

Fourth International Conference on
**Violence in the
Health Sector**
Towards safety, security and wellbeing for all



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KAVANAH

Violence in the Health Sector



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Violence in the Health Sector

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Preface

Everyone fortunate enough to have experienced the comfort given by caring persons in times of distress will no doubt appreciate feeling safe, secure, and well. The concepts of safety and security are – according to the hierarchy of needs of Abram Maslow (1908-1970) – necessary in order to fulfill higher level needs such as self actualization. Independent of Maslow one may here suspect that safety and security also pave the way for wellbeing.

Health sector institutions are created to tend to patients' needs and challenges in a caring way. When entering the health care system patients trust they will be in safe hands and expect safety, security and optimum wellbeing. Professional and ethical codes endorse and encourage care givers in striving to fulfill such expectations. For example the Code of Ethics of the International Council of Nurses (2012) states: "Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. [...] Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect [...] irrespective of a patients' age, color, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status". These principles are valid for all health disciplines and institutions. One of the very last things patients and care givers alike expect is a health care environment and workplace in which hostility, aggression and violence prevail.

However, we do not live in a perfect world. Daily news reports constantly remind us of hostility, violence, combat, subjection, denigration, bullying, and many other forms of human conflict at various levels of encounter ranging from minor squabbles up to fully fledged wars between alliances of countries. Aggressive behaviour is a universal phenomenon or an "anthropological constant" and is regarded by Konrad Lorenz (1963) to be an intrinsic characteristic of the *conditio humana*. Thus the channelling or the management of aggression presents a great challenge to all societies. The World Health Organization (2002) reports that 1.6 million people worldwide lose their lives annually to violence, 14% of the deaths among people aged 14 to 44 years of age (Krug 2002). When including the countless numbers of victims debilitated by psychological violence, dealing with the inherent social issues is a daunting affair. On assuming that the general societal situation is reflected in the health sector it is not surprising that abuse, aggression and physical violence are present and a critical issue for care institutions.

Patients entering health care facilities may demonstrate aggressive or violent behaviour as a function of their illness or as a response to the immediate physical or social environment. Health care personnel may be subjected to violence from colleagues, management and in some cases from patients and their families. Organizational and environmental factors have an impact on both patients and health care staff which may nurture abuse and violence. It goes without saying that health care systems are not perfect and may by way of their structures and procedures contribute to the genesis of violent behaviour manifested by patients, their families and/or health care personnel.

These topics and many more are the issues addressed by the presenters at the conferences on "Violence in the Health Sector". The past three conferences – "Together, creating a safe work environment" (Amsterdam 2008), "From awareness to sustainable action" (Amsterdam 2010)

and “Linking local initiatives with global learning” (Vancouver 2012), as well as the current conference “Towards safety, security and wellbeing for all” (Miami 2014) are designed to generate, present, discuss and disseminate options for dealing with the complex phenomenon of violence in its many facets. The conferences on “Violence in the Health Sector” do not offer a “magical” solution to problems pertaining to violence in health care settings. They cannot eradicate violence as an anthropological constant or render the uncontrollable controllable.

Thanks to the dedicated work of our conference presenters and participants the initiatives shared and exchanged do help raise awareness and lead to sustainable action in order to create a health care environment and workplace characterized by safety, security and wellbeing for all.

Selection of conference contributions

All submitted abstracts undergo a rigorous selection process with every abstract being anonymously adjudicated by at least three members of our international scientific committee. The abstracts are evaluated according to the following criteria:

- relevance to the conference themes and subthemes,
- interest to an international audience,
- scientific and/or professional merit,
- contribution to knowledge, practice, and policies, and
- clarity of the abstract.

Following the evaluation the Organization Committee assesses the merit of each individual abstract and deliberates on the acceptance, the rejection or on provisional acceptance pending amelioration of the work. For the present conference 81% of the 281 abstracts were accepted. Unfortunately numerous authors with accepted submissions were unable to attend and have had to withdraw their contributions.

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Chapter 1 - Keynote speeches and invited workshop

The Sanctuary Model: On organizational approach to Trauma-Informed Care

Keynote speech and special workshop

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The Sanctuary Model

The challenges that children in intensive therapeutic treatment are up against are complex and often originated in exposure to multiple forms of adversity. In brief, they have 1) difficulty with maintaining safety in interpersonal relationships largely due to disrupted attachment experiences and the erosion of trust that accompanies such experiences; 2) significant challenges in adequately managing distressing emotions in ways that are not self-destructive including exercising the capacities for self-discipline, self-control, and willpower; 3) cognitive problems, particularly when stress occurs and the development of essential cortical functions has not gone smoothly; 4) problems with open and direct communication at home and at work that pose significant challenges and they frequently communicate through behavior, not directly, openly, or in words; 5) feelings of helplessness and powerlessness in the face of a world they perceive as unjust and cruel and as a result may be repeatedly bullied or become bullies themselves; 6) no clear sense of social responsibility even into adulthood and their moral development may have been affected by disrupted attachment experiences and inadequate role models; 7) likely experienced significant loss while lacking the capacity to grieve secondary to the emotional management problems, and 8) a tendency to repeat the experiences that are a part of their past, and 9) often lack any hope that the future will be any better than the past, while their emotional and cognitive challenges interfere with the capacity to plan ahead and tolerate delayed gratification.

All of this means that in the context of the treatment/intervention setting, much is demanded of managers, therapists, caregivers and educators. We must teach, role model and support the development of: 1) safety skills and significant improvements in the capacity for interpersonal trust; 2) emotional management skills, including self-control, self-discipline, and the exercise of willpower; 3) cognitive skills including identifying triggers and problematic patterns while still being able to think in the presence of strong emotion; 4) communication skills that include rehearsals in what to say and how to say it; 5) participatory and leadership skills; 6) judgment skills, including socially acceptable and fair behavioral schemas; 7) skills to manage grief and plan for the future. This work is complicated, complex, and interactive, demanding much of those who work to change the developmental trajectories of children and adolescents suffering from complex posttraumatic problems.

What characteristics best describe people who are able to do this challenging work? They need to be secure, reasonably healthy adults, who have good emotional management skills themselves. They must be intellectually and emotionally intelligent and the latter is probably even more important than the former. They need to be able to actively teach new skills and routines while serving as role models for what they are teaching. There are constant demands on them for patience and for empathy so they must be able to endure intense emotional challenge. As they balance the demands of home and work, managers and supervisors, child/clients and their own families, they must be self-disciplined, self-controlled, and never abuse their own personal power.

Given this description, it becomes easier to understand why, as a society and in particular in its mental health and social service systems, we are facing a workforce crisis. As a national report has stated, "a growing proportion of the U.S. workforce will have been raised in disadvantaged environments that are associated with relatively high proportions of individuals with diminished cognitive and social skills" (p.10155) (Knudsen, Heckman, Cameron, & Shonkoff, 2006). Given the rates of exposure to childhood adversity in the general population, staff members at all levels of social service and other mental health organizations are likely to have their own past histories of experiences that are not entirely dissimilar to the people they are supposed to help and they may have unresolved interpersonal challenges that are also not dissimilar (Felitti & Anda, 2010). In a recent survey of a residential treatment setting for children, almost three-quarters of staff respondents to the Adverse Childhood Experiences questionnaire had an ACE score of at least 1 and 16% had an ACE score of 4 or more (Esaki & Larkin, 2011), making this issue a significant part of the workforce crisis.

Additional factors play an important role in this crisis. Extraordinary demands are placed upon social service workers who are paid low salaries and whose organizations receive inadequate funding. The job complexity and ambiguity is high while the payoff is low, particularly for those in any type of institutional setting where the least-educated, trained, and supervised staff spend the most time with profoundly injured children. And these workers are not in environments that are safe. Forty-eight percent of all nonfatal injuries from occupational assaults and violent acts occur in health care and social services (Occupational Safety and Health Administration, 2004). In fact, after law enforcement, persons employed in the mental health sector have the highest rates of all occupations of being victimized while at work or on duty (Bureau of Justice, 2001). Actual rates of violence expose the problems with physical safety. But there are other safety issues as well that can be thought of as threats to psychological, social and moral safety.

Thus, although working with traumatized children can be stressful, the main causes of workplace stress cannot be laid at the feet of the children and their families: "The main sources of stress for workers are the ways in which organizations operate and the nature of the relationships that people experience within the work setting." (p.70)" (Bloom & Farragher, 2010). This is not an individual problem but a social one, partly due to controllable but severe dysfunctions within those organizations and largely related to inadequate and unscientific paradigms for intervening in the lives of traumatized people, families, and communities.

Managing Organizational Culture

The Sanctuary Model is designed to address these dilemmas by intervening at the level of organizational culture in order to change the habits and routines of everyone in the organization and the organization-as-a whole. The Sanctuary Model is an evidence-supported, theory-based, developmentally-grounded and trauma-informed methodology for helping all members of staff and whole organizations to become healthier while achieving better outcomes for the populations they serve. Although the roots of the Sanctuary Model go back to Moral Treatment and Quaker philosophy of the 18th and 19th centuries as well as the democratic therapeutic community movement and the human rights movements of the 20th century, the Sanctuary Model was originally developed from 1980-2001 in a short-term, acute inpatient psychiatric setting for adults who were traumatized as children (Bloom, 2013). The Sanctuary Model is currently being used as a systematic organizational change process for over two hundred human service delivery systems around the country and internationally, many of them serving children and adolescents.

A computer metaphor is most useful in conveying the significance of this model. An operating system in a computer is the master program that controls the computer's basic functions and allows other programs to run on the computer if they are compatible with the operating system. As our understanding of trauma survivors has grown, we recognize that exposure to severe and overwhelming trauma, particularly when it begins in childhood, disrupts the individual's normal development of brain and mind - their "operating system" - resulting in profound "software" problems as described above, and a personality that has become "trauma-organized" (Bloom & Farragher, 2010).

Similarly, organizational culture represents the operating system for an organization. Every organization has an organizational culture that represents long held organizational patterns, routines, and habits that--although remembered and taught to every new employee-- are largely unconscious and automatic, as most habits are. The nature of the organizational culture largely determines whether or not the organization is able to fulfill its mission and reach its stated goals. Organizational culture may or may not be aligned with the actual values and mission that the organization claims to follow (Schein, 1999). Alignment of values is usually seen as management-driven, if it is referred to at all, and mental health and social service organizations are at a distinct disadvantage in this regard.

Within social services and mental health organizations, there is no universal requirement for anything that resembles management training. CEO's and CFO's may have had training in their background if the organization is large and especially if they came up through the ranks of some other business sector. They are also more likely to have MBA's or some administrative degree that at least academically qualifies them for the job of managing other people. But the key middle managers who actually set in motion the routines that guide daily interactions with staff, children, and families usually are promoted from within the organization or at least from within the social service, education, and social service professions. The training these professionals typically receive is whatever they experienced being managed by other people in similar circumstances beginning, of course, with their own parents.

Contrast this with an organization like Starbucks where even a newly hired high school drop-out working as a barista in the first year will spend at least fifty hours in Starbucks' classrooms, and dozens more at home with Starbucks' workbooks and talking to the assigned Starbucks mentor. Or the Container Store where employees receive more than 185 hours of training in their first year alone. They are taught to recognize what to do when confronted with an angry coworker or an overwhelmed customer, and rehearse routines for calming shoppers or defusing a confrontation (Duhigg, 2012).

Not so for staff in our caregiving institutions who must engage in the emotional labor of spending eight to twelve hours a day trying to help some of the most wounded, suffering and sometimes dangerous children and adults

on the planet to heal and recover from the adversity that life has dealt them. This startling contrast sums up what is a social, political, and economic problem, not a professional one. Starbucks is selling coffee; the company is enormously profitable and its management realizes that continuing profitability has as much to do with the good service of their employees as it does to the quality of their brew. We, on the other hand, are trying to develop and change minds and rewire brains and our society has not yet awakened to the fact that not changing those brains is costing our society uncounted billions of dollars every year. The Centers for Disease Control estimates that child abuse and neglect alone cost us \$124 billion a year (Fang, Brown, Florence, & Mercy, 2012).

Compound the lack of adequate education, preparation and training with breaches in basic safety; diminished funding; an unstable reimbursement system; social devaluation of caregiving work; and an inadequate theoretical framework for delivering services and we end up with hauntingly parallel processes where symptomatic behavior is replicated at every level – clients, staff, management, organization (Alderfer & Smith, 1982). The fundamental rationale for the Sanctuary Model is to create parallel processes of recovery by radically altering the operating system for organizations as a whole and everyone who has contact with that organization. That means intervening at the level of organizational culture in order to change the habits and routines of everyone in the organization as well as the organization-as-a-whole.

Key features of the Sanctuary Model

The Sanctuary Model is structured around a philosophy of belief and practice that shifts organizations' existing ways of operating in approaching treatment of traumatized children and families. To make such a shift, the organizations must identify the habits and routines that are not compatible with developmentally-grounded, trauma-informed care, and develop new and more useful habits and strategies. Organizational change of this sort requires radical alterations in the basic mental models upon which interventions have traditionally been based; without such change, treatment is bound to fall short of full recovery or fail entirely. Mental models exist at the level of very basic assumptions, far below conscious awareness and everyday function, yet they guide and determine what individuals can and cannot think about and act upon (Senge et al., 2000). A change in mental models must occur explicitly on the part of the leaders of the organization and the staff in order to change their implicit models, and then taught to the children and their families.

“Creating Sanctuary” refers to the shared experience of creating and maintaining physical, psychological, social and moral safety within a social environment - any social environment but especially one directed towards mental health treatment- and thus reducing systemic violence. The process of “Creating Sanctuary” begins with getting everyone on the same page – surfacing, sharing, arguing about, and finally agreeing on the basic values, beliefs, guiding principles and philosophical principles that are to guide attitudes, decisions, problem-solving, conflict resolution and behavior (Bloom & Farragher, 2013). The Sanctuary Model is built upon Four Pillars that are described below: Trauma Theory, the Sanctuary Commitments, S.E.L.F.; and the Sanctuary Toolkit.

Trauma theory

Although the impact of overwhelmingly horrific experiences – natural or humanmade – has been recognized throughout history, the modern scientific study of trauma originated in the disasters, terror, and wars of the 20th century (Bloom, 2000). Trauma Theory has challenged and undercut many “sacred cows” involving centuries of reductionism best characterized for those of us in mental health by either “mindless” or “brainless” psychiatry (Eisenberg, 1986). It has demonstrated, among other things, the interconnected and interdependent nature of human biology, psychology, sociology, and morality.

As the study of psychological trauma has developed, much has been learned about the entire stress continuum and the extent to which stress, particularly repetitive conditions over the course of childhood, can impact normal development (usually if not always, adversely). Along with the expanding field of interpersonal neuroscience we are learning how limited our freedom really is since so much of behavior once learned becomes automatic and runs outside of conscious awareness. As it turns out, what we call “free will” is not nearly as free as we would like to believe it is (Gazzaniga, 2011). At the same time, much is being learned about how the social milieu can influence the brain, now known to be more malleable and “plastic” than was once assumed and how important belief, faith, meaning and purpose are in changing the brain (Duhigg, 2012).

