OBD
850
750
650
550
450
350
250
150
2013
2014
2015
2016
2017

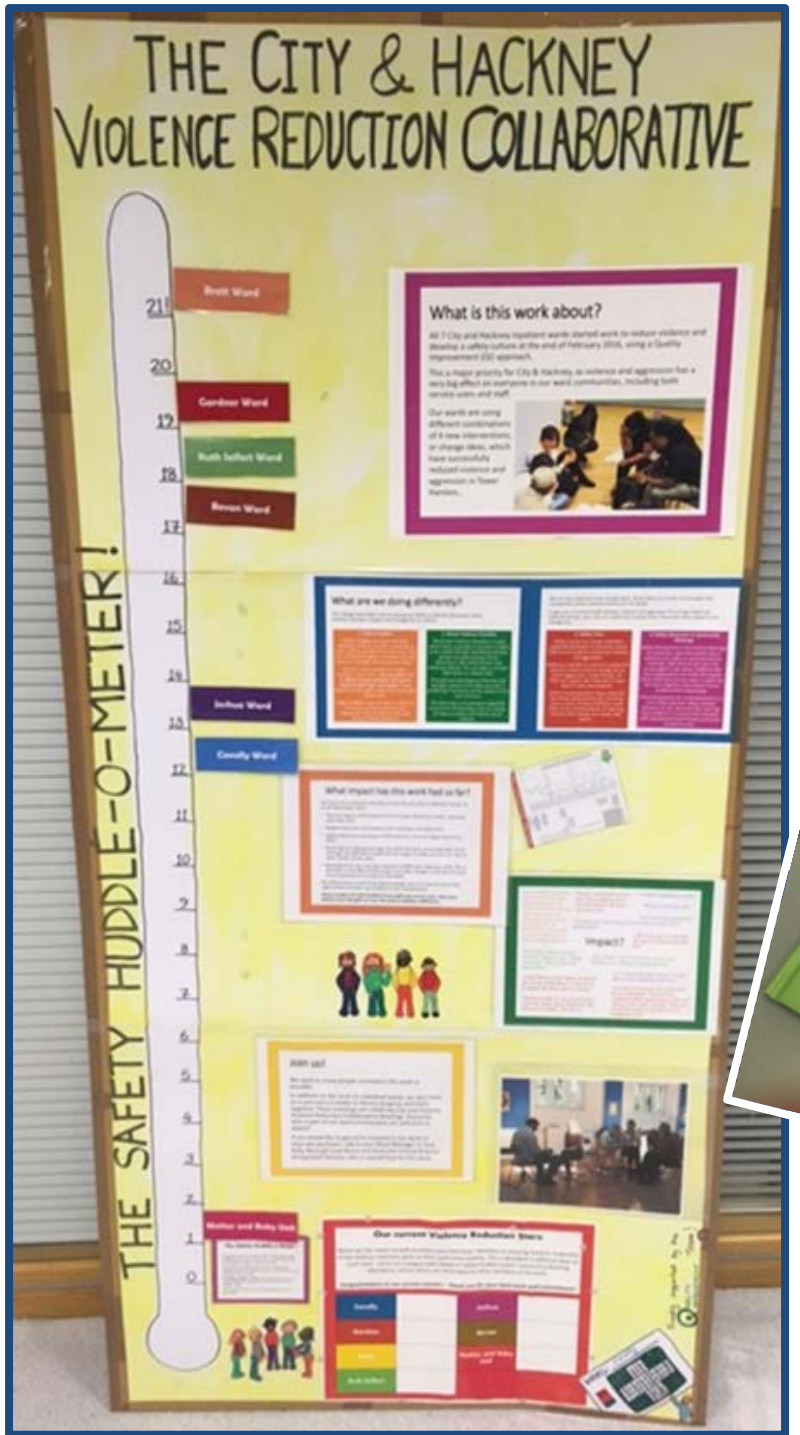

Physical violence to staff (per 100,000 occupied bed days)
No. of Incidents per 100,000 OBD
850
750
650
550
450
350
250
150
2013
2014
2015
2016
2017

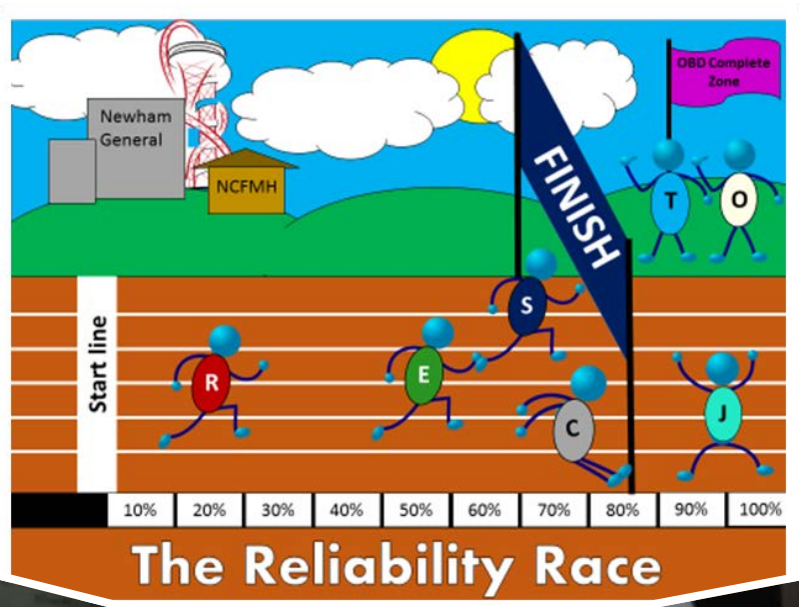
Learning #1:
Bring people together to share their experiences and start the conversation

Learning #2:

Involve the whole community.

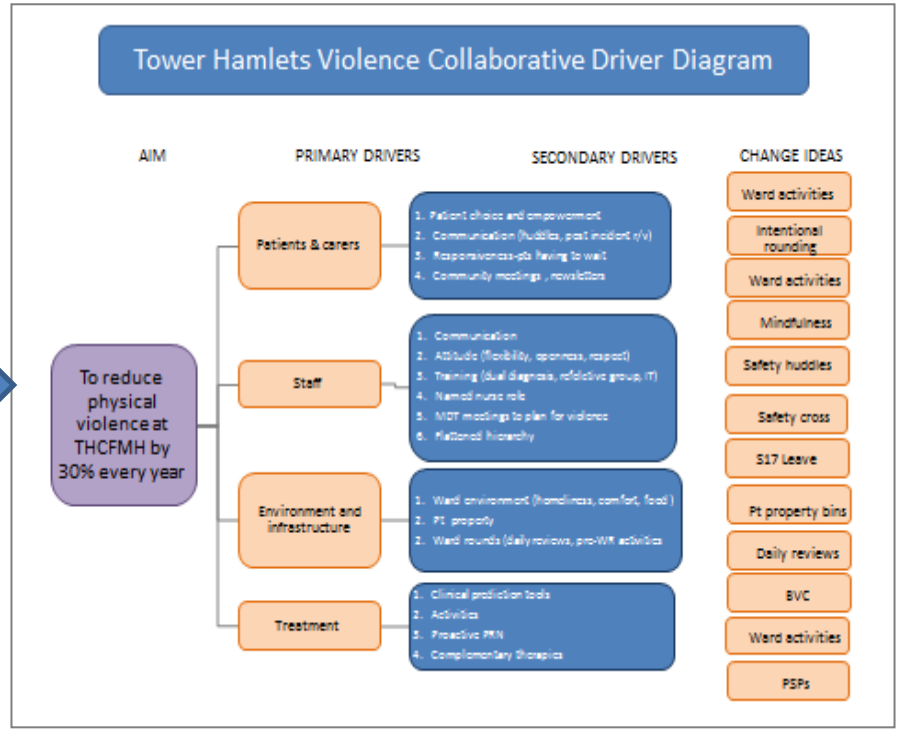
Use creative techniques to enable people to express their feelings and hopes.





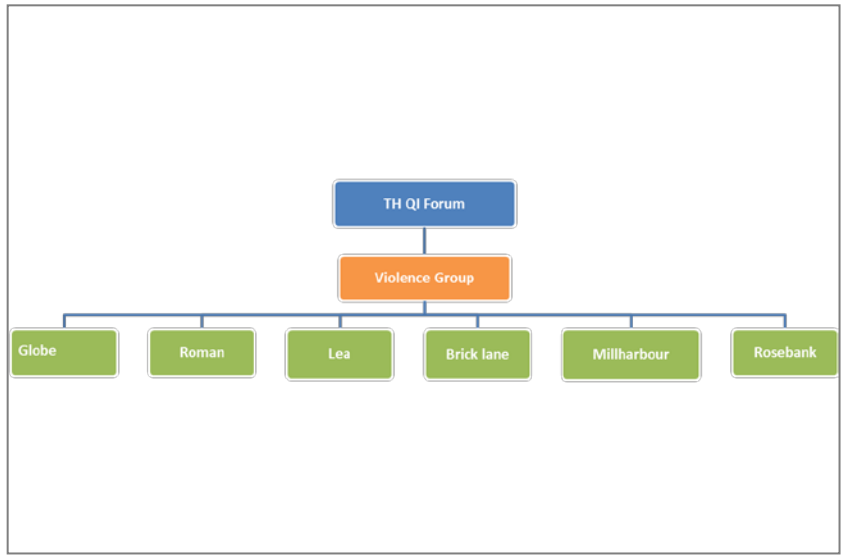
Learning #3:
Find ways to keep it local and FUN!

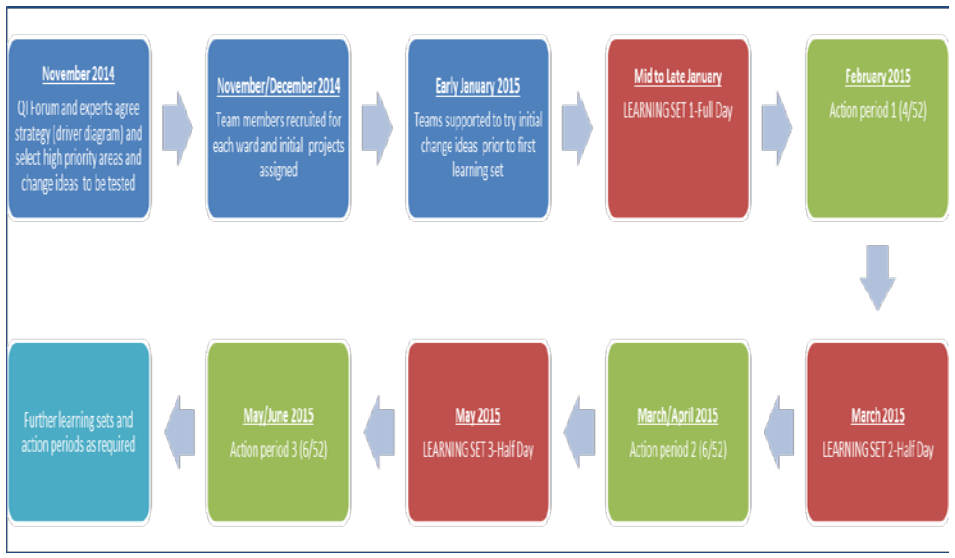
Co-design the strategy…



Engagement of the system = joy in work!

A structure for oversight and learning…

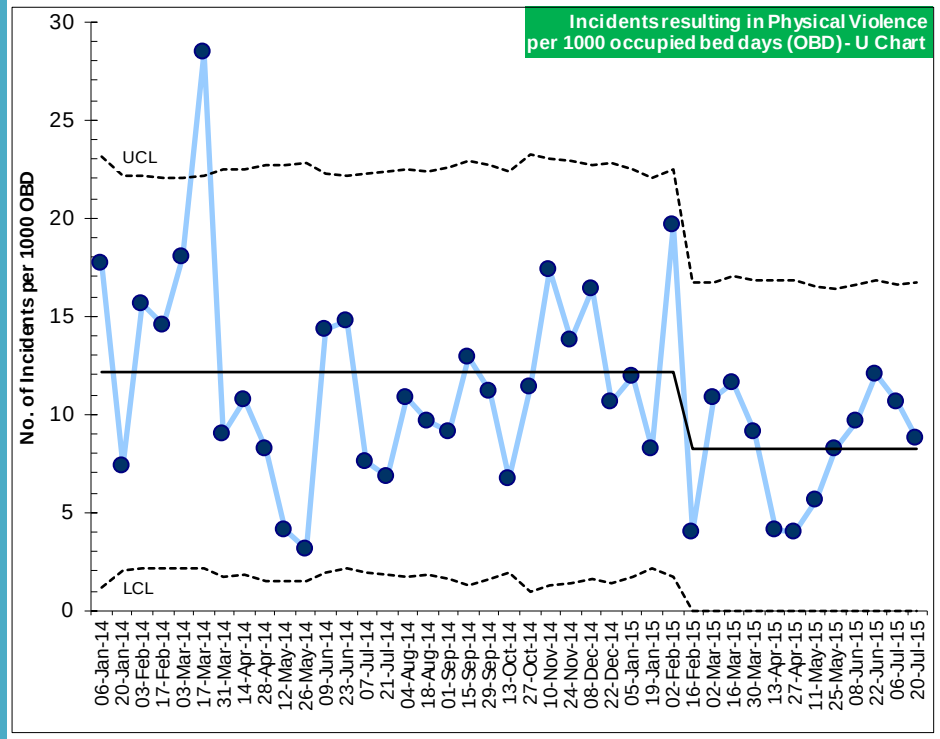


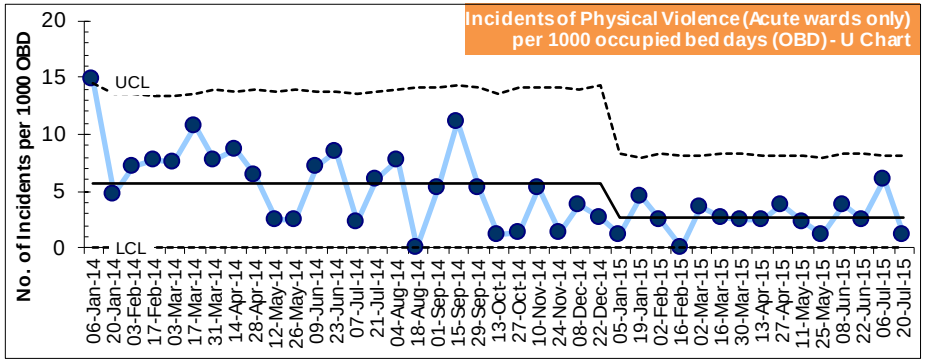


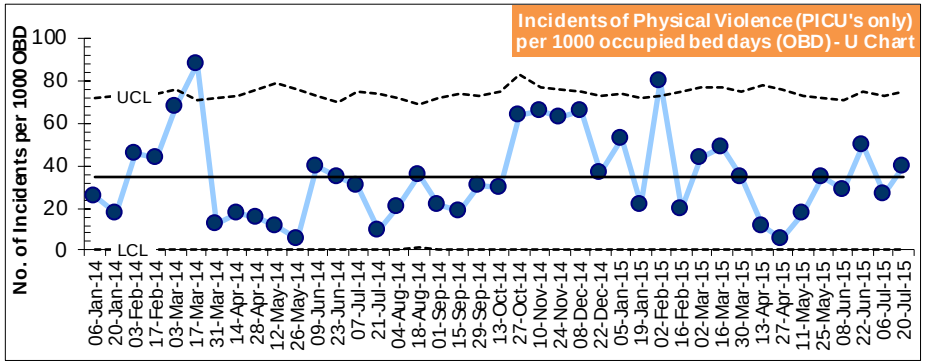
A measurement system for learning…

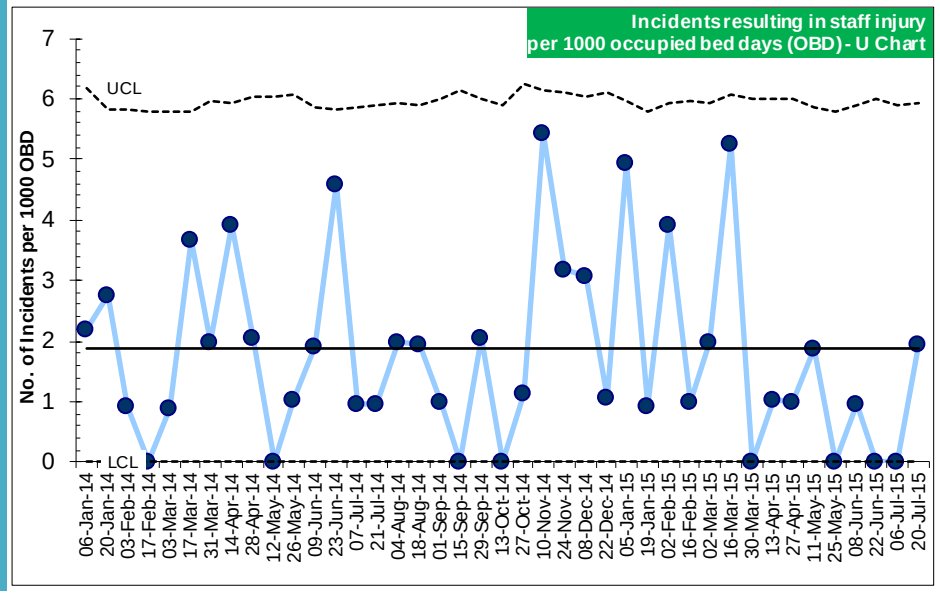
OUTCOME MEASURES

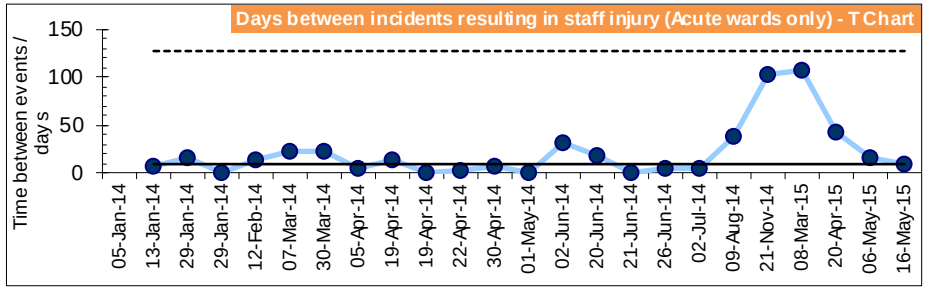
Key
- Trust-wide data
- Tower Hamlets data
- Combined wards data
- Individual ward data

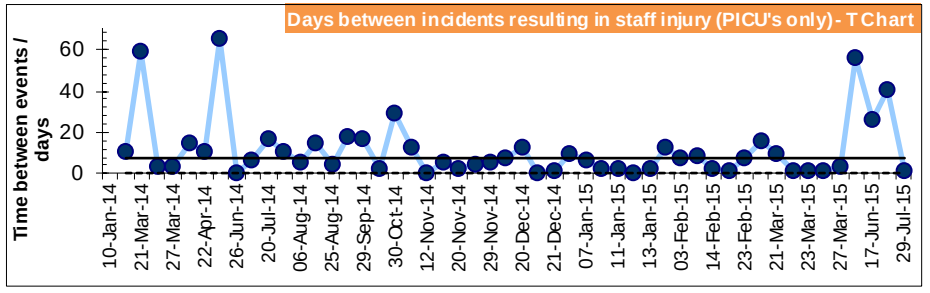










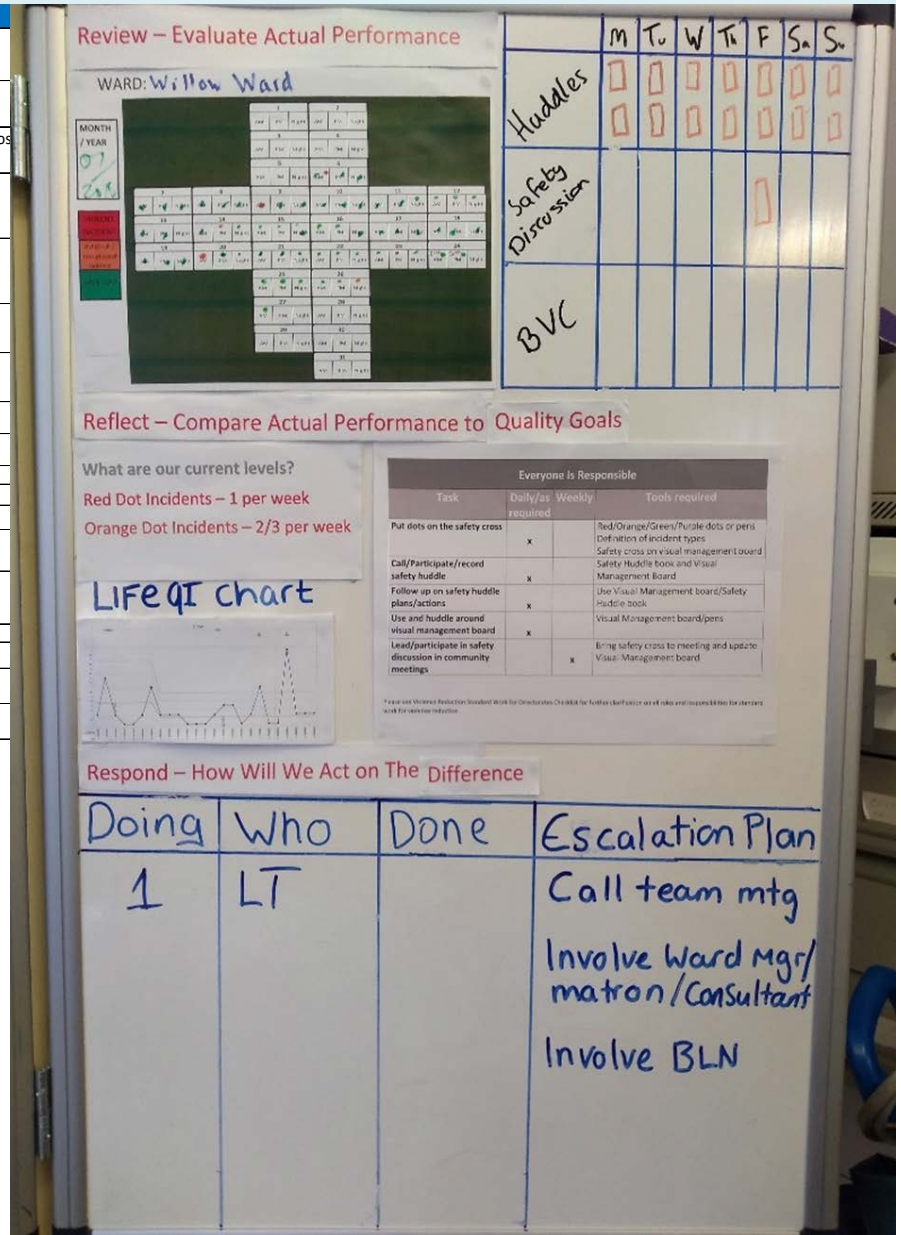


Build local control systems to sustain the gains…

Standard work

Everyone's Responsibilities					
Task	**Daily**	**Weekly**	**Monthly**	**As required**	**Tools required**
Put dots on the safety cross as an incident happen on the ward	x				Red/Orange/Green/Purple dots or pens Definition of incident types (colour dots)
Change the safety cross (frequency depends on type of safety cross used by the ward)	x		x		Printed copies for daily or monthly safety cros
Call/Participate/record safety huddle at least twice a day	x				iddle book
Follow up on safety huddle plans/actions	x				
Active/Lead/Guide/participate in safety discussion in community meetings					Bring safety cross to meeting
Participate in patient led safety huddles					
Have access to LifeQI for violence reduction d		x			LifeQi log ins
Induct new starters				x	Welcome packs
Modern Matrons/Ward Managers					
Allocate who will input LifeQi data		x			
Present and interpret data to MDT/comm ity meetings			x		LifeQi log ins
Allocate time in away days to discuss performance (review), compare to standards (reflect), and any actions required (react) to prevent detorioration			x		Data
Service Users					
Participate in Service User led safety huddle		x			
Induct new service users to the ward				x	Welcome pack

Visual management boards



Ward, unit and Trustwide huddles to review, reflect & react

Thank you!

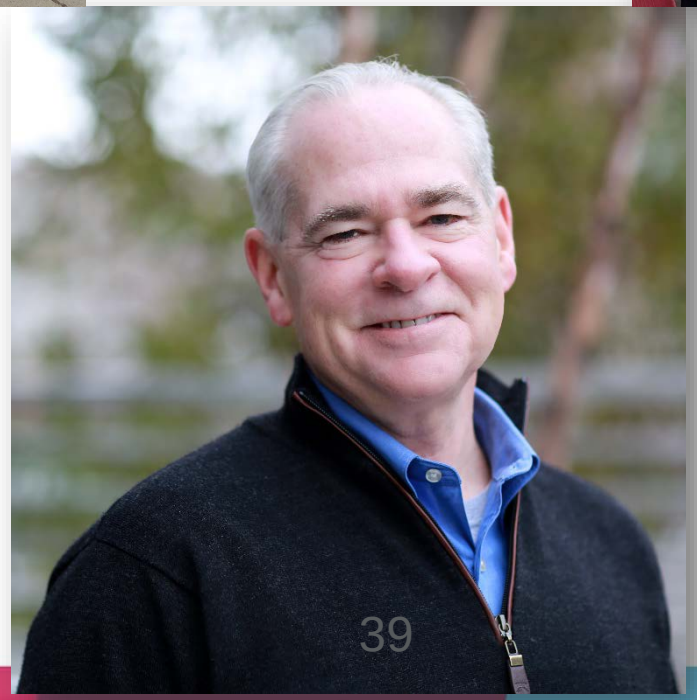
 @DrAmarShah

Cincinnati Children's and the Children's Hospital Learning Network: Sharing Our Experience

Stephen Muething, MD
Chief Quality Officer
Co-Director, James M. Anderson Center for Health Systems Excellence
Professor of Pediatrics

James M. Anderson Center
for Health Systems Excellence

Cincinnati Children's
changing the outcome together



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Cincinnati Children's Snapshot

- Over 15,000 employees and 678 Beds
- More than 20 sites of care, >120 mental health beds
- >1.2 million patient encounters
- Patients from 50 states and nearly 70 countries, employees from >90 countries
- >2600 students; >380 residents; >640 fellows
- >1200 new employees every year
- >100 continuous clinical trials

Vision:

To be the leader in improving child health

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT HONOR ROLL 2018-19

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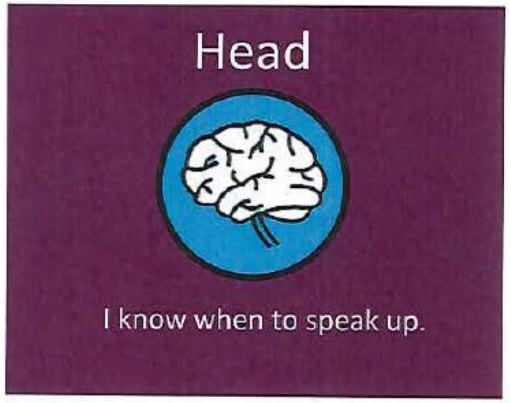
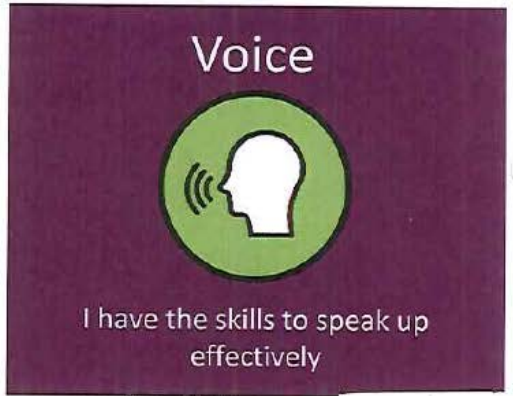
Safer Together: *Safety Culture Awareness*

Training curriculum focuses on the importance of speaking up and listening up.

- **Head** – I know when to speak up
- **Heart** – I feel safe to speak up
- **Hands** – I have the skills to effectively speak up and listen up





SaferTogether

41

Failure Mode Effects Analysis

- Situation awareness – prediction and preparation
- Care model design
- Catalyzing enhanced partnership with the community

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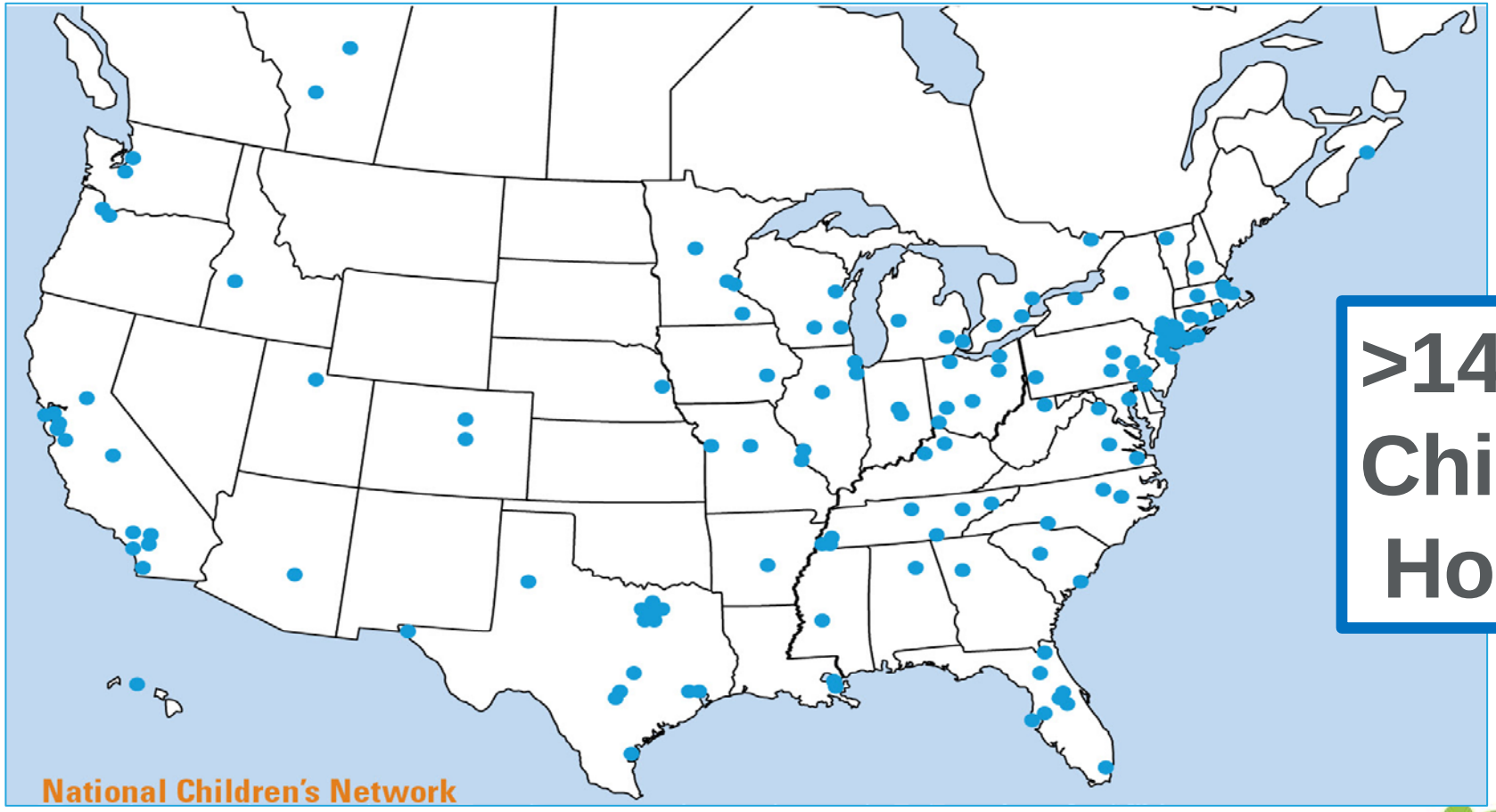
Solutions for Patient Safety



>140 Children's Hospitals

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changing the outcome together

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Solutions for Patient Safety

OUR MISSION:

Working together

to eliminate serious harm across all

children's hospitals

All Teach, All Learn

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Senior Leadership Best Practices

- Making patient and workforce safety foundational
- Safety as an investment rather than a cost
- Transparent learning system

Thank you



Through the CNO Lens

Mary Beth Kingston, PhD, RN, FAAN

Few Stats

- One in four nurses report being assaulted
- Up to 80% of workplace violence incidents affecting nurses go unreported
- 13% of missed workdays can be attributed to workplace violence

(ANA End Nurse Abuse, 2018)

BUHD Behaviors

Bullying

Unreasonable behaviour that creates risk to the physical or mental health or safety of an individual

Discrimination

Unjust or prejudicial treatment of an individual with a particular attribute or personal characteristic which can be legally protected

Harassment

Unwanted conduct related to a relevant protected characteristic, which has the purpose or effect of violating an individual's dignity or creating an intimidating, hostile, degrading, humiliating or offensive environment for that individual

Undermining

Behaviour that has undermined professional confidence and/or self-esteem

Impact is Well Documented

- Dependent on type of injury - may be minor, long-term, death
- Lost individual productivity
- Decreased wages
- Career impact
- Stress and psychological effects further impacting health – fear and anxiety in workplace
- Increased organizational costs: turnover/worker’s comp

Systems Approach – Linked with Patient Safety

Requires organization commitment and infrastructure

- Only 50% of hospital and health system board respondents had knowledge of risks to workforce safety and awareness of dashboards that measure harm to team members

- Press Ganey Survey of CEOs and senior leaders, none listed workforce safety in their proposed metrics to support safe, high quality care.

1 - NPSF Survey

2- Press Ganey Survey

Implementation Guide - NAP

Every health care organization has a detailed violence prevention program:

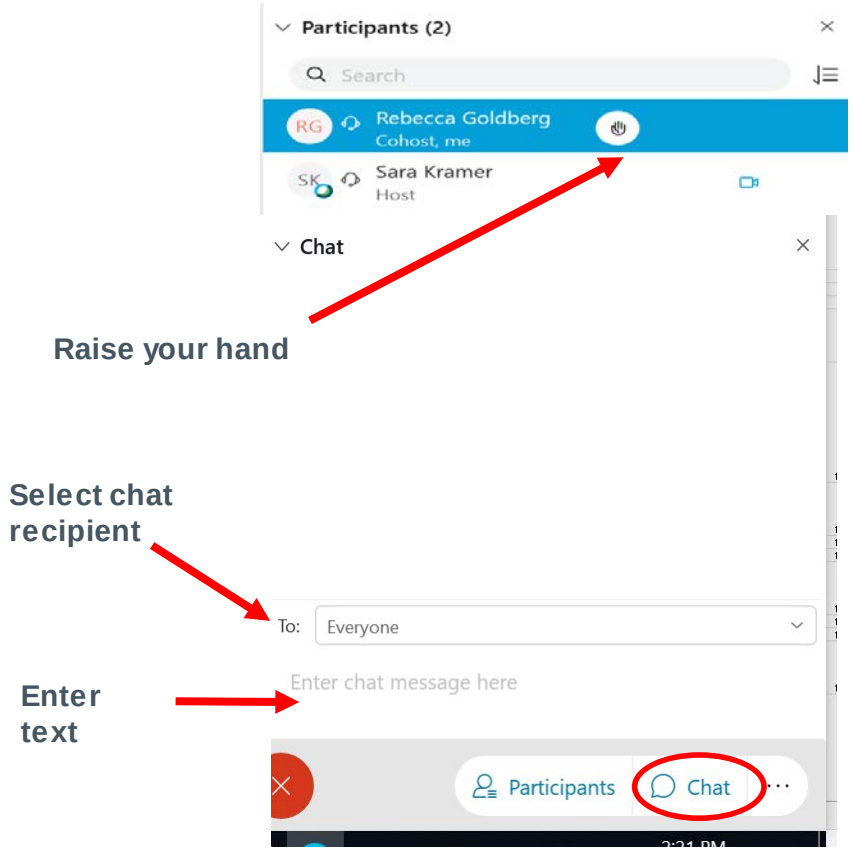
- Assessment
- Risk mitigation/prevention (including training and proactive planning)
- Defining behaviors and reporting
- Monitoring, trending, action
- Support

Advocate Aurora Health Journey

- Organizing structure
- Link with patient safety
- Lessons learned
- Progress to date

Questions?

Please use chat to **“Everyone”** for discussion questions



Institute for Healthcare Improvement

IHI Patient Safety Congress May 11–13, 2021

ihi.org/Congress

#IHICongress

Thank you!