Health Care Workers and the Disruptive Patient

Michael L. Drexler, Ph.D., CPRP
Coordinator, Workplace Violence Prevention Program, Director of Telemental Health Section of Mental Health Service
San Francisco VA Health Care System
Associate Clinical Professor, UCSF
(415) 221-4810 x26980
Michael.Drexler@va.gov
Disclosures: None

March 2018

Disclosures: I have nothing to disclose

March 2018

Acknowledgement: Workplace Violence Program, Research, &QI Studies

Natalie Purcell, Ph.D., MPA
Erik Shovein, J.D.
Claire Hebenstreit, Ph.D.
Sierra Shumate, M.A.

Workplace Violence: Definitions

I. Defining Workplace Violence:
   A. OSHA definition of workplace violence: Workplace violence is any act or threat of physical violence, harassment, intimidation, or other threatening disruptive behavior that occurs at the work site. It ranges from threats and verbal abuse to physical assaults and even homicide. It can affect and involve employees, clients, customers, and visitors.
   B. VHA definition of workplace violence: Workplace violence is an act of aggression, physical assault, or threatening behavior that occurs in a work setting and causes physical or emotional harm to customers, coworkers, or managers. Broad definitions of workplace violence also often include acts of sabotage on work-site property.
   I. Disruptive behavior is more broadly defined: Any behavior that disrupts the ordinary course of business.
Workplace Violence: Definitions—the significance of the problem

Healthcare workers are among the most likely to confront violence in the workplace, creating a need for effective behavioral threat assessment and management strategies tailored to hospitals and other healthcare workplaces.

Workplace Violence: Definitions—includes such things as:

- Beating
- Stabbing
- Suicides
- Near suicides
- Shootings
- Rapes
- Psychological traumas
- Threats or obscene phone calls
- Intimidation
- Bullying
- Harassment of any nature
- Being followed, sworn at, shouted at
- Being repeatedly asked the same question when no new information is available (in person, by phone, other communication medium)

Workplace Violence Prevention Program

Workplace violence is one of the most complex and dangerous occupational hazards facing personnel working in today’s health care environment, with nurses particularly at risk. The complexities arise, in part, from a health care culture resistant to the notion that health care providers are at risk for patient-related violence combined with complacency that violence (if it exists) “is part of the job.” The dangers arise from the exposure to violent individuals combined with the absence of strong violence prevention programs and protective regulations. These factors together with organizational realities such as staff shortages and increased patient acuity create substantial barriers to eliminating violence in today’s health care workplace.

1. Workplace violence is one of the most complex and dangerous occupational hazards facing personnel working in today’s health care environment, with nurses particularly at risk.
   A. The complexities arise, in part, from a health care culture resistant to the notion that health care providers are at risk for patient-related violence combined with complacency that violence (if it exists) “is part of the job.”
   B. The dangers arise from the exposure to violent individuals combined with the absence of strong violence prevention programs and protective regulations.
   C. These factors together with organizational realities such as staff shortages and increased patient acuity create substantial barriers to eliminating violence in today’s health care workplace.
   D. Emotionally distraught patients in mental health facilities and the emergency department, elderly patients with Major Neurocognitive Disorder (dementia) in medical and geriatric wards, nursing homes and rehabilitation centers, and any patient with a history of assault in mental health, hospital care, and community health are common sources of verbal and physical violence against nurses and other health care providers.

“I realize nurse Anne is hard to work with, but hiding from her isn’t the answer.”
Workplace Violence: Categories

III. Although no nosology is broad enough, an increasingly popular conceptual scheme is posited by the California Division of Occupational Safety and Health (Cal/OSHA). The key to this typology is the relationship of the perpetrator to the workplace.

A. Type I workplace violence—perpetrator has no legitimate connection to the workplace. For example, during the commission of a robbery at a small late-night retail establishment such as a liquor store, gas station, or convenience store, an employee or proprietor is killed or injured.

B. Type II workplace violence—event involves fatal or nonfatal injuries to individuals who provide services to the public. These events involve assaults on public safety personnel, bus or taxi drivers, teachers and social workers, sales personnel and medical, psychiatric, and nursing care workers.

C. Type III workplace violence—event consists of an assault by an individual who has some employment-related involvement with the workplace. These events generally involve threats or assaults by a current or former employee, coworker, supervisor, former spouse or lover, or some other person who has a dispute involving an employee of the workplace.

D. Type IV workplace violence: the violence in the workplace is by someone who doesn’t work there, but has a personal relationship with an employee. This refers to domestic violence situations and is usually perpetrated by an acquaintance or family member while the employee is at work.
Workplace Violence: Contributors and Issues

IV. Emotional reactions including real or perceived injustice, losses, rejection, wounded pride may be reacted to with aggression, and a small number will react with violence

A. Workplace targeted or intended violence: Conscious decision to kill of physically harm identified or symbolic targets in a workplace or work context.

B. Intended violence is consistent with predatory violence—planned, emotionless in the moment, and offensive in contrast to affective violence which is reactive, emotional, and defensive.

C. More frequent than homicide but commonly underreported are acts of non-fatal violence including rape, sexual assault, robbery, and aggravated and simple assault.

D. In 2009, there were at least 572,000 nonfatal violent crimes directed at individuals while at work or on duty.

E. Workplace assaults are usually affective acts of violence but can be predatory, as in some cases of rape or sexual assault.

F. Homicidal targeted workplace violence:

1. Begins with a deeply felt personal grievance, often the loss of a job or a significant career setback, at times with parallel personal losses, especially financial stress.

2. Accumulation of difficulties and frustrations and resultant real or felt insults may contribute to the momentum towards violence.

3. Amid a life often spiraling downward, the perpetrator escalates within a varying time frame along a “pathway to violence” to achieve his or her definition of justice.

4. Usually the perpetrator sees him or herself as a victim and believe that nonviolent alternatives to resolve differences are unattainable, unsatisfactory, frustrating, or untrustworthy.

L. The perpetrator often possesses a rigid “black and white” cognitive style, often a striking sense of entitlement, and limited capacity for positive self-directed change.

2. Interpersonal histories are often replete with conflict and many ups and downs.

3. Chronic anger, overtly expressed or not, is common.

H. The violence may be clinically understood as rooted in extreme sensitivity to narcissistic injury—a felt insult to one’s sense of self or identity, beyond the bounds of angry feelings experienced by more resilient employees following a job or career setback.

J. Scenario may be highly personal—for example, rejection by an intimate partner resulting in violence as his or her workplace by the aggrieved lover or husband.

K. By destroying hated or envied others, the perpetrator denies them what has been lost—life and its possibilities—the perpetrator forces the rejecters to respect.

L. Rage fuels the decision but is unlikely to be felt immediately preceding or during the attack.

M. The attack is seen by the perpetrator as an acceptable and final solution to their assessment of the current circumstances, and a reflection of a life felt unrealized.

O. Assessment includes not only individual risk factors, but also situational and organizational risk factors.

P. Those around an individual who is considering violence may be highly influential by ignoring, permitting, provoking, a subject’s violence—“incivility spiral.”

Workplace Violence: Contributors in the Individual

G. The primary causal factors for some, and a contribution to risk for others are troubling mental states—delusions, paranoia, extreme moods especially depression—may lead the individual to fixate on specific others in the workplace.

H. The violence may be clinically understood as rooted in extreme sensitivity to narcissistic injury—a felt insult to one’s sense of self or identity, beyond the bounds of angry feelings experienced by more resilient employees following a job or career setback.

I. So unbearable is such a state of mind that the violent perpetrator is often willing to sacrifices his or her own physical life, with a concluding act of suicide or by provoking a fatal response by law enforcement, in order to restore some sense of pride and self-importance.

J. Scenario may be highly personal—for example, rejection by an intimate partner resulting in violence as his or her workplace by the aggrieved lover or husband.
Workplace Violence: Contributors in the Individual

Q. Case studies provide widely accepted warning signs as well as intuitive understanding of risk factors and their interaction. However, research is challenged by:

1. Low base-rate of the behavior.
2. Shortage of perpetrators to study due to death or unwillingness.
3. Varying quality of information available from incidents:
   a. Sensationalized or premature media coverage.
   b. Court documents with biased adversarial views of the perpetrator from opposing counsel.
   c. Reluctance of organizations to allow access to data about the incident and organizational details.

Workplace Violence: Contributors in the Individual

R. Some characteristics of those at risk for becoming violent or disruptive:

1. Highly impatient, hypersensitive and hyper-reactive to even the smallest issues.
2. Unreasonably judgmental; has rigid and righteous standards by which everyone else will fall short.
3. Highly suspicious (bordering on paranoid); often has an “it’s me against the big, bad world” attitude.
4. Preoccupied by a need to control everything around himself or herself.
5. Creates unrealistic goals and timeframes.
6. Believes he or she is entitled to break the rules and, therefore, should be immune from consequences.
7. Engages in intimidation of others through extremely aggressive behavior or by constantly ridiculing or demeaning others.
8. Has sharp and dramatic mood swings.
9. Constantly allows himself or herself to be bullied and picked on by others.
10. Has history of violence, substance abuse or problems dealing with authority.
11. Is preoccupied with or owns a large number of weapons.
12. May have been subject to a recent traumatic event, such as an adverse employment action or domestic violence, or to recent or frequent disputes with supervisor or co-workers.

SFVAHCS WVPP

V. SFVAHCS WVPP: WVPP Committee—develops and implements policy for workplace violence prevention in the HCS. To support a culture of safety, SFVAHCS has adopted a simultaneous, multi-pronged approach.

A. Employee Education and Training: Prevention and Management of Disruptive Behavior (PMDB)—personnel safety skills training.

1. PMDB Program objectives include:
   a. Ensuring that the PMDB employee training program reflects the best and most up-to-date practices in the field and addresses the risks to VHA employees working in the constantly evolving setting for healthcare delivery.
   b. To enhance the PMDB training methodology, including the use of Web-based learning to standardize the employees’ knowledge base, and ensure that all VA staff have needed information.

SFVAHCS WVPP

B. Event Reporting and Data Management: Disruptive Behavior Reporting System (DBRS)

1. VHA has developed and installed in every facility, a secure, web-based DBRS that allows all employees to have a voice regarding any concerns they may have about safety.
2. The DBRS provides information back to employees that their reports have been received and that action is being taken to address their concerns.

C. Disruptive Behavior Committee: In accordance with current community best practice standards, VHA has implemented multi-and interdisciplinary teams in every facility to make individual assessments and develop customized safety plans.

1. VHA emphasizes the ethical use of evidence-based, data-driven threat assessment and management practices—static and dynamic risk factors.
2. Individualized Assessment and Management Plan—may include parameters on the time, manner, and/or place of care as clinically appropriate.
   a. Letters: Concern, Warning, Restriction (OBR)
SFVAHCS WVPP

D. Safety Plan Communication
1. VA has developed and implemented an electronic alert and notification system to communicate safety plan information at the initial moments of a patient encounter.
2. In so doing, VA’s program model communicates directly with employees, thus completing the interactive and ongoing process of promoting workplace safety.

D. Employee Threat Assessment Team (ETAT): In accordance with community best practice standards, an interdisciplinary team provides evidence-based employee threat and risk assessments.
1. Recommendations and guidance to management
2. Discussion with supervisors

Workplace Violence Prevention Program

IV. Prevention and Management of Disruptive Behavior (PMDB)—personal safety skills—an EBP—all techniques tested in ergonomics lab

A. Level is based on Workplace Behavioral Risk Assessment (DBRS-WBRA)
Level I – all employees
Level II – de-escalation (role play)
Level III - evasion (role play)
Level IV – therapeutic containment (role play)
Workplace Violence Prevention Program—lessons learned

1. Threat assessment teams function best when they are embedded in a comprehensive violence prevention program.
2. The gold standard in threat assessment combines standardized assessment and inter-disciplinary professional discussion; abandon either at your peril.
3. Threat assessment teams are strongest when they include diverse voices, and when every member feels empowered to ask questions and to share their perspective.
4. A threat is in the eye (and the body) of the beholder. It is no less real, and no less significant, for that fact.
5. Threat assessment is (mostly) evidence-based, but threat response is (mostly) values-driven; choose those values consciously and wisely.

Selected References

- VA-Directive 2018-013
Appendix; Workplace Violence Prevention Program—Static and Dynamic Risk Factors Worksheet—Short Form

- Veteran’s history of violence in and outside of health care facilities.
- Veteran’s self-report of arrests and convictions for violent crimes.
- Documented credible threats toward VA employees or patients.
- Prior supervision/treatment plan failures (e.g., probation, mandated Drug & Alcohol treatment).
- Presence of serious psychiatric disorder.
- Head injury with loss of consciousness by history.
- Recent incidents of disruptions, threats, or violence in or out of health care settings.
- Recent abuse of illicit substance(s) or alcohol.
- Presence of situational stressors and destabilizing events, incarceration, death of loved ones, financial problems, estrangement from family, homelessness.
- Chronic pain or narcotics seeking behavior.
- Documented impulsivity (e.g., financial, sexual, or other decision making).
- Veteran’s claims of access to weapons.
- History of bringing weapons to health care facility.

Question 1
1. Workplace violence includes all of the following except?
   A. Bullying
   B. Shouting at someone
   C. Complaining to the complaints department about care concerns
   D. Blocking someone from exiting an area

Question 2
2. Which of the following is an example of predatory violence?
   A. Screaming at a pharmacist when a prescription is not ready for pickup
   B. Waiting in an area known to be where a provider parks to direct an angry tirade toward him or her.
   C. Slapping at the hand of a phlebotomist when in sudden pain at the site of entry
   D. Throwing magazines on the floor in a waiting room upon hearing that a provider may be late for an appointment

Question 3
2. Which of the following is not characteristic of someone at risk for violent behavior?
   A. Unreasonably judgmental; has rigid and righteous standards by which everyone else will fall short
   B. Highly suspicious (bordering on paranoid); often has an “it’s me against the big, bad world” attitude
   C. Preoccupied by a need to relinquish control of everything around him or herself
   D. Creates unrealistic goals and timeframes