In the Sanctuary Model, everyone in an organization needs to have a clear understanding about how toxic stress and trauma has affected the children served, and often the staff as well. Furthermore, it is vital that everyone recognize that unacknowledged and unaddressed stress responses can result in problematic and unhealthy behaviors in both clients and staff. This understanding can be liberating and can lead to major changes in attitudes and behavior. One comprehensive training manual and accompanying training materials on the definitions and impact of traumatic stress on human development are provided for all of the clinical staff who have direct contact with children and families (Sanctuary Institute Direct Care Staff Training Manual) and another for all of the indirect care staff (i.e., administrative assistants, finance officers, maintenance and food service staff, and all the other people who are necessary to keep an organization functioning).

The Sanctuary Commitments

The Seven Sanctuary Commitments represent the guiding principles for implementation of the Sanctuary Model, the basic structural elements of its “operating system.” Each of the commitments supports trauma recovery goals for children, families, staff and the organization as a whole. They are designed to create a parallel process that provides support for the organization and its staff at the same time as they provide an environment of recovery. Other than the newer scientific findings regarding stress, trauma and attachment, these commitments represent universal principles typical of all human rights cultures. They become the norms that structure the organizational culture and make it easier for organizational leaders to consciously and deliberately apply the principles to whatever they do.

For the organizational climate to be ethically consistent, the Sanctuary Commitments need to be embraced by the Board of Directors and senior leadership, conveyed throughout the organization, through middle management, to the direct care and support staff and ultimately to the children and families. Often, when organization leaders hear the Seven Commitments, they believe them to already constitute their organizational culture. In many cases this is at least partially true since it is likely that there are many divergent views of these commitments and what they mean and how to actualize them in everyday interactions.

The change process, however, can be frightening for organizational leaders and they rightfully perceive significant risk in opening themselves up to criticism when they attempt to level hierarchies and share power. The gains can be substantial, but a leader only finds that out after learning how to tolerate the anxiety and uncertainty that inevitably accompanies real change. It should also be noted that change does not occur just because a leader wants it to. Leaders may be willing to share power with others, but this does not necessarily mean that those others are always willing to assume power and the responsibility that comes with it. Although staff and clients may indicate they want a greater voice, creating the conditions in which they have one is not always welcomed. It is easy to stay in or slide back to a familiar and comfortable non-participatory arrangement.

The challenge in the Sanctuary Model is to establish and maintain a value-based system, even in the face of what are extraordinary ethical dilemmas, the kinds of dilemmas that human service delivery professionals encounter every day (Bloom & Farragher, 2010). There are all sorts of tensions that exist within any meaningful value system. The Sanctuary Commitments are trauma-informed objectives that apply to children, their families, staff, and the organization as a whole. They are not cure-alls: there are inevitable conflicts, unintended consequences, and unforeseeable circumstances which will need to be resolved each day in each program, requiring judgment and flexibility. Organizational processes are needed that provide enough structure to be able to respond flexibly in ways that support the emergence of innovative solutions to complex problems. The seven Sanctuary Commitments are described in fuller detail in Bloom and Farragher (2013).

S.E.L.F.: A compass for the recovery process

S.E.L.F. is an acronym that represents the four interactive key aspects of recovery from bad experiences. S.E.L.F. provides a nonlinear, cognitive behavioral therapeutic approach for creating new, developmentally-grounded, trauma-informed routines for facilitating change, regardless of whether these involve individual children, families, staff problems, or the organization as a whole.

S.E.L.F. is a compass that allows the exploration of four key domains of healing: Safety: attaining physical, psychological, social and moral safety in self, relationships, and environment; Emotional management: identifying various emotions and their levels of intensity and modulating emotion in response to memories, persons, events; Loss: feeling grief and dealing with personal losses while recognizing that all change involves loss; Future: trying out new roles, ways of relating and behaving as a “survivor/thriver” to ensure personal, professional, and organizational safety, to find meaning, to make more viable life choices and to help others. A focus on the future compels imaginative planning, and to think ahead in ways that may have previously been precluded by ongoing posttraumatic symptoms.

While using S.E.L.F., the children, their families, and staff are able to embrace a shared, non-technical language that is neither blaming nor judgmental. It allows all to put the larger recovery process in perspective, recognizing that safety issues may crop up repeatedly as the child wrestles with painful feelings and memories. Accessible language demystifies what sometimes is experienced as confusing and even insulting clinical or psychological jargon that can confound children, families and staff.

In the Sanctuary Model, S.E.L.F. is used as a habit-changing tool for many different organizational and treatment tasks. When faced with the complex problems that are typical of the children and families served, it is easy for a helper to lose his or her way, to focus on what is the most frightening or the easiest to understand and manage, rather than what may be the true underlying stumbling block. Similarly, clients are most likely to pay attention to whatever problems are causing the most pain in the present, even though from a helper’s point of view, what they are doing or not doing will likely cause them greater suffering in the long term.

As a result, it is easy for staff and children to get stuck on safety issues. When someone is doing something that is obviously dangerous, it is hard not to focus entirely on that danger. But an exclusive focus on physical

safety may lead nowhere if underlying issues are not identified and addressed. S.E.L.F. helps functions as a kind of compass to get out of the maze of confusing symptoms. By using these four apparently simple concepts that actually are like the cardinal points of a compass, helpers and children can rapidly organize problems into categories of “safety”, “emotions”, “loss” and “future” which then can lead to a more complex treatment or service plan. It has the added value of conveying it is possible to change what has previously seemed insurmountable by “chunking out” the chaos of people’s lives into more manageable bits without losing sight of the complexity of the challenges.

But S.E.L.F. is not only applied to the children and their families. In parallel, these compass points represent problems that arise within the treatment or service setting between staff and children, among members of staff, and between line and support staff and administrators. Applied to such issues as change management, staff splitting, poor morale, rule infraction, administrative withdrawal and helplessness, misguided leadership, and collective disturbance, S.E.L.F. can also assist a stressed organization to conceptualize its own present dilemma and move into a better future through a course of complex decision-making and conflict resolution. To do so, an organization must envision the Future it wants to get to, wrestle with the inevitable barriers to change that are related to Loss, develop skills to manage the individual and interpersonal Emotions and multiple conflicts surrounding change, while calculating what the present and potential Safety issues are in making change, but also in not making change.

The Sanctuary toolkit

The Sanctuary Toolkit includes a range of practical, routine skills that enable individuals and organizations to develop new habits and more effectively deal with difficult situations, build community, develop a deeper understanding of the effects of adversity and trauma, and build a common language and knowledge base. Community Meetings and universal Safety Plans promote a focus on social responsibility, democracy and nonviolence on a routine, daily basis. The Sanctuary Toolkit “rewires” the organization and in doing so opens up new pathways for communal problem-solving.

Many of our tools are organized around S.E.L.F. so that we teach S.E.L.F.-based Treatment Planning, Psychoeducation, Team Meetings, Organizational Assessment, and use S.E.L.F. to structure Red Flag Reviews, emergency team meetings called to deal with an urgent concern. The model helps staff, children, and parents to maintain focus while providing a shared language and meaning system for everyone, regardless of their training, experience, or education. It also helps staff members to see the parallels between what the children and their families have experienced and what is going on with the staff and the organization and to intervene when that the unfolding of a collective disturbance is noticed. This helps everyone to see the interactive and interdependent nature of their shared lives.

Implementing the Sanctuary Model

The Sanctuary Institute

The Sanctuary Institute is a five-day intensive training experience on the Sanctuary Model. Teams of five to eight people, from various levels of the organization, come together to learn from our faculty, who are colleagues from other organizations implementing Sanctuary. Together teams begin to create a shared vision of the kind of organization they want to create. These teams will eventually become the Sanctuary Steering Committee for their organization. The training experience usually involves staff from several organizations and generally these organizations are very different in terms of size, scope, region and mission. This diversity helps to provide a rich learning experience for the participants.

During the training, the Steering Committee engages in prolonged facilitated dialogue that serves to surface the major strengths, vulnerabilities, and conflicts within the organization. By looking at shared assumptions, goals, and existing practice, staff members from various levels of the organization are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions that have never been overtly asked previously. Many of these questions have not been raised because participants have never felt safe enough to speak their minds or their hearts, even after many years of working together. Although the continual focus is on the fundamental question of “Are we safe?”, participants quickly learn that in the Sanctuary Model, being safe means being willing to take risks by being willing to say what needs to be said and hear what needs to be heard. Safety is vital but being safe does not necessarily mean being comfortable.

Participants look at the change process itself and are asked to anticipate the inevitable resistance to change that is a fact of life in every organization. They look at management styles, the way decisions are made and conflicts resolved. In the process of these discussions, they learn about what it means to engage in more democratic processes on the part of leaders, staff, and children in terms of the simultaneous increase in rights and responsibilities. They evaluate the existing policies and procedures that apply to staff, children and families and ask whether or not they are effective in achieving their shared goals. They are asked to learn about and become thoroughly familiar with the psychobiology of trauma and disrupted attachment and the multiple ways that PTSD, complex PTSD and other trauma-related disorders present in the children, adults and families they work with. They are challenged to begin thinking about the implications of that knowledge for treatment. They also learn how high levels of stress in the organization can impact relationships, emotions, and decision-making at

every level of the organization. They develop an understanding of the conceptual tool for organizing treatment that we refer to as “S.E.L.F.”. They learn about vicarious trauma, traumatic reenactment and the importance of understanding themselves and providing support for each other, along with the concept of posttraumatic growth. They are introduced to the various components of the Sanctuary Toolkit and the role the Toolkit plays in changing organizational habits.

The Sanctuary Steering Committee is instructed to go back to their organization and create a Core Team – a larger, multidisciplinary team that expands its reach into the entire organization. It is this Core Team that will be the activators of the entire system. The Core Team should have representatives from every level of the organization to insure that a “voice” from every sector is heard. It is vital that all key organizational leaders become actively involved in the process of change and participate in this Core Team. The Core Team is armed with a Sanctuary Direct Care Staff Training Manual, a Sanctuary Indirect Staff Training Manual, a Sanctuary Implementation Manual, several psychoeducational curricula and on-going consultation and technical assistance from Sanctuary faculty members. The process of Sanctuary Implementation extends over three years and aims toward Sanctuary Certification. Organizational change takes several years to really get traction and then continues – hopefully – forever. The objective of the implementation and technical assistance is to edge an organization closer and closer to the “edge of chaos” where creative, self-organizing change occurs, without destabilizing it to such a point that it becomes chaotic and dangerous.

The responsibility of Core Team members is to actively represent and communicate with their constituents and to become trainers and cheerleaders for the entire organization. The Core Team works out team guidelines and expectations of involvement for individual team members as well as a meeting schedule and decides on safety rules for the constructive operation of the team itself. The Core Team is ultimately responsible for the development of an implementation process aimed at including the entire organization in the change process that involves teaching everyone about the Sanctuary Commitments, Attachment Theory, Trauma Theory, S.E.L.F., and the Sanctuary Toolkit. The Core Team facilitates the development of educational programs for direct care staff as well as indirect care staff who work in human resource, finance, facilities management, food service, and administration. It is likely that the Core Team facilitates changes in admissions, interviewing of new staff, orientation programs, supervisory practices, as well as training and education policies. They oversee a plan for greater client participation in planning and implementation of their own service plan and figure out how they are going to engage a wider network of their stakeholders in the community in the Sanctuary change process. The ultimate goal is to take meaningful steps to change the organization’s culture and engage as many community members as possible in the process.

As discussions begin in the Core Team, participating staff begin to make small but significant changes. Members take risks with each other and try new methods of engagement and conflict resolution. They feed these innovations and their results back into the process discussions. The Core Team must always maintain a balance between process and product. It is not enough to talk about how things will change. There must also be actual changes in the way business is conducted. The Core Team therefore not only plans together how best to share what they are learning with the larger organization but also decides how to integrate the Sanctuary Toolkit into the day-to-day operation of the organization and how to evaluate how these initiatives are taking hold in the organization, and trains all agency personnel and children in the Sanctuary principles.

Through the implementation steps, staff members engage in prolonged dialogue that serves to surface the major strengths, vulnerabilities, and conflicts within the organization. By looking at shared assumptions, goals, and existing practice, staff members from various levels of the organization are required to share in an analysis of their own structure and functioning, often asking themselves and each other provocative questions. As this happens, the development of more democratic, participatory processes begin to emerge. These processes are critical because they are most likely to lend themselves to the solution of very complex problems while improving staff morale, providing checks and balances to abuses of power, opening up the community to new sources of information, and achieving better outcomes with the children.

From the outset of implementation the Core Team must decide on indicators they want to use to evaluate their program in an on-going way – their Sanctuary Program Evaluation Plan. The indicators should be observable and measurable and consistent with standards established by Sanctuary leaders. There should be a regular process of evaluation and review that involves all Core Team members. It is vital that there be a thorough method for reviewing problems and failures and establishing remedial courses of action. But likewise there must be methods for reviewing and capturing successes.

The impact of creating a developmentally-grounded, trauma-informed culture using the Sanctuary Model should be observable and measurable, often by paying special attention to things that are already being measured in the organization. The expected outcomes include: less physical, verbal, emotional violence, including but not limited to reduced/eliminated seclusion and restraint; system-wide understanding of complex biopsychosocial and developmental impact of trauma and abuse and what that means for the service environment; less victim-blaming; less punitive and judgmental responses; clearer more consistent boundaries on the part of staff, higher expectations, better linkage between rights and responsibilities; earlier identification of and confrontation with abusive use of power in all of its forms; improved ability to articulate goals and create strategies for change; expanded understanding and awareness of reenactment behavior, resistance to change and how to achieve a

different outcome; more democratic environment at all levels; more diversified leadership and embedding of leadership skills in all staff; and most important, better outcomes for children, staff, and the organization.

Sanctuary Network

The Sanctuary Institute is the gateway to the Sanctuary Network, a community of organizations dedicated to the implementation of developmentally-grounded, trauma-informed services. All members are committed to the belief that we can do better for our clients and our colleagues as well as our society if we can accept that the people we serve are not sick or bad, but injured and that the services we provide must provide hope, promote growth and inspire change.

As of the beginning of 2012, the Sanctuary Institute has trained over 200 organizations world-wide. These include adult inpatient psychiatric and substance abuse facilities, domestic violence shelters, residential programs and group homes for children, schools and educational programs, juvenile justice facilities and a number of large programs that have a wide variety of inpatient, outpatient, partial, community-based and residential programs. The Sanctuary Network has grown into a community of organizations helping each other to become more trauma-informed and to improve services and outcomes. The Sanctuary Network sponsors an annual conference that features innovations in practice. The Network also disseminates new materials to its members, has a website, and holds regular webinars and other opportunities for members to share and learn. With greater geographic spread, local networks are beginning to form as well.

Sanctuary Certification

Sanctuary® is a registered trademark and the right to use the Sanctuary name is contingent on engagement in the certified training program and an agreement to participate in an on-going, peer-review certification process. The Sanctuary Certification process is designed to promote, sustain and strengthen an organization's commitment to the maintenance of a healthier, developmentally-grounded, trauma-informed culture for all stakeholders. Programs usually seek Sanctuary Certification in the 2-3 year period after participation in the Sanctuary Institute. Research is under way in the hope of moving the Sanctuary Model from an "evidence-supported" to an "evidence-based" approach.

Certification is a symbol that an organization provides a higher level of care, a trauma-sensitive environment for children and their families and a better environment for staff who provide care. This process affirms our commitment to ensure fidelity to the Sanctuary Model and meet the standard of providing a safe, secure and developmentally appropriate environment in which children and staff will recover and thrive. Agencies that meet the Sanctuary Standards can expect to experience: improved treatment outcomes; enhanced staff communication; reductions in violence and critical incidents; increased job satisfaction; lower rates of staff turnover; and better leadership.

When an organization becomes a Certified Sanctuary Organization, there is an agreement that that each organization will maintain its practice in accordance with the tenets of Sanctuary, utilize the S.E.L.F. framework for Sanctuary practice, maintain Sanctuary training, expand the scope of developmentally-grounded and both trauma-informed and trauma-specific clinical treatment, and routinely re-certify their staff and the organization. Certified Sanctuary Organizations also agree to follow and maintain the certification standards post-certification between surveys.

Sanctuary Model Outcomes

To date, one controlled, randomized trial of the implementation of the Sanctuary Model in children's residential settings has been conducted. The model was piloted in four residential units that self-selected to participate in the initial phase of the project then four additional residential treatment units were randomly assigned to implement the Sanctuary Model the following fall. Eight other units that provided the standard residential treatment program served as the control group. Changes in the therapeutic communities and in youth were assessed every three to six months. To summarize the results of the randomized control study, from baseline to six months, there were five changes in the staff attitudes and perceptions among those who received the Sanctuary Model training: Support: how much children help and support each other; how supportive staff is toward the children; Spontaneity: how much the program encourages the open expression of feelings by children and staff; Autonomy: How self-sufficient and independent staff perceive that the children are in making their own decisions; Personal Problem Orientation: the extent to which children seek to understand their feelings and personal problems; Safety: The extent to which staff feel they: can challenge their peers and supervisors, can express opinions in staff meetings, are not blamed for problems, and have clear guidelines for dealing with children who are aggressive. Changes in the children were just beginning to unfold as the study ended, including a decrease in children's conflict-escalating communication and increases in their positive management of tension (Rivard et al., 2004). In a quasi-experimental study of residential programs for children using the Sanctuary Model, there were similar positive changes in organizational culture, while comparable programs not using the Sanctuary model did not report those improvements (McSparren & Motley, 2010).

The first seven child-serving facilities that participated in the five-day training that begins the process of Sanctuary implementation were evaluated for changes in their rates of restraints and holds. Three programs exhibited over an 80% decrease in the number of restraints, two had over a 40% drop, one exhibited a 13% decrease and one had a 6% drop. A subsequent three year study of child organizations using the Sanctuary

Model showed an average of 52% reductions in physical restraints after the first year of implementation (J. A. Banks & A. L. Vargas, 2009). Within the first six years of implementation in the Andrus Center residential program and school, there was a 90% decrease in critical incidents with a 54% increase in the average number of students served (J. Banks & L. A. Vargas, 2009a).

Working with schools is part of the Sanctuary Institute focus. In one school for emotionally disturbed children that has become certified in the Sanctuary Model, after two years of implementation, 64% of the students achieved realistic or ambitious rates of reading improvement. In addition, 99% of the children were promoted to the next grade. There was a 41% reduction in the number of children requiring inpatient psychiatric hospitalization and a 25% reduction in days children spent in inpatient hospitalization. The same school enjoyed a 56% placement rate in public and private school programs once the students graduated (J. Banks & L. A. Vargas, 2009b).

As part of the Pennsylvania Department of Public Welfare's (DPW) efforts to reduce and eliminate restraints in children's treatment settings, DPW entered into a partnership with the Sanctuary Institute to bring the Sanctuary Model to Pennsylvania in 2007. The University of Pittsburgh worked with Pennsylvania Department of Public Welfare, the Sanctuary Institute, and thirty participating provider residential sites to conduct an open evaluation of the implementation of the model. Annual surveys were conducted from 2008-2010. The evaluation of the implementation of the Sanctuary Model in residential facilities found that greater implementation was associated with a number of positive outcomes: lower staff stress and higher staff morale, increased feelings of job competence and proficiency and a greater investment in the individuals served. The implementation of the Sanctuary Model was also significantly associated with improved organizational culture and climate and a substantial decrease in the reported use of restraints by many sites (Stein, Kogan, Magee, & Hindes, 2011).

Additionally, an analysis of service utilization from 2007-2009 of children discharged from Sanctuary Model residential treatment facilities (RTF) versus other RTF's, was conducted by Community Care Behavioral Health (CCBH). It demonstrated that although both groups had a similar average (mean) length of stay in 2007, by 2009 Sanctuary Model RTF providers had: a substantially shorter length of stay and a somewhat greater decrease in median length of stay; a substantial increase in the percentage of discharged youth who received outpatient services in the three months following discharge; and a lower increase in the percentage of children readmitted to RTF's in the 90 days following discharge (Community Care Behavioral Health, 2011). As the authors of the report wrote, "The implementation of the Sanctuary Model in residential facilities in Pennsylvania appears to have had a positive impact, with the greatest benefits being seen by residents and staff of those sites who were most successful in implementing the full Sanctuary Model."

Conclusion

The positive outcomes associated with implementing the Sanctuary Model have occurred at a time of uncertainty and programmatic and staffing change in many facilities, which speaks to the dedication of all involved in the implementation of Sanctuary. At the same time, the variation observed in implementation does suggest an opportunity to consider strategies to support future implementation efforts, as well as the need for providing continued support to sites that have implemented Sanctuary to ensure sustained positive outcomes" (p.7) (Stein et al., 2011).

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Biographical information

Dr. Sandra L. Bloom is a Board-Certified psychiatrist, graduate of Temple University School of Medicine and recently was awarded the Temple University School of Medicine Alumni Achievement Award. In addition to her faculty position at the School of Public Health at Drexel, she is President of CommunityWorks, an organizational consulting firm committed to the development of nonviolent environments. Dr. Bloom currently serves as Distinguished Fellow of the Andrus Children's Center in Yonkers, NY.

From 1980-2001, Dr. Bloom served as Founder and Executive Director of the Sanctuary programs, inpatient psychiatric programs for the treatment of trauma-related emotional disorders. In partnership with Andrus Children's Center, Dr. Bloom has established a training institute, the Sanctuary Leadership Development Institute, to train a wide variety of programs in the Sanctuary Model®. The Sanctuary Model® is now being applied in residential treatment programs for children, domestic violence shelters, group homes, homeless shelters and is being used in other settings as a method of organizational development.

Dr. Bloom is a Past-President of the International Society for Traumatic Stress Studies and author of *Creating Sanctuary: Toward the Evolution of Sane Societies* and co-author of *Bearing Witness: Violence and Collective Responsibility*.

Getting hospital staff involved in keeping the healthcare community safe

Keynote Speech

Marilyn Hollier

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Introduction

Getting hospital staff to understand and perform their role in keeping the healthcare community safe is critical to a healthcare security department successfully achieving the overall mission of maintaining a safe and secure environment. There is no one program, service or recipe to achieve this. A multifaceted approach must be taken. Continuing to review/revise programs and services, measuring/evaluating for effectiveness, as well as continuing to develop new innovative programs and services is also key to gaining community support and involvement. Security must become irreplaceable partners of the healthcare team. This takes time to do but is very effective in establishing the value of Hospital Security.

Summary

The Healthcare Security Director cannot do this alone and must lead by example. The Director should market, network and promote the value of security to Senior Leadership and the Healthcare Community. The Director should hire educated and talented security staff. Motivate and challenge security staff to get involved and take ownership in developing and maintaining security's services and programs.

The Director should provide healthcare security specific training and encourage professional certifications and continuing education for their leadership team and security staff. This will enhance credibility and reduce liability. This type of training is available through the International Association of Healthcare Security and Safety's (IAHSS) Training and Professional Certification programs. This association also provides very valuable healthcare security and safety resources, policies and guidelines.

An organizational stance must be taken to provide a multifaceted approach to gaining community's trust with hospital security to report crime as well as disruptive/aggressive behavior. Examples of such training are:

- New Employee Orientation
- Yearly mandatory training
- Security academy
- Foundations of Supervision
- Non-Violent Crisis Intervention training for front line staff
- Web-site hosted by Hospital Security
- Security Awareness Day/Week of events
- Security sponsored newsletter.

The Hospital Security department must also continue to develop innovative services to the healthcare community to promote trust and the timely reporting of crime and/or disruptive behavior such as:

- Community Oriented Patrolling or Community Resource Officers
- Daily Safety rounds with clinical staff
- Person(s) of Concern (POC) tracking
- Potentially Violent Person(s) (PVP) tracking
- Become involved with hospital leadership initiatives such as LEAN (Waste reduction/quality improvement process) and Patient & Family Centered Care (PFCC).

In conclusion, the Hospital Security team must learn to take risks, get involved and become a valued/trusted member of the healthcare team. Achieving this will reap big rewards such as enhanced resources, timely crime reporting and early identification and intervention with potentially disruptive/violent behavior.

Learning Objectives

Participants will...

1. be able to provide ideas on how to get hospital staff to understand and perform their role in keeping the healthcare community safe.
2. be able to provide ideas on how to get the healthcare community to understand that early intervention via early reporting of disruptive, aggressive and bullying behavior is the key to minimizing workplace violence.
3. be able to provide ideas you can use, modify or expand upon to educate and motivate your healthcare community to get more involved with helping Security maximize safety/security, crime reporting and minimize violence in the workplace.

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Biographical information

Marilyn Hollier has been in the Security/Law Enforcement field for over thirty years. She holds a Bachelor's degree in Education from Southern Illinois University and a Master's degree in Human Resources/Urban Studies from Georgia State University. She is a Certified Healthcare Protection Administrator (CHPA) since 1997 and a Certified Protection Professional (CPP) since 1996. Tenure includes seven years with the Emory University Police Department and nine years as Assistant Director and Acting Director of Security Services at Grady Health System in Atlanta, Georgia. She has been the Director of Security and Entrance Services at the University of Michigan Hospitals and Health Centers since 1998. UMHHC Security and Entrance Services won the coveted IAHS "Lindberg-Bell" award for the most advanced healthcare security department nationally in 2008. Marilyn has been actively involved with IAHS and ASIS International for many years and has served in the following volunteer leadership positions:

- IAHS President 2014 (Executive Board)
- IAHS Vice President and President Elect (Executive Board): 2012 - 2013
- Vice Chair and Chair of the IAHS Council on Education: 2008 – 2011
- ASIS International Healthcare Security Council: 2000 - 2014
- Vice Chair and Chair of ASIS Detroit Chapter: 2008 - 2009
- IAHS Training Council: 2006 - 2007
- IAHS Regional Chairperson (Region14): 2004 - 2007
- Chairperson for Great Lakes Chapter of IAHS: 2002 – 2004.

Microaggressions: A Native American Perspective

Keynote speech

John Lowe

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Microaggressions, a contemporary form of violence, are defined as “events involving discrimination, racism, and daily hassles that are targeted at individuals from diverse racial and ethnic groups” [1]. They are current events, chronic, can occur on a daily basis, and are often covert in nature. Some groups of people, such as Native Americans, may be susceptible to both historical trauma and microaggressions. Microaggressive acts can perpetuate the trauma. Historical trauma response is defined as “the cumulative effect of historical trauma brought on by centuries of colonialism, genocide, and oppression” [2]. The term colonial trauma response (CTR) also incorporates the historical group trauma response but also includes contemporary and individual responses to injustice, trauma or microaggression. The defining feature of CTR is its connection to colonialism. [3] Colonialism is defined generally as “a relationship of domination between an indigenous majority and a minority of foreign invaders”. [4]

A definition of colonial trauma specific to Native Americans is “historical and contemporary traumatic events that reflect colonial practices to colonize, subjugate, and perpetuate ethnocide and genocide against contemporary Native American peoples”. [5] Native Americans have unique experiences directly related to surviving colonization within the boundaries of the United States. Through government sponsored policies of tribal/racial genocide and ethnocide, the federal government has attempted to acculturate and deculturate Native Americans on their own lands. Examples of institutionalized acculturative practices include forcing Native American children into boarding schools and forbidding them to speak their Native languages; outlawing Native religious practices; forcibly removing and relocating Native Americans away from traditional lands; and disproportionately removing Native American children and placing them into non-Native American homes. [6] Native Americans who have experienced the loss of children due to the creation of boarding schools and forced removal of children from their families are at risk for producing a historical trauma response in offspring. [7] The effects of boarding schools on these children have been examined by researchers, but little has been done to examine the effect on their parents.

Some Native Americans tend to carry more of the grief and trauma for others and feel a stronger burden to carry the pain of their tribal members. [8] The historical trauma response in offspring is influenced by how parents communicate about the traumatic event. A sense of dread and secrecy about events is created by silence. [9] The absence of information that is not communicated to those close to survivors can result in heightened curiosity, increased sense of dread, and misinformation that is sometimes worse than what was experienced. Greater inner impact on the individual who experienced the trauma can result from more profound silence. [10] Similarly, holocaust survivors often meet denial and avoidance when sharing their stories with others. [11] The survivor’s experience is affected by the denial which intensifies their already profound sense of isolation, loneliness, and mistrust of society. They choose to remain quiet about their experiences. As a result, the conspiracy of silence only intensifies isolation and prevents healing.

Descriptions of “survivor syndrome” were included in the 1980 DSM-III definition of Post-traumatic Stress Disorder (PTSD). [12] While standardized definitions such as PTSD reflect some of the symptoms resulting from historical trauma, they are limited in their ability to explore the additive effects of multiple traumatic events occurring over generations. Definitions of PTSD overlook the variety of types of posttraumatic syndromes and neglect communal responses to trauma. Definitions can be expanded to better reflect the historical trauma experience by capturing the compounding nature of responses to multiple stressors; addressing familial and social impacts of trauma reactions; exploring how historical and contemporary traumas interact; and including factors that buffer the impact of trauma.

Many Native Americans and other people groups who experienced historical trauma as part of their community are also subject to microaggressions as individuals. These everyday injustices serve to connect the individual with a collective and often historical sense of injustice and trauma. The individual can feel more closely connected with ancestors who have experienced historical trauma and sometimes feel a particularly strong reaction to the microaggression. Some characteristics related to historical trauma response include anxiety, intrusive trauma imagery, depression, survivor guilt, elevated mortality rates from cardiovascular diseases, suicide and other forms of violent death as a result of identification with ancestral pain and deceased ancestors, psychic numbing and poor affect intolerance, and unresolved grief. [13] Several factors can influence the degree to which an individual experiences historical trauma.

Microaggressive acts may be clear and recognizable. However, they are more often subtle and hard to define, articulate, and address. The power of racial microaggressions lies in their invisibility to the perpetrator and, oftentimes, the recipient. [14] Interpreting and responding to a microaggressive act becomes the burden of the individual experiencing the incident. The victim must determine whether the incident was intentional or perhaps reflects misunderstanding or ignorance. Then the victim must make a decision about whether or not

to address it. A further negative response may be promoted, such as anger, denial, and accusations, if attention is brought to the incident. Microaggressive acts may not be specific or verbal. They can refer to environments that are either intentionally or unintentionally unsupportive to a person because of his or her racial identity. For example, an educational or health-care institution with buildings that are all named after white heterosexual upper class males. The message is "You don't belong here, you won't succeed here, there is only so far you can go". Microaggressions affect the psyche of the individual victim and the group to which he or she belongs. They also deliver persistent, inaccurate messages about a group of people. As a result, they obscure the true cultural nature of the group and replace it with a stereotype. Each of these events might be tolerated in isolation, however, the overall cumulative effect of microaggressions can be devastating. Microaggressions are significant because daily discrimination can result in more distress and stronger negative health outcomes than time-limited episodic discrimination.

The following three types of microaggressions have been identified [15]:

1. A microinsult is characterized by communications that convey rudeness and insensitivity and demean a person's racial heritage or identity (for example, eye rolling during a discussion about an individual's racial identity).
2. Microinvalidations are communications that exclude, negate or nullify the psychological thoughts, feelings, or experiential reality of a person of color. An example is a white person stating to a person of color that they "don't see color", which denies that person's racial and ethnic experiences. Another example is a non-Native person asking someone of Native American culture whether or not he or she is a "real Indian". This demands an explanation that few others are required to deliver.
3. A microassault is an explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim. This can happen through name-calling, avoidant behavior, or purposeful discriminatory actions. Microassaults against Native American people also appear in the form of advertisements that depict white models in Native clothing, associations between Native American people and aggressive sports teams, and messages that connect Native American people with alcohol use. Microassaults are typically more conscious and deliberate than other forms of microaggression.

All health-care professionals should become aware of historical trauma and microaggression. These concepts should be included into provider training and education, and used to inform program development and health-care delivery models. Specifically, this needs to be a part of educational and professional development. A full understanding of historical trauma and microaggressions needs to be personally understood in order to apply them professionally and in daily interactions. It is critical to incorporate the concepts of historical trauma and microaggressions into everyday communications and work within health-care systems. Concern, pause, and reflection about health-care systems and its pre-assumptions of health-care services and delivery models related to historical trauma and microaggressions should be prompted. People coming into the health-care system as clients or employees, are affected by their history. Often, the dynamics of historical trauma and microaggressions teach people to go underground. Those who suffer do so quietly, and are taught to do this because of what happened to their elders, people, and communities. They may believe that the health-care system does not support them and are not likely to in the future. Many enter the health-care system looking to corroborate what they have heard from members of their communities. Policies need to be supportive of these issues. Additionally, nearly all inter-racial encounters are prone to the manifestation of racial microaggressions. Racial microaggressions are potentially present whenever human interactions involve participants who differ in race and culture. No racial/ethnic group is immune from inheriting the racial biases of the society and environment where they were raised. Gender, sexual orientation, and disability microaggressions may have equally powerful and potentially detrimental effects.

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Biographical data

Dr. John Lowe is a Cherokee Native American Indian tribal member and currently one of only 19 doctoral prepared Native American nurses in the United States. Dr. Lowe is an alumnus of the pre-doctoral ANA Ethnic Minority Fellowship and now serves as the Vice-Chair of the Advisory Committee. He is also a Fellow into the American Academy of Nursing and currently the John Wymer Distinguished Professor of the Florida Atlantic University Christine E. Lynn College of Nursing. He actively serves in elected, appointed, advisory and consultant positions such as the National Institutes of Health, American Colleges of Nursing (AACN) California Endowment for Cultural Competencies in Graduate Nursing, American Nurses Foundation, Florida Nurses Association, Florida Nurses Foundation, National Coalition of Minority Nurses Associations, National Alaskan Native American Indian Nurses Association, Pathways into Health, United States Department of Health and Human Services, United Keetoowah Band of Cherokee Indians Health Department, University of Southern Queensland Centre for Rural and Remote Area Health Research, Indigenous Wellness Institute, Indigenous HIV/AIDS Research Training Institute, and the Indian Health Service. Dr. Lowe has represented Native American and Indigenous nurses in many national and international forums and with national leaders such as the U.S. Surgeon General and the former first lady, Mrs. Rosalyn Carter. Globally, he has provided health-care services and research consultation to underserved/disadvantaged groups in countries such as Australia, New Zealand, Tanzania, Costa Rica, Jamaica and China. He advocates for the cultural competent health care of Native Americans and indigenous people globally. Models that have emerged from his funded research are being used to promote the health and well-being of Native Americans. He developed and studies an intervention for the reduction of substance abuse and other risk behaviors among Native American youth. Dr. Lowe developed the Cherokee and Native Self-Reliance Models which are being used in several intervention research projects that utilizes the traditional Talking Circle format to reduce substance abuse and other risk behaviors among Native American youth. He is currently the Principal Investigator of several National Institutes of Health funded research projects. Dr. Lowe also co-authored the Native American Nursing Conceptual Framework which is being used to guide nursing curriculums. His work has been acknowledged through his induction as a fellow in the American Academy of Nursing and numerous awards such as the Florida Nurses Association Cultural Diversity Award, ABNF Lifetime Achievement in Education and Research Award, Great 100 Centennial Research Award, the Nursing Educator of the Year Award, and the Researcher of the Year at the Professor Rank Award. Dr. Lowe has presented nationally and internationally and has published several articles and books that report the findings of his research.

The power to co-create a safe place to heal and work

Keynote speech

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Keywords: Safe working environments, safe patient healing environments, leadership, power

Problem Statement

Of 270,491 deaths, 238,337 were potentially preventable between 2004 and 2006. Did you know that 400,000 plus medication errors occur every year and \$8 to 29 billion has been spent annually due to a lack of a safe healing environment. I propose that when the healing environment is not safe, the work environment is equally unsafe. And yes, the opposite is also true: An unsafe healing environment and an unsafe working environment are two sides of the same coin.

The root causes of these events start with communication and include leadership. – Other variables range from orientation/training to environment safety and security and yet all relate to leadership. These are some of the more staggering details (Leape, 2000). US health care is more hazardous than driving, chemical manufacturing, airlines, European railroads and nuclear power. Slightly more dangerous than health care are mountain climbing and Bungee jumping. If airlines were only as safe as health care, there would be 84 unsafe landings/incidents per day and one crash every one to three days. The earthshaking Institute of Medicine report, *To Err is Human* (Kohn, Corrigan, Donaldson, 1999) concludes: “It is simply not acceptable for patients to be harmed by the same health care system that is supposed to offer healing and comfort.” Leadership is the key to providing, building, and sustaining a culture of safety for both patient and staff.

As the National League for Nursing implements our mission, we are guided by four dynamic and integrated core values (NLN, 2014) that permeate the organization and are reflected in our work: Let me share the definitions with you.

Caring; promoting health, healing and hope in response to the human condition. I think we’ve all become clear that we desire a “health system,” and not one based on illness. And healing is such a natural part of being a nurse. If my forefathers and mothers had not crossed the seas in less than a luxury conveyance, I would be in someone’s village crying: “I’m the village healer.” Well, I am your village healer. It’s in my blood and it’s allowed me to be a psychiatric mental health nurse extraordinaire.

And then there’s hope. Hope is a sought after commodity, but we as nurses should not wait until we get to a patient care encounter to inquire, “Did anyone bring any hope with them?” We should have a self-generating mechanism of hope with us at all times. We care. One individual nurse’s caring is not sufficient; we really need a culture of caring as a fundamental part of the healing disciplines. It characterizes our concern and consideration for the whole person, our commitment to the common good, and our outreach to those who are vulnerable. All organizational activities are managed in participative and person-centered ways, demonstrating an ability to understand the needs of others and a commitment to act in the best interest of our patient, client, consumer, family, fellow colleague, and community.

Now on to integrity. We define it as **respecting the dignity and moral wholeness of every person without conditions or limitations.** The esteemed psychologist Carl Rogers used to speak about unconditional regard, basically suggesting that if you are breathing you should be respected. And with nursing, even if you’re not breathing you garner our respect. This is who we are as nurses.

A culture of integrity is evident when organizational principles of open communication, ethical decision-making, and humility are encouraged, expected, and demonstrated consistently. Not only is doing the right thing simply how we do business, but our actions reveal our commitment to truth telling and to how we – through reflection – see ourselves and meet our standards from the perspective of others in the larger diverse community that we as nurses serve.

And Diversity: Affirming the uniqueness of and differences among persons, idea, values, and ethnicities.

This is the idea of inclusion that transcends all of our usual suspects into diverse ideas and values. It’s not to deny the unique history of the US in terms of racial issues that are still alive and well in various ways; but it is to acknowledge that we have to think in different ways for a different time, that old, outdated arguments are of no use to nursing. And we nurses cannot deny that we are incredibly good at sustaining an argument for an indeterminate period of time. A culture of diversity embraces acceptance and respect. We understand that each individual is unique and recognize individual differences, which can be along the dimensions of race, ethnicity, gender, age, socio-economic status, physical abilities, political beliefs, and other descriptors. A culture of diversity is about inclusiveness, understanding ourselves and each other; moving beyond simple tolerance to embracing and celebrating the richness of each individual while believing that we are all more similar than

different. And while diversity can be about individual differences, it also encompasses institutional and system-wide behavior. Simply stated, diversity brings complexity. I have come to believe that without diversity and all its complexity, there can be no excellence.

So now Excellence: Co-creating and implementing transformative strategies with daring ingenuity. The NLN's Board of Governors, in their annual review of our mission and values, delivered on their wisdom by adding two letters within our definition of excellence. The two letters are 'C' and 'O', thereby changing creating to co-creating and clarifying that no one actually creates alone and that true excellence is the result of some level of collaboration. A culture of excellence reflects a commitment to continuous growth, improvement and understanding. It is a culture where transformation is embraced and the status quo and mediocrity are not tolerated. It is all about promoting a collaborative presence in health care work setting and the health professions, realizing the importance of working together to achieve goals for improved patient care outcomes.

And the concept of daring ingenuity. For me it's simply falling off a cliff. When you are in the business of transformation there is bound to be some cliff behavior. And if one has time to anticipate the cliff, to arrive early and put a safety net across the chasm, everyone will then proclaim, "Did you see how lovely Beverly just floated off that cliff?" But in the transformational flow, often there will not be enough time to anticipate the cliff and one just has to fall "ugly." But it's never been about the falling, falling is inevitable; it's always been about how one gets up.

These Core Values can provide the pathway to a safe healing and working environment. But it's not enough to identify core values, we have to use them and build our operational and organizational culture on them. And leadership is required for implementation.

Leadership and Power

The root word of leadership is lead from the Anglo-Saxon Old English word *loedan*, the causal form of *lithan* – to travel. The Oxford English Dictionary defines lead as "to guide with reference to action and opinion; to bring or take (a person or other) to a place; while the term *ship* indicates a state or condition". One could determine that leadership is the capacity, (the state of being), to guide or take others to a place or an outcome (Grace, 2003). The term power is the ability or force to move an object or other from point A to point B. For example when faculty move the minds of their students from Point A to Point B, it is called education. It is a powerful act. When a staff nurse moves the patient through the hospital system from entry to discharge, this activity is not often recognized as powerful or a vivid example of leadership yet it is powerful leadership. Leadership and power are closely aligned.

Power provides the fuel for leadership. It sits under the umbrella of leadership along with five other components:

- (1) dreaming
- (2) visioning
- (3) boundary management
- (4) risk taking
- (5) mastery.

Dreaming is the antecedent to having a vision. It may be night or day dreaming, conscious and unconscious associations with parts and pieces of ideas, experiences, and feelings. I once worked with an individual who exclaimed "I think I have it. I'm now dreaming during the day. I got into my car and the next thing I knew I was at work. I must have been dreaming." No, I explained, that was a blackout.

From dreaming comes **visioning**. A **Vision** has a destination requiring action even if the pathway and the required resources are in question. Some have described a vision like a tree without leaves. As your vision unfolds, leaves are added. As others buy into your vision, the roots of the tree deepen. The vision is the result of dreaming and the intentional framing of pictures in the mind that portray the possible and the seemingly impossible becoming reality. As a psychiatric nurse and clinical psychologist, I have pondered the difference between a vision and a hallucination and I've decided that a vision without action is a hallucination. It is only through a plan of action shared with others that the vision's potential reality takes root.

However it is with the use of **Boundary Management** that visions are shared with others – our colleagues and our followers. Leaders need to know the extent of their influence and where and when to build a bridge of collaboration, provide guidance for others, or simply when to lead and when to follow.

Following, especially by leaders, requires skill and competence. Some leaders are unclear as to how to provide space for others. The ability and awareness of when to step back making room for others to lead is an important accomplishment for a leader. There is a rhythm to leading and following. A great leader knows also how to follow.

Bridge building may not always be timely or effective since the leader may find herself (or himself) in a situation where there is a need to move forward without the safety of a bridge. This is the **Risk Taking or daring ingenuity leadership component**.

Mastery is the personal owning and acknowledgment by others of one's expertise, knowledge, skills, abilities, and experiences. To sit with authority and comfort in one's own abilities is a gift that every provider needs when providing safe quality care to patients, families, and communities. Some describe it as being comfortable in one's own skin.

These four components of leadership provide useful resources for the journey but without **Power**, they tend to dissipate quickly. The journey to safe healing and work settings underpinned by values is accomplished through the use of power. For example, informational power or communication.

Informational Power

Nurses in the hospital or community possess more information than any other provider about the patient/consumer of services. This 24-hour information is critical to the organizational functioning of any health care system. But information has to be transmitted across boundaries to other nurses and providers as well as to the patient and family. The potential for error through faulty communication rises for all health care providers. The following scenario highlights that lack of communication can lead to an unsafe workspace.

In the early days of my nursing career, I worked as a psychiatric clinical nurse specialist at an academic health care center. I was the first nurse in my particular role and was permitted to write my own job description. While carrying a case load of psychiatric patients, I also consulted to any concerns related to inter- or intra-professional teamwork.

One day I received a call from a nurse manager of a neuro floor who had concerns about her staff's working relationships. She explained that she had two staff who were not speaking to one another. In fact, they had not spoken to one another for a three-year period. One staff member was a registered nurse and the other was a licensed practical nurse. The RN was white and the LPN was black. The racial piece was interwoven with the role and it was difficult to determine what the issues were. The most interesting aspect of this situation was the rest of staff. The nursing team had divided almost in half with one side for the RN and the other for the LPN. Since the two were not speaking, there were volunteers from each side who kept information flowing frequently and in the absence of any real information, created their own version. The involvement of the entire unit resulted in a highly dysfunctional nursing staff with patient care suffering from a lack of communication.

My intervention was simply to ask the two identified protagonists to join me for a conversation. I was quickly warned by the nurse manager that they could not be in the same room with one another because of the possibility of violence toward one another or towards me. Being a psychiatric mental health nurse, this did not deter me from asking them to join me for a conversation.

I asked them, my colleagues, how they felt about professionalism. They both responded with strong declarations of their professionalism. I followed that question with how they perceived quality patient care. Their responses were similar: Quality patient care was a priority. I told them that I was not clear and asked their response to the following situation: If the RN was working with a patient and called out for assistance, the LPN would not respond. They both said of course not, there would be no response since they were not speaking to one another. I shared with them that I could not understand how this aligned with professionalism or with quality patient care. Neither of them had thought about their relationship in this particular way, that it actually affected patients and their own sense of professionalism.

I provided a model of working with difficult team relationships where the core value of caring and the primacy of professionals superseded one's own personal issues.

1. You don't have to love people in order to work with people.
It's not a requirement.
2. You don't even have to like your colleagues in order to work with your colleagues.
Liking is a strong nursing attribution. We like to be liked.
3. However it is non-negotiable that to have a safe healing and working environment, you have to respect one another.
An operational definition of respect can begin with basic courtesy and civility. Good morning, Thank you. Can I help you?

My two colleagues, the RN and LPN, thought they could do this and amazingly were very successful, not at loving or liking but at respecting. With the two of them refusing to play the role of acting-out staff, the rest of the unit revised their roles and became more civil and tolerant with one another. The only casualty was the nurse manager. As the unit became healthier, her own inability to lead became more evident and she was removed from her leadership role.

Understanding the link between leadership, power, and a culture of safety for patients and staff is essential. The nurse manager may not have known how to intervene into this three-year-old conflict, but it should not have taken a leader three years to know that the care on her unit was being imperiled by the behavior of her staff toward one another and seek help.

When one reflects on the core values initially introduced in this presentation – caring, integrity, diversity, and excellence – it is clear that they were all directly involved in this vignette. Sadly it was the lack of caring and integrity, the complexity of the staff’s diversity, that were the primary drivers resulting in a lack of excellent patient care. Violence toward one another in patient-care settings is unacceptable as it violates basic civility and professionalism, but most importantly, it jeopardizes patient care. It is my basic belief that a part of professional health disciplines – intra- and inter- violence (e.g. a surgeon shouting at residents or nurses) – is related to the failure to exercise adequate self-care management.

There are three stressors that are continually and simultaneously operational in our lives:

1. Inevitable stress: aging, illness, and death,
2. Imposed stress: someone else’s stress,
3. Chosen stress.

Without adequate attention to self care, internal mediators of anger or aggression may not be well activated allowing space for inter and/or intra acting out staff behavior. As a collaborative team we owe our patients, our colleagues, and ourselves the caring, respect, and excellence necessary to achieve safe quality care in a safe working environment.

Through leadership, we have the power to co-create a safe place to heal.

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Biographical data

Beverly L. Malone, PhD, RN, FAAN, is the chief executive officer of the National League for Nursing (NLN). Dr. Malone’s tenure at the NLN has been marked by a retooling of the League’s mission to reflect the core values of caring, diversity, integrity, and excellence and an ongoing focus on advancing the nation’s health.

Her distinguished career has mixed policy, education, administration, and clinical practice. Dr. Malone has worked as a surgical staff nurse, clinical nurse specialist, director of nursing, and assistant administrator of nursing. During the 1980s she was dean of the School of Nursing at North Carolina Agricultural and Technical State University. In 1996, she was elected to two terms as president of the American Nurses Association (ANA), representing 180,000 nurses in the USA. In 2000, she became deputy assistant secretary for health within the US Department of Health and Human Services. Just prior to joining the NLN, Dr. Malone was general secretary of the Royal College of Nursing (RCN), the United Kingdom’s largest professional union of nurses, from June 2001 to January 2007. Dr. Malone was also a member of the Higher Education Funding Council for England (HEFCE).

In 2010, she was ranked #29 among the 100 Most Powerful People in Healthcare by Modern Healthcare magazine. Dr. Malone is a newly elected member of the Institute of Medicine.

Safety and Security in Africa

Keynote speech

Margaret Mungherera
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Abstract

Introduction

The most vulnerable persons to violence in the African health care setting include patients, family members of patients, health workers (clinical, support, managers) and students. Violence in the African health care setting occurs most frequently in primary health centres, emergency wards, theatres, labour wards, admitting wards, isolation centres, mental health clinics and wards, and management offices. Forms of violence include physical (slapping, kicking, pushing, beating, homicide), psychological (threats, insults) and sexual (touching, groping, hugging, rape).

Magnitude

Violence is a common occurrence as demonstrated by a study carried out in Rwanda 2007-2008 showing that 39% of health workers had experienced some form of violence in the year prior to the study.

Impact

Violence is associated with poor quality of health service delivery and inequitable distribution of health services and results in poor health outcomes, high morbidities and/or mortalities, increased healthcare costs, and increased poverty.

Contributory factors

Factors contributing to the occurrence of violence include:

1. Communities perceptions – causes and treatment of illness, dying and death.
2. Communities' expectations dissatisfaction - quality of health services (availability, affordability, efficiency, effectiveness, patient centeredness, patient safety, lack of constant supply of drugs, sundries, supplies, equipment, services, lack of adequate, skilled and motivated health workers).
3. Gender discrimination - Negative stereotypes of women, discrimination based on pregnancy, maternity and family responsibilities.
4. Demoralised health workers: High work load, long working hours, poor pay, working environment, housing, transport, career development, lack of compensation.
4. Health workers incompetence: compassion, communication, risk assessment.

Recommendations

In order to alleviate the problem of violence in the African health care setting the following recommendations are proposed:

1. Laws (e.g. compensation, regulation of health professionals).
2. Policies on e.g. communication, training, security, burn out, sexual harassment, incident reporting).
3. Protocols (death and dying).
4. Community awareness to be raised in community leaders, patients' organizations, general public, armed forces.
5. Human resource training including communication, risk assessment, inter-professional collaboration, leadership and management, teamwork, healthcare ethics, and mental health.

Another major recommendation is the implementation of internationally developed and endorsed policy statements and/or guidelines such as the 2002 Framework Guidelines for Addressing Workplace Violence in the Health Sector (Training Manual and Guidelines) jointly developed by International Labour Organisation (ILO), International Council for Nurses (ICN), Public Services International (PSI), the World Health Organization (WHO). However, the implementation of such guidelines in Africa is poor and their wider dissemination combined with the political will and commitment of all involved is strongly recommended.

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Dr. Margaret Mungherera is a Ugandan medical doctor specialised in psychiatry. She has been a medical doctor for 30 years and a psychiatrist for 20 years with Forensic Psychiatry as her specific area of interest. She has expertise in training health professionals and Community Health Workers (CHWs), mental health research, human rights advocacy, non-profit organizational governance and development.

Currently she has responsibilities as the Clinical Head of the Directorate of Medical Services (Departments of Internal Medicine and Psychiatry) and is Senior Consultant Psychiatrist, Mulago National Referral Hospital in charge of psychiatry emergency services. Some other selected current or past responsibilities include roles as Visiting Psychiatrist for Uganda Prisons Medical Services, Honorary Lecturer, Makerere College of Health Sciences (2000 to date), member of the Gulu University Council and of the Kampala International University Council.

Margaret Mungherera is a founder member of the Association of Uganda Women Medical Doctors and was the first Publicity Secretary (1995-1998). I have attended Medical Women International Association meetings held in Uganda and Kenya and she was the first woman to be elected Honorary President of the Uganda Medical Association and is the longest serving president of the Association having served from 1998-2005 and then again from 2010 to date. She is President of the World Medical Association 2013-2014.

Other activities of Dr. Margaret Mungherera include the coordination of the piloting of the Istanbul Protocol Implementation Project (IPIP) in Uganda, services for non profit organisations such as The Uganda Human Rights Network, Transcultural Psychosocial Organization (Uganda) and Hope after Rape. She is also an passionate Rotarian and member of the Rotary Club of Kampala West.

Her hobbies include singing, classical music and watching movies.

Safe staffing, patient outcomes and risks to quality in the practice environment

Keynote Speech

Anne Marie Rafferty

Florence Nightingale Faculty of Nursing and Midwifery, King's College London, United Kingdom

Abstract

Patients are more likely to die after common surgical procedures when they are cared for in hospitals with heavier nurse workloads and fewer nurses with bachelor's degrees. The largest investigation of nursing and hospital outcomes in Europe to date studied more than 420000 patients in 300 hospitals across nine European countries, indicating that every extra patient added to a nurse's average workload increases the chance of surgical patients dying within 30 days of admission by 7%, but a 10% increase in the proportion of nurses holding a bachelor degree is associated with a 7% decrease in the risk of death (Aiken, Rafferty et al, 2014). Findings emphasized the risk to patients that could emerge in response to nurse staffing cuts under recent austerity measures, and suggest that an increased emphasis on bachelor's education for nurses could reduce hospital deaths.

To assess whether differences in patient-to-nurse workloads and nurses' educational qualifications affect patients' survival after surgery, we analyzed responses from more than 26500 nurses, and reviewed medical records for 422730 patients aged 50 years or older discharged after common surgery such as hip or knee replacement, appendectomy, gall bladder surgery, and vascular procedures in nine European countries (Belgium, England, Finland, Ireland, the Netherlands, Norway, Spain, Sweden, and Switzerland).

The analysis examined the association of nursing workload and education with patient outcomes, after taking into account each individual patient's risk of death including age, sex, type of surgical procedure, and the presence of chronic conditions such as hypertension or diabetes, as well as hospital characteristics including bed size, teaching status, and technology availability.

The overall percentage of patients who died in hospital within 30 days of admission was low, ranging by country within an average of 1.0–1.5%. However, in every country, death rates varied significantly across individual hospitals, ranging from hospitals where less than 1% of patients died, to hospitals where more than 7% died.

Nurse staffing (workload) and education levels varied widely both between countries and between hospitals within each country. The average patient-to-nurse ratios varied from 12.7 in Spain and 10.8 in Belgium to 6.9 in Ireland and 5.2 in Norway. In Spain and Norway, all nurses had a bachelor's degree compared with an average of just 10% in Switzerland and 28% in England.

The findings suggest that patients have the highest risk of death after surgery in hospitals where nurses with lower levels of education care for more patients. For example, in hospitals where nurses care for an average of six patients each, and the proportion of nurses with bachelor's degrees is 60% or greater, the risk of hospital deaths would be almost 30% lower than in hospitals where nurses care for an average of eight patients, and in which only 30% of nurses have bachelor's degrees.

Findings in Europe closely mirror those from the USA demonstrating that a safe level of hospital nursing staff might help to reduce surgical mortality, and challenge the widely held view that nurses' experience is more important than their education.

Link

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62631-8/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62631-8/abstract)

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Professor Anne Marie Rafferty works at the Florence Nightingale Faculty of Nursing and Midwifery and conducts research on the following topics: Workforce research and policy; quality of work environment; nurse and patient outcomes; nursing history, international and colonial nursing; research and health policy.

Chapter 2 - Evidence of threats to safety

Ethical decision making and zero tolerance: Meeting needs of the patient and healthcare provider

Paper

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Perspective: Guidance

Keywords: Ethics, Home Healthcare, Zero Tolerance, Patient Violence, Provider Safety

Abstract

As the healthcare industry places a greater emphasis on providing patient care in non-institutional settings, healthcare providers are at a heightened risk of experiencing safety hazards from patient violence and aggression. With a goal of providing care in alignment with the Patient Centered Care Model (PCCM), an ethical dilemma arises for agencies when this objective is in conflict with ensuring provider safety. This paper examines these potentially competing objectives utilizing the principles of beneficence and nonmaleficence in relationship to bioethics and the concept of need. Application of two different ethical frameworks, teleology and deontology is utilized to create a framework for healthcare agencies and providers to make morally and ethically sound decisions.

Introduction

There is an increasing emphasis being placed on providing medical and psychosocial care to clients in non-institutional settings (Brennan, 2010; Silver et al, 2011). Fostering a patient-centered approach for providing healthcare services, this shift in service setting has led to increasing utilization of the evidence-based PCCM. Since the passage of the Patient Protection and Affordable Care Act, it is expected that delivery of healthcare services in patient homes will continue to expand (National Association for Healthcare Quality, 2011). As this transition occurs there are increased risks and safety concerns for staff regarding patient violence and aggression.

Health care workers experience one of the highest rates of client violence than any other career field, estimated 16 times higher than any other service profession (Bureau of Labor Statistics, 2006; Janocha & Smith, 2010). This risk is heightened when working in non-institutional care settings (Geiger-Brown et al, 2012) and transcends discipline boundaries, affecting home health aides, nurses, psychologists, social workers, chaplain, physicians and other direct care staff. The consequences of this impact the entire healthcare industry (Kingma, 2001). This is especially evident with home care workers, who are likely to be less effective when working in dangerous environments, experience greater compassion fatigue, decreased job satisfaction and decreased organizational commitment (Barling & Rogers, 2001; Spencer & Munch, 2003). Thus, healthcare agencies face conflicting objectives of providing patient-centered healthcare in non-institutional care settings and ensuring the safety of their healthcare providers.

While policies and guidelines have been developed on federal, local and agency levels to guide healthcare agencies and providers on reconciling these sometimes competing objectives, the question of what is the ethical choice for service setting is rarely raised in the literature. Is the 'ethical' choice to provide patient-centered care in patient homes or to protect the safety and security of healthcare providers? Evaluating the philosophical assumptions within the healthcare industry can help determine which choice is morally correct. This paper examines the concept of need and examines the ethical quandary through application of teleology and deontology. The philosophical application valued by the healthcare agencies then guides decision making for the ethical decision.

Bioethics and Need

The field of bioethics has emerged to provide guidelines for navigating ethical quandaries. Founded in 1969 as the Institute of Society, Ethics and Life Sciences, the Hastings Center was established to promote bioethics and research, providing a framework to resolve ethical dilemmas in healthcare. Founders of the Hastings Center argue that there are multiple principals of justice that arise and that no one principle has precedence (Kass, 2001).

Two primary principles of bioethics which require balancing in selection of healthcare service setting are nonmaleficence and beneficence (Beauchamp, 1994). These principles are examined in relationship to the principle of need as it applies to the patient rights and provider safety. Need is a socially constructed concept including both receipt of healthcare services and avoiding harm to the patient/client and healthcare provider (Daniels & Roberts, 2008). In the instance of patient aggression and violence towards healthcare workers in non-institutional care settings, these two constructs of need can be mutually exclusive. Defining need as that which is minimally necessary to avoid harm and recognition that when conflicting needs arise, the morally correct choice is that which minimizes final injustice (Miller, 1999).

In selection of the most ethical healthcare service setting, the question arises as to whether the final injustice is injury to a healthcare provider when patient violence is perpetrated or is the client not receiving home care in alignment with the evidence based practice PCCM the greater injustice? This question can be answered examining the construct of need, applying teleology and deontology.

Using a teleological approach, an emphasis is placed on the outcomes: receipt of healthcare services and the avoidance of provider harm. In this approach, an action is right or wrong based purely upon its consequences (Beu et al, 2003); the morally right choice is that which provides the greatest good for the greatest number (Richter & Burke, 2007). Teleology prescribes that there are no moral principles which provide justification for an action, intent and action are not relevant concepts, a choice is right or wrong insofar as it results in a 'good' outcome for the greatest number.

The primary concepts within teleology applicable here are those of outcomes justice and utilitarian justice. The idea of the greatest good for the greatest number is a utilitarian approach, however what constitutes the outcome which benefits the greatest number must be evaluated. The concept of outcomes justice must be explored, as outcomes justice is not always able to be predicted. Fortunately in this case, multiple accurate risk assessment tools are offered may aide in outcome prediction (Campbell et al, 2014).

With an outcome goal in the industry of enhancing patient health, wellbeing and welfare, the 'good' outcome is the receipt of healthcare services to the client. This goal however may be met in a variety of settings while also avoiding injury to the healthcare provider. While the PCCM evidence based, it does not prescribe one service setting over another when examining mutually exclusive objectives. As such, a 'good' outcome is also that which simultaneously avoids injury, abuse or violence to the healthcare provider. Verbal abuse, the most common form of patient aggression, is estimated to be perpetrated on anywhere between 33%-87% of home care staff, and prevalence of actual or threatened physical assault is estimated to be between 17% and 74% (Bussing & Hodge, 2004; Magin, 2008; McGowan et al, 1999; Schulte et al, 1998). As the risk of such incidents is heightened when working in non-institutional care settings, the 'good' outcomes are those which do not contribute to verbal abuse or physical assault of the provider.

Further clarification is required regarding the outcome which provides the greatest good for the greatest number. Assuming that patient aggression and violence injuring the healthcare provider results in the provider being unable to continue to provide services to others, the greatest good for the greatest number would be that outcome which ensures provider safety. When patients and healthcare providers are viewed as having a shared responsibility for outcomes, patients and providers both must be considered in this ethical dilemma. Utilizing a teleological approach, healthcare agencies and providers would be viewed as making the ethical and morally right choice by terminating home healthcare services for clients who engage in aggressive or violent behaviors. From the patient perspective, recognizing that healthcare services provided in the home environment are not the sole source of services, patients who become ineligible for non-institutional care services based on aggression may still avoid harm through receiving their healthcare in alternate settings. As such, the greatest good for the greatest number approach would suggest that the ethical decision would be to terminate provision of non-institutional healthcare services to violent or aggressive patients, so long as those patients may continue to receive healthcare services in other settings.

Application of teleology and need can be understood as what is minimally necessary to avoid harm (Miller, 1999). Healthcare services that are provided in the home are not the sole source of services; patients who become ineligible for non-institutional care services based on aggression are not precluded from receipt of services in institutional care settings. Therefore argue that receipt of healthcare services in the home does not meet the 'minimally necessary' criteria. Additionally, personal safety of the healthcare provider ensures the greatest good for the greatest number. As such, termination of home healthcare services for aggressive or violent patients would be ethically permissible, according to the outcomes justice principle of need and a teleological approach.

In contrast to teleology, deontology places a focus on procedural justice (Beu et al, 2003); what is morally right or wrong is determined based upon the application of the principles applied (Richter & Burke, 2007). In this approach, ethical principles must be applied rationally, to provide absolute respect to each individual and not ignoring the rights or needs of some to obtain a greater benefit for others (Wakefield, 1988).

It is possible to utilize the principle of beneficence, in this instance protecting the safety and sanctity of the individual, as the categorical imperative. Another categorical imperative applied in this case could be the mandate to provide healthcare services to the patient. One of the concerns in the instance of patient violence and aggression towards staff is that these two categorical imperatives may be in conflict. When this conflict arises, deontology would suggest looking at the higher categorical imperative.

A criticism of deontology is difficulty determining which categorical imperative is 'higher.' Rational decision-making could facilitate this determination along with the identification of issues and development of policies regarding how to universally address the issues (Bowen, 2005). Another criticism of deontology, is how one determines that the assumptions are valid. For example, the definition of patient aggression and client violence may define client-enacted violence as "actual physical assault, threats, or any other event the individual worker may deem as violent; the violent incident is defined by the worker's perceptions and the context in which the incident occurred" (Spencer & Munch, 2003, p. 534). Utilizing this definition, whereby the worker's perception is key in defining client violence, critics of deontology may argue that this perception is not a legitimate rationale for choosing the preservation of provider safety to be the 'higher' categorical imperative.

In rebuttal, for the choice to be moral it is not the consequences that makes the choice moral or immoral; it is the adherence to the relevant categorical imperative that matters. Therefore, if the categorical imperative is defined as the patient's behavior which results in violence or aggression (perceived or experienced) to the healthcare provider, then the patient is viewed as an autonomous participant dictating the application of a policy or procedure. Focusing on the act, not the consequences of the act, the moral and ethical choice would be to apply a policy or procedure universally, to each and every patient which exhibits aggressive or violent behavior.

Deontology and Need

What is considered need and what is considered harm are, socially constructed. The receipt of healthcare services is a socially constructed and validated human need, receipt of such services is supposed to avoid harm (Daniels & Roberts, 2008). Similarly, the need for personal (and provider) safety is also a recognized basic need. From a deontological perspective, so long as a policy or procedure to address these conflicting needs is universally applied as a categorical imperative, then there is no ethical dilemma. A note of caution, however, termination of homecare services for clients who are assessed as high-risk for aggression or violence towards healthcare staff would require detailed clarification in an agency policy or procedure, ensuring that the profiling of patients does not violate the autonomy of the patient and provider and the relevant principle could be universally applied (Hopton, 1998). Once this determination is clarified and policy is created using a deontological approach, the ethical option one could argue, is to deny aggressive or violent patients home healthcare services.

From a purely pragmatic position whether a teleological approach or deontological approach is preferred by healthcare agencies, the principles of social justice of beneficence and nonmaleficence require operationalized definitions. In this case, beneficence focuses attention on the receipt of healthcare services to the client: not receipt of services in the setting of patient choice. Nonmaleficence addresses avoidance of harm to the healthcare provider and to the patient. The provider could provide healthcare services to patients in non-institutional care settings for patients who do not engage in violent or aggressive behaviors. Patients who are violent or aggressive in the home may still be considered for healthcare services in an institutional care setting.

This paper has discussed the ethical issues that arise when the objectives of providing patient care in a non-institutional setting and ensuring provider safety are mutually exclusive values. Healthcare agencies may embrace principals of bioethics and the concept of need from either a teleological or deontological philosophical approach to better guide decisions regarding the provision of or denial of healthcare services in non-institutional care settings. While alternate approaches may be favored dependent upon the philosophical approach and assumptions valued by the healthcare agency, an understanding of the underlying assumptions and principles employed allows for agencies and providers to justify their decision as morally right or wrong when navigating through the ethical dilemmas arising when providing health care in non-institutional care settings.

Whether utilizing a teleological or a deontological approach, this paper asserts that the 'ethical choice is that which ensures the safety of healthcare providers. The implications of this conclusion suggests that healthcare agencies and administrators should enhance programs and policies to ensure the safety of home healthcare workers. Further research on those programs and policies which best provide this protection would enhance understanding of the phenomena and as well as the ability of healthcare agencies to meet ethical mandates of ensuring the safety of employees.

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Learning objectives

Participants will...

1. have an understanding of the concept of need, as outlined within bioethics and be aware of the ethical conflicts regarding zero tolerance policies in the healthcare industry.
2. know the impact and application of teleology and deontology and differentiate between the two ethical approaches to determining an appropriate healthcare service setting for both the patient and the healthcare provider.

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How does vertical and horizontal abuse (VHA) in nursing transcend time and space?

Paper

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Perspective: Research

Background and context

Nursing scholars have engendered the notion of vertical and horizontal abuse (VHA) in nursing, framing it in subjectivity and power imbalance paradigms, while governments have limited their exploration of the phenomena to the individual, “a few bad apples” (Zimbardo, 2008). Both approaches support the basic principles of neoliberalism. Individualising VHA negates the need to explore it in a broader context such as identifying possible physical, organisational and social determinates that may influence and sustain VHA within nursing.

Current healthcare policy in most industrialised nations including Australia is based on the world view of neoliberalism. With health care reform, the traditional biomedical dominant frameworks shifted to make way for new evidence based approaches. This changed the healthcare landscape both in terms of language, policy structure, management and in the physical architecture of healthcare facilities. Patients have been reconceptualised as consumers and evidence based design (EBD) has taken the place of traditional hospital architecture.

Private and public hospitals are sharing infrastructure and resources, moving away from an organisational position where the hospital took “pride of place”, to environments which are more luxurious, with hotel style receptions and atriums, environments which are more appealing to a consumer. Winston Churchill’s epic statement, “(we) shape our buildings and afterwards, our buildings shape us,” urges us to explore how the physical environment impacts on its inhabitants. Nursing literature has limited studies that have explored workplace environments as a source of VHA.

Methodology

This qualitative study aims to investigate VHA using critical ethnographical methods underpinned by Pierre Bourdieu’s Social Practice Theory to reveal situational factors that may contribute to episodes of VHA in nursing. This study will be conducted in a regional Australian hospital. The fieldwork will take place in 3 different clinical spaces in which nurse’s work within; surgical, medical and acute care units. The observations will be of the interactions nurses make with their environment on a day to day basis. The field notes will be supported by a series of interviews and focus group discussions in order to substantiate the observations.

Findings

Data collection will take place in early 2014 and will include researcher passive observation, informal conversational style interviews with nurses, focus group data, field notes and personal reflections of the researcher. This data will be categorised into themes and sub themes. The themes will be plotted against the floor plans of the observation sites. In true ethnographic style the data will drive the analysis. This paper will present the preliminary findings of the study.

Implications

This study will create a greater awareness of how environments impact on episodes of VHA. As a result of this study hospital and organisational stakeholders will be better informed on the impact healthcare environments have on VHA and therefore influence hospital and organisational design. The potential of this study is to highlight the multi-factorial nature of VHA.

Learning objectives

Participants will...

1. have a greater understanding of the context in which vertical and horizontal abuse takes place.
2. have a greater appreciation for the impact social, physical and organisational environments have on episodes of vertical and horizontal abuse.

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Sexual abuse among female healthcare providers of Karachi, Pakistan

Paper

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Perspective: Research

Background and context

Although high prevalence rate of domestic violence has been reported in every culture and society across the world, however, few data is available regarding sexual abuse among married female healthcare providers.

Methodology

A descriptive cross-sectional study. A random sample (N=350) married female nurses and doctors, from three tertiary care hospitals. Measure self administered modified version of “WHO Multi-country Study” (2005) tool.

Findings

Of the total sample of 350 female married healthcare providers, 97.7% (n= 342) were reported one or more forms of domestic violence at some point in their married life. Whereby, 59.6% (n= 204) reported sexual abuse by their husband or in-laws at some point in their married life. Out of which mainly the husband 94.6% (n=193) created sexual abuse, followed by brother in-law 17.6% (n=36). Participants living in extended families, those who were undergraduate and nurses experienced sexual abuse by in-laws.

Implications

This study identified that sexual abuse is highly prevalent among nurses and doctors. Socio-demographic factors of women who were living in extended family, educated and professional were confronting sexual abuse to the same extent as those who were uneducated and poor. Domestic Violence (Prevention and Protection) Act 2012 has been passed but need strategies and commitment for enforcement.

Learning objectives

Participants will...

1. have knowledge on the background and literature review of sexual abuse among female and specially healthcare providers (doctors and nurses) and identify purposes of sexual abuse among healthcare providers (doctors and nurses).
2. have knowledge of the Heise, Socio-ecological Framework for the proposed study and be able to interpret the methodology of the study.
3. be able to critically appreciate the recommendations to female healthcare regarding the prevention of sexual abuse.

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Debrief Model: a learning tool to investigate inpatient violence against staff in psychiatric hospitals

Workshop

*Dor Bar Noy, Hava Kostisky, Danniell Ben – Shoshan, Yasar Atamna, Alexander Grinshpoon
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Perspective: Organisational

Background and context

Mental Health personnel are at high risk for injury resulting from patient violence in the workplace. Various aspects of the phenomenon of patient violence towards staff in the health system have been thoroughly studied. In most instances, the victims of violence are among the nursing staff because they are with the patients 24 hours a day, and provide primary treatment for violent patients, especially during aggressive outbursts. The nurses that work in forensic units describe their work as an ongoing conflict between their traditional role as caregivers and healers, versus the basic need to avoid patient inflicted harm.

Psychological, physical and verbal patient-aggression negatively impact employees and health care institutions. More than 2% of the US Psychiatric hospitals' budget in 2009 was spent on salaries of employees hired to replace personnel who were absent from work owing to patient inflicted injuries. Research findings suggest that there is an especially high rate of violence in psychiatric, geriatric and emergency departments. Analysis of the causes of patient assaults revealed that patient aggression resulted from the human and physical environments, inappropriate nursing leadership, lack of intra-staff communication, professional knowledge, experience, staff satisfaction, and reduced safety climate. In fields such as healthcare where there are high levels of uncertainty and high risk in decision making processes, it is especially important to foster a climate of safety that is reflected in less aggressive incidents.

Methodology

In 2007 Shaar - Menashe Mental Health Center began using a Debriefing Model (DM) for internal investigation in order to reduce staff injuries caused by patient aggression.

DM is a root cause analysis investigation method that utilizes all the information and data necessary to establish a cause effect relationship of the incident from which lessons can be learned. The DM uses a systematic approach that reinforces a team concept, communication and prevention by investigating the past but focuses on the future and avoids the "Bad-Apple" approach.

Workshop program

The workshop will begin with a description of the instrument used to investigate critical incidents, basic concepts (malfunctions, errors and appropriate actions) and instructions how to use it as a working tool to draw conclusions and write recommendations on departmental and management levels. Participants will then be shown an interview with a nurse who was attacked and injured by a patient. The incident will be investigated using the DM model, and the investigation process and conclusions drawn will be explained (40 minutes). The second part of the workshop will include active participation. Participants will be divided into two work groups, and each will receive a description of an incident that they will analyze using the DM mode. A representative from each group will then present the findings of the investigation, conclusions and recommendations (25 minutes). To conclude, there will be a panel discussion with the participants about the findings of the investigation and the learning processes (25 minutes).

Learning objectives

Participants will...

1. have thorough understanding of the Debriefing Model (DM) and will be able to use it to analyze and ultimately minimize inpatient violence towards staff.
2. gain basic tools to conduct event investigations using the DM.

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Organizational and personal factors influencing the frequency of verbal abuse of registered nurses

Paper

Michael Groves
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Perspective: Research

Background and context

Nurses experience verbal abuse as a nearly daily occurrence in the workplace. Sources of this abuse include patients and their families, visitors, physicians, managers and peers. This presentation will describe and present the findings of a doctoral dissertation study that evaluated the effect of individual and organizational characteristics on the frequency of verbal abuse among registered nurses.

Methodology

The study tested a model of verbal abuse theorizing that abuse frequency is mediated by both individual and organizational characteristics. Anonymous surveys were collected from registered nurses in Maryland, Virginia and West Virginia. Data were analyzed using structural equation modeling and a final sample of 256 participants was sufficient to attain acceptable statistical power. Individual characteristics included in the final model were years in practice and organizational position. Organizational characteristics in the final model were the violence prevention climate and the workplace tolerance for aggression. An additional factor, ANCC Magnet® status was included as having both individual and organizational components. Participants were asked to report the number of verbal abuse episodes, by source of abuse, in the 30 days prior to the survey.

Findings

1. A statistically significant, moderately strong effect for the organizational characteristics construct and a non-significant weak effect for the individual characteristics construct on the outcome variable of verbal abuse frequency.
2. The four observed variables; years in practice; organizational position; workplace aggression tolerance; and violence prevention climate behaved as predicted and had moderately strong effects for the latent constructs.
3. ANCC Magnet® status did not behave as predicted and was not significantly related to either latent construct.

Implications

The findings of the study indicated that verbal abuse of registered nurses may most effectively be reduced through attention to the characteristics or culture of the organization versus attempts to intervene with individual nurses.

Learning objectives

Participants will...

1. be able to describe the influence of organizational and individual characteristics on the frequency of verbal abuse of registered nurses.
2. be able to identify strategies with the greatest potential for decreasing verbal abuse within healthcare organizations.

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Gender violence and aggression: A case study from health educational institutions in South Africa

Workshop

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Perspective: Research

Abstract

Workplace aggression in the health care sector is a well-known phenomenon. However workplace violence in health care education institutions is under represented. Worse still aggression perpetuated by male nurse educators on female nurse educators is not well researched. Many health educational institutions have processes in place to deal with any form of violence against one another but there is no known process used to deal with gender violence known to the researcher.

The purpose of this paper is to report on the findings of two case studies from two educational institutions on the aggression perpetuated by male nurse educators on female nurse educators. The interpretations of the case studies are based on the feministic perspective. The findings support what is already known in literature that men, as a minority in nursing, are protected by the system and have a free way to mete physical, emotional and sexual violence against their female counterparts. The paper concludes by making suggestions aimed at curbing aggression against female colleagues in health care sectors.

Learning objectives

Participants will...

1. learn that gender based violence may occur in educational institutions.
2. have ideas to propose strategies for its minimization.

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Horizontal violence and job satisfaction in hospital staff nurses: The mediating role of peer relationships

Paper

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Perspective: Practice

Background and context

Horizontal violence connotes negative behavior among peers (i.e. staff registered nurses (RNs) who provide direct care to patients) who have the same social standing in a hierarchical institution (i.e. a hospital). Horizontal violence is a major predictor of nurses' job satisfaction, a person's attitude toward his or her work. Amidst the worldwide shortage of nurses, job satisfaction is a critical variable to study because it is a major predictor of nurses' intent to leave their job or profession. Yet, not enough is known about how horizontal violence relates to job satisfaction. To learn more is to identify variables, such as peer relationships (the extent that relationships are supportive among staff nurses in hospitals), that might also be affecting job satisfaction. Thus, the purpose of this study was to describe the extent that peer relationships mediate the association between horizontal violence and job satisfaction. Additionally, the association of nurse and work characteristics to job satisfaction were determined.

Methodology

A random sample of eligible staff RNs (n=175) working in hospitals in California participated via survey in this mediational model-testing study. The Negative Acts Questionnaire-Revised measured horizontal violence. A peer relations subscale of work environment measured peer relationships. A modified version of Brayfield and Rothe's Index of Job Satisfaction measured job satisfaction. Bivariate and multivariate analyses tested the study hypotheses.

Findings

As predicted, a statistically significant negative correlation was found between horizontal violence and job satisfaction and a statistically significant positive relationship was found between peer relationships and job satisfaction. Peer relationships were a strong mediator between horizontal violence and job satisfaction. Job satisfaction was reported as higher by nurses working in teaching hospitals. There were no statistically significant differences in job satisfaction based on gender, ethnicity, basic RN education, highest degree held, size of hospital, or clinical area.

Implications

Findings draw attention to peer relationships as a critical factor when considering effective interventions in hospitals that promote staff RNs' job satisfaction in the presence of horizontal violence. Similar consideration can be made in the broader healthcare context when negative behavior among workers within all levels of the hierarchy impacts job satisfaction. Future research is needed to test the study hypotheses in different populations of nurses and other providers of healthcare in hospitals. Furthermore, other variables that may also be affecting job satisfaction should be identified and tested to better understand the complex relationship between horizontal violence and job satisfaction.

Learning objectives

Participants will...

1. learn of associations between horizontal violence, job satisfaction and peer relationships.
2. be able to use study findings to support peer relationships as a critical factor when considering interventions that promote hospital staff nurse job satisfaction in the presence of horizontal violence.

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Either accept it or leave your job: Sexual intimidation in clinical settings

Paper

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Perspective: Organisational

Background and context

Be it sexual orientation or sexual education, speaking about the word “sex” is uneasy and considered a taboo in many cultures. Although sexual harassment is being reported in several countries, it is not commonly a concept of openly discussed in the Middle East and often goes unreported or under-reported. Sexual harassment, a form of sex discrimination, is one of the most persistent and destructive problems and has increased in recent years.

Methodology

In clinical areas many health care providers are victimized by sexual harassment either by patients, relatives, or even their colleagues with nurses were placed at the top ranking as victims. Many cases go under the table meaning that they will not be reported to avoid feelings of shame, guilt, fear of losing their job and dignity and being labeled by others.

Findings

The stories of violence and sexual harassment are widely spoken among nurses themselves behind closed doors or in the staff resting areas. Tears are shed and scars of the psychological wound stay for ever. As a result, the victimized nurses will turn to what is so called “walking wounded”. In other words, the victims will suppress the negative feeling of violence in which it will negatively influence their psychological aspects and later in their entire life productivity.

Implications

It has been documented that the victim/s may unknowingly react in a violent or unaccepted ways towards colleagues or patients as a coping mechanism. Other victims can simply leave their jobs to avoid experiencing further unwelcomed occasions of sexual harassment. To heal the psychological wounds among nurses, awareness of the concept of sexual harassment and creating safe environment which encourages confidential reporting are highly recommended. By doing that, it will aid the victim to turn from being “walking wounded” to be “wounded healer” who will not only protect her/himself from the act of sexual harassment but also be supportive in the prevention among colleagues and the entire community. Four cases will be discussed:

- A female nurse who was attempting to insert an IV cannula for a male patient and her hand was squeezed and bruised in a bizarre way.
- The female nurse who was sexually harassed by her male colleague who enforced her to date her out of hospital and she as a wounded healer informed the charge nurse.
- The female nurse who was sexually harassed by an escort who hugged her forcefully as he claimed that he liked her and wanted to marry her.
- A nurse who noticed her colleague went through sexual intimidation by her charge nurse through his way of looking at her body and flirting with her continually but the victim did not dare to report it for the sake of keeping her job.

This paper will explore the concepts of sexual intimidation/harassment in clinical areas in a Muslim country elaborating on real stories shared by nurses and will reform strategies to minimize and protect health care providers from facing such situations.

Learning objectives

Participants will...

1. Have knowledge of the impact of sexual intimidation in the health sector.
2. Become acquainted with strategies addressing the problem of sexual intimidation which work in a Muslim society.

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Disruptive behavior among staff in the workplace

Paper

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Keywords: Workplace violence, disruptive behavior, health care environment, verbal abuse, electronic abuse, and physical abuse

Perspective: Research

Introduction

As a nurse with many years of experience, my first thoughts regarding disruptive clinician takes me back to when I was doing a rotation in the emergency department. A nurse was updating an ER physician on the status of a patient and the physician went into a rampage and verbally berated the nurse in front of staff and patients. His behavior was tolerated by the hospital because he was a “good clinician”. No consideration was given to the impact on the work environment. In the past this type of behavior was tolerated but research has shown that disruptive clinician behavior whether it is physician-to-physician, nurse-to-nurse or physician-to-nurse, or any combination of these professionals and staff it undermines the organization (Cleary, Hunt, & Horsfall, 2010). Undermining includes poor morale, high staff turnover, poor communications, poor self-esteem among staff, financial cost, and an unsafe workplace both for staff and patients. The Joint Commission of Accreditation of Health Care Organizations (JCAHO) mandated that all health care organizations establish guidelines to deal with disruptive behavior and “zero tolerance” should be the norm (The Joint Commission, 2008). Even though zero tolerance is the standard, disruptive clinician behavior still exists. Therefore the following research was undertaken to determine the incidence of disruptive behavior among staff in the healthcare workplace, the details that are associated with its occurrence, and the organizational procedures utilized when disruptive incidents occur.

Clinical question and objectives of the study

Do nurses rate their overall work environment free from disruptive behavior and feel confident in being able to address a breach in employee behavior with a therapeutic intervention and avoid reprisal? More specifically, the following objectives of the research include: (1) determine if the nurses view the organization as a safe work environment that is free from disruptive behavior; (2) determine if nurses have experienced verbal, electronic, or physical abuse in the workplace; (3) determine their relationship with the persons and situations in which abuse occurrences are most likely to occur; (4) determine the duration of the verbal, electronic, or physical abuse that occurred; (5) determine the location where the type of abuse occurred; and (6) determine if the organization’s procedure to handle disruptive behavior is used by the nurse.

Disruptive clinician behavior is multi faceted and although efforts have been established to change the culture of an organization to minimize such personal interaction the current research has shown it still exist and is detrimental to all involved. The following definitions and examples were used in the study (Porterfield, 2010).

- Verbal abuse is a statement or behavior that creates emotional pain and mental anguish. Examples of verbal abuse include: withholding, bullying, defaming, defying, trivializing, harassing, diverting, interrogating, accusing, blaming, locking, countering, lying, berating, taunting, put downs, abuse disguised as a joke, discounting, threatening, name calling, yelling, raging, shouting, gossiping, or obscene language.
- Electronic Abuse is a statement or behavior that is reasonable for a worker to interpret as a threat or abuse via email. Examples of abuse via email include: withholding, bullying, defaming, defying, trivializing, harassing, diverting, interrogating, accusing, blaming, locking, countering, lying, berating, taunting, put downs, abuse disguised as a joke, discounting, threatening, name calling, yelling, and raging.
- Physical abuse is the threat or actual physical force against a worker in a workplace that causes or could cause physical injury to the worker.

Methodology

This quantitative, descriptive design used an online survey to ask nurses if they had experienced disruptive behavior within the past 12 months and how this was handled by their organization. Disruptive behavior included any type of verbal abuse, electronic or email abuse, or physical abuse within the work environment.

Subjects and setting

The population for this study was individuals who are licensed practical nurses (LPN), registered nurses (RN), and advanced practiced nurses (ARNP) licensed in the state of Florida and who have been in practice for the past 12 months. Email addresses were obtained through the public domain registered by the Florida Board of Nursing. There were a total of 255,376 total online surveys sent out, and a total of 3,067 participants (1.2%

response rate). The populations that received the emails were: 54,149 Licensed Practical Nurses, 184,317 Registered Nurses, and 13,910 Advanced Practice Registered Nurses.

The tool for this research was a 27 question online survey. Therefore, the healthcare settings varied and included private offices, clinics, urgent care or surgery centers, hospitals, home-health, and rehabilitation facilities across the state of Florida.

Intervention and Data Collection

After the Institution Review Board (IRB) approval, the survey was deployed via Qualtrics, an online survey tool. The potential participants received an informational email explaining the study and its purpose, and contained an informed consent. Individuals who volunteered to participate were asked to go to the electronic survey tool link in the email, which took them to the informed consent and questionnaire. The survey took approximately eight to ten minutes to complete and was available to the subjects for four months.

Results

There were 3,067 participants: 2,512 females (90.1%) and 276 males (9.9%). The majority of nurses (79%) were 31 and older. Seventy percent of the participants were Registered Nurses, with an Associate (AA or AS), Bachelors (BSN), or Masters (MSN) degree. The years of experience varied from five years to greater than 40 years but overall the participants had multiple years of experience. See Table 1: Correlations Between Participant Characteristics and Type of Abuse for the statistically significant relationships.

Verbal abuse

More than 80% of the participants indicated they experience some form of verbal abuse within the past 12 months. Of the 3067 participants a third (1074) of them indicated that a coworker was the abuser, and 673 occurrences where from a manager or supervisor. When asked if they reported the verbal abuse, 109 males (47.4%) and 1, 159 females (54.4%) reported the abuse either by verbal or written report. The disciplinary outcome of the reported verbal abuse was unknown by greater than 70% participants. Of those that knew the disciplinary outcome, 10% indicated that the abuser received verbal reprimand, 2% indicated the abuser received a written reprimand.

Electronic abuse

Thirty-two males (11.9%) and 285 females (11.6%) had experienced electronic or email abuse. When asked about the relationship with the person involved, the largest margin of participants, 19 males (48.7%) and 187 females (51.4%), claimed that the abuser was a manager or supervisor, while 14 males (35.9%) and 113 females (31.0%) reported that the abuser was a co-worker. Less than half of the incidences were reported verbally or both verbally and written. The data indicates that not much was done in regards to dealing with the abuse: less than 8% received a verbal reprimand.

Physical abuse

The majority of participants who experienced physical abuse, 37 males (54.4%) and 275 females (53.8%) reported the relationship with person involved was either a client or patient. Co-workers were indicated > 20% of the time as the physical abuser. The majority, > 96% of physical abuse was experienced in the workplace. Of the participants that experienced physical abuse, 51 males (78.5%) and 393 females (80.9%) reported the incident by verbal or written report. Despite the majority of physical abuse victims reporting the incident, the majority 48 males (71.6%) and 300 females (62.6%), were unaware of the organizational policies followed in dealing with the abuse.

Overall work environment

When the participants were asked how susceptible they believed their work environment was to workplace violence, 137 males (55.2%) and 1,273 females (54.9%) indicated that there was a high risk of workplace violence, 69 males (27.8%) and 661 females (28.5%) reported there was medium risk (experienced at least once every one-five years), and 42 males (16.9%) and 383 females (16.5%) indicated there was a low risk of workplace violence (experienced once in a working lifetime of an individual).

Discussion

This research indicates that disruptive clinician behavior exist in the workplace and it is key in undermining the organizations mission and culture. According to Porterfield (2010) there can be overt and direct disruptive behavior by physician and nurses are more passive-aggressive and are directed more at peers. There is not a clear answer on how to deal with disruptive behavior but Piper (2003) outlines four main contributors: not having a common organizational vision or mission; minimal quality performance standards for all employees; lack of focus on patient safety and patient outcome; and generational differences among the employees. Piper also summarizes that "one size" does not fit every organizations. In order for an organization to move toward a healthy work environment then a review of the culture of that organization needs to occur.

What is not indicated in the statistical results is the number of study participants that emailed or spoke to the authors wanting to tell their story. One individual call me to ask if I was a lawyer as she was in the middle of a legal battle with her previous organization due to verbal and physical abuse and wanted to make sure that our research was not just a ploy to gain information from her for her case.

The data infers that verbal abuse is the most common disruptive behavior among co-workers with physical abuse being second most common. The surprise, for me was the minimal electronic abuse, although the managers and supervisors were responsible for the majority of incidences.

Although this study was only conducted in Florida the question is what is next.

The first thing you can do is ensuring that your organization has developed specific behavior standards and that everyone in the organization knows what they are and how they are handled. Linked with the organizational standards each nurse can do the following (Rosenstein & O’Daniel, 2005; Rowe & Sherlock, 2005):

1. Recognize incivility that disruptive the workplace to include overt and covert activities (passive aggressive emails to coworkers; cell phone texting versus face to face confrontation).
2. Define acceptable standards of behavior and hold everyone to the standards no matter who they are.
3. Recognize when you are being a target of disruptive behavior and doing something about it. Recognize when your coworkers are being targets of incivility and do not tolerate it.
4. Recognize that gossip is disruptive and do not tolerate it
5. Recognize humiliation and degradation of others and speak up and share concerns with each level of hierarchy through chain of command.
6. Explore why nurses do not speak up which can lead to an intervention to correct the disruptive behavior
7. Help establish a vehicle to discuss disruptive behavior problems at all levels.
8. Be a part of the solution, be proactive, be a role model.

Conclusion

Although The Joint Commission mandate for health care facilities to have policy and procedures in place to minimize abuse and its sequela, it is evident that disruptive behavior exists verbally, electronically, and physically, and that the overall work environment is felt to be at high risk of experiencing disruptive behavior. It is imperative that further actions be taken to learn more about the behaviors that exist, what can be done to decrease the incidences of disruptive behavior, and implement strategies that all individuals can buy into in order to be effective. If disruptive behavior is not stopped facilities will continue to see retention problems in nursing and staff, continue putting patients at risk, and unwanted financial burdens.

Table 1 Correlations Between Participant Characteristics and Type of Abuse

Demographics	Verbal	Electronic	Physical
Gender	.452	.880	.032*
Age	.001**	.000***	.472
Position	.000***	.003**	.000***
Education	.009**	.001**	.003**
Years of Experience	.031*	.000***	.675
Note. Significance p < .05 is *, Significance p < .01 is **, Significance p < .001 is ***.			

Acknowledgement

I would like to acknowledge Dr. Charlene Small, a recent Doctorate of Nursing Practice graduate, whose hard work on this research prompts more questions on how we can reverse the trend of disruptive clinician behavior in the workplace.

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Learning objectives

Participants will...

1. Learn of which types of abuse exist in health care in Florida.
2. Be able to ascertain whether the organization's procedures are adequate in handling disruptive behavior.

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Occupational jeopardy and hazards associated with home midwifery care in Egypt

Poster

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Perspective: Research

Background and context

Home midwifery care by professional nurses and birth attendants creates an important area of inquiry into the prevalence of occupational hazards to home visiting employees. It carries the hazard of workplace violence that may be an important source of occupational injury, workplace stress, lost workplace productivity, increased turnover and poor patient outcomes in the home care work setting.

Methodology

A total sample of 167 midwives were surveyed in the period from August 2012 to February 2013. A standard questionnaire in semi structured interview was used in surveillance to assess the prevalence of occupational risks and health hazards. Data was collected among samples of caregivers from both Upper and Lower Egypt.

Findings

Data analysis identified three categories of occupational hazards including biological, social and psychological categories. In biological category, among health workers conducting home midwifery care 29% have risk of unsafe exposure to bodily fluids. About 31% indicated they had experienced a needle stick injury. In consequence health workers are exposed to blood-borne viruses and about 8% are infected with hepatitis C. In social category, midwives are at risk of unwelcome advances, assaults, touching, verbal or emotional abuse. Physical assault was rare and only reported by 2.8% of the sample. In contrary 45.2% experienced verbal abuse from their clients or their relatives. In psychological category, home care givers are under mental stress, fear of violence, emotional or verbal abuse, depression, and intimidation in the workplace. About 17% complained of frequent stress headache and 12% reported that they have hypertension. Regarding cognitive issue, about 23% complained of loss of focus and poor morale that could result in procedural or judgment errors, which reduces productivity and service provision quality.

Implications

The results revealed that insufficient access to clean water, lack of universal precautions for protection against blood-borne diseases, lack of sterile equipment and proper waste management, and exposure to blood-borne organisms carry great hazards to home health care providers. Female health workers may be exposed to gender-based violence as assaults, touching, verbal or emotional abuse. Negative psychosocial environment might adversely affect interpersonal communications and could increase the likelihood of procedural or judgment errors, which reduces productivity and service provision quality. There is an urgent need to examine the home care work environment to minimize risk factors and provide midwives with sterile instruments and clean gloves to decrease exposure to contaminated tools and bodily fluids. Training of service providers is mandatory to properly handle physical hazards and face the probable difficult situations that they might be encountered in the vicinity of home visits.

Learning objectives

Participants will...

1. have knowledge on how to assess the prevalence of workplace violence in the home midwifery care settings.
2. have knowledge on how to analyze risk factors faced by health workers in resource-constrained places and identify avoidable danger that jeopardize home birth attendants.

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The Violence in Emergency Nursing and Triage (VENT) Study in Australia

Paper

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Perspective: Research

Background and context

Violence in the Emergency Department (ED) is a significant concern for all nurses, who have been identified as the group most vulnerable to such violence. This paper presents the major risk factors identified in a national survey of Australian Emergency Department nurses' experiences with patient-related violence in the workplace (The VENT Study).

Methodology

This study involved the distribution of surveys to the 1150 members of the College of Emergency Nursing Australasia. A survey comprising 75 items was developed based on current literature on the topic and tested on an expert panel of nurses to establish face and content validity of the instrument. A response rate of 51% was achieved following the return of 537 completed surveys. Quantitative data were analysed using the Stata software package and free-text answers were categorised using content analysis.

Findings

The majority of nurses reported experiencing violence in their workplace in the preceding six month period: 86% (n=455), while 40% (n = 211) had been involved in an episode in the preceding week. Almost half of those surveyed (49%, n = 224) expressed concerns for their safety at work. Alcohol intoxication and substance abuse were identified as the two main risk factors. Triage (OR 3.63; 95%CI 2.24, 5.9), patient cubicles (OR 3.13; 95%CI 1.93, 5.06), and the waiting room (OR 1.85; 95%CI 1.15, 2.97) were identified as the highest risk areas for violence for nurses working in the ED. There were several additional risk factors reported in this study that could precipitate or contribute to episodes of patient-related violence.

Implications

The results of this Australian national survey confirm that violence from patient-initiated violence is a serious workplace hazard in Australian EDs. This has consequences for the safety of not only for nurses but for people who present to the ED. This problem requires targeted risk-management and prevention strategies to protect nurses at work and minimise the risk of patient-related violence against ED nurses.

Learning objectives

Participants will...

1. realize the magnitude of violence in emergency departments.
2. Be able to name risk factors of patient-related violence in the emergency department.

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An urgent need to address the safety and well-being of hospital 'sitters'

Paper

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Perspective: Research

Background and context

Hospitals in the United States (USA) increasingly rely on sitters (i.e., constant observers) to provide continuous, direct observation of patients known to be at risk of harm to themselves or others. Certified nurses' aides or patient care attendants may fill this role, as may family members. Despite considerable attention on reducing costs and enhancing the efficiency of hospital sitter use, there is a paucity of research or policies addressing the occupational safety and health of this vulnerable workgroup. There is a need for research related to sitters' job exposures and their workplace violence experiences to identify areas in which tailored prevention efforts can be most effective.

Methodology

We conducted a mixed-methods study of 6 hospitals in the USA focused on understanding patient and visitor perpetrated violence against hospital workers (type II), including sitters. At these hospitals, sitters are often nurses' aides, managed centrally through hospitals' float pools and assigned to various units. Sitter utilization is required for patients who are suicidal, committed, in behavioral restraints, or a case of suspected child abuse. Quantitative and qualitative data were collected through hospital staff surveys, telephone interviews, key informant interviews, and focus groups. Previously, sitters were identified as being at high risk of type II violence. Through these analyses, we sought to further examine sitters' roles and workplace violence experiences.

Findings

Eighty percent of sitters indicated they had experienced type II violence in their career, compared to half of other survey respondents. Although sitters expressed fear and anxiety over violent events, violence was also perceived as 'part of the job.' There was a lack of clarity among sitters and unit nursing staff over sitters' roles and responsibilities, in terms of basic patient care and with regard to preventing and responding to violence. Sitters were sometimes asked to observe more than one patient at a time. They expressed frustration over a lack of response from others when calling for assistance with patient care and even when asking for a lunch/restroom break during their shifts. They described not being well-known on units or part of units' teams, with concerns of how this impacts their own safety and that of the patient. Sitters and unit-level staff recognized needs to enhance patient-related communication. All expressed urgent needs for training and educating sitters in type II violence recognition and prevention. However, they described a lack institutional support for such efforts for nurses' aides/sitters, in contrast to opportunities provided to nurses and physicians.

Implications

Efforts to address the context in which type II violence in hospitals occurred revealed a need for comprehensive, enforced institutional policies related to sitters' roles and training, as well as unit-level responsibilities related to sitter use. Such policies are in line with, and should respond to, international calls by regulatory and accreditation groups for all health care workers to be trained in workplace violence prevention.

Learning objectives

Participants will...

1. appreciate that hospital sitters are at high risk of patient and visitor perpetrated violence.
2. Recognize the need for comprehensive, enforced institutional policies related to sitters' roles and training.

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Attitudes towards aggression in psychiatric care in the Netherlands

Poster

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Perspective: Research

Background and context

Violent and aggressive behavior towards clinical staff, other patients and material is a common issue in psychiatric care in the Netherlands. Aggression involves forms of behavior that cause pain or damage to property, including: verbal, threatening, and humiliating aggressive behavior; provocative aggressive behavior; threatening and destructive physical aggressive behavior; suicide and its threatening; and sexual intimidation and abuse. Such behavior threatens people's safety and well-being in the clinical therapeutic environment, and can bring physical, psychological, social and financial consequences for all concerned. Staff is at particular risk of aggression and violence as they are often in the 'front line'. A theoretical model that can explain attitudinal behavior is the Theory of Planned Behavior - TPB, which proposes a relationship between attitudes and behavior by focusing on the behavior antecedents to understand elements that can predict behavior that is not under the individual's volitional control. In the TPB, attitude is directly related to beliefs towards a specific behavior and the assessment of the behavior's outcomes. This theory gives basis to the assumption that, in the evaluation of aggressive behavior, the individual's general attitude towards violence is a key element in conflict management.

Methodology

This theoretical background calls for a research design in which the individual's attitude towards violence shall be taken into account to plan the most adequate intervention aiming to change behavior. In line with this several scales and questionnaires were developed to measure attitudes towards aggression in psychiatric organizations. The present research has considered a thorough literature review on these instruments, selecting the most valid and reliable, which are also often applied in the Netherlands: the Perception of Prevalence of Aggression Scale (POPAS) and the Staff Observation Aggression Scale – Revised (SOAS). These two instruments were applied to a sample of staff and in-patients of a mental health organization in the province of Zeeland, in the Netherlands for an in-depth analysis. The researchers final goal was to select the most reliable instrument to be used as previously and after an intervention to reduce violence in psychiatric care.

Findings

The results of the research will be discussed in the conference.

Learning objectives

Participants will...

1. be aware of the advantages and the disadvantages of scales used to measure attitudes towards aggression of staff members of a mental health facility.
2. identify the reactions of participants of a pilot study to the Attitudes towards Aggression Scale (ATAS) and the accuracy of the ATAS.

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Using power, knowledge, resistance and differences to examine violence in nursing academia

Paper

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Perspective: Research

Keywords: Differences, knowledge, power, resistance, violence

Introduction

Nursing is considered a caring profession. Despite this, violence among nurses is a well documented and significant issue confronting the profession, frequently described in the literature as horizontal violence (Duffy, 1995; McKenna, Smith, Poole & Coverdale, 2003; Walfaren, Brewer, Mulvenon, 2012; Woelfle & McCaffrey, 2007). Horizontal violence involves nonphysical conflicts and antagonistic behaviors such as “sarcastic comments, abusive language, unkindness, discourtesy, divisiveness and lack of cohesiveness” (King-Jones, 2011, p. 81) and includes any behavior that intimidates or demeans another person (Dumont, Meisinger, Whitacre & Corbin, 2012). It has been suggested that horizontal violence has existed in nursing for over seventy-five years, across a wide variety of settings, including nursing academia, and that this phenomena, which has been linked to the culture of nursing, has not been addressed by the profession (Stevens, 2002). When disruptive behaviors are tolerated, and go unchecked, they can become ingrained into the culture (Longo, 2012); “routinized and thus normalized” (Munck, 2008, p. 11). Horizontal violence, defined as “overt and covert nonphysical hostility such as criticism, sabotaging, undermining, infighting, scapegoating, and bickering” (Duffy, 1995, p.9) has a significant negative impact on nursing faculty. Toxic work environments, job dissatisfaction, and physical and psychological stress are all experienced by those impacted. Inability to sleep, anxiety, depression, and poor morale can result from violence, and when employees are impacted to this extent, the overall organization is affected (Applebaum, Semerjian & Mohan, 2012; Dillon, 2012; Namie, 2003; Samnani & Singh, 2012). “Universities and colleges are not immune to acts of violence” (Fletcher & Bryden, 2009, p. 181), and faculty, staff and students may all be affected by horizontal violence (Altmiller, 2012; Clark & Ahten, 2012; Clark & Springer, 2010; Dalpezzo & Jett, 2010; Marchiondo, Marchiondo & Lasiter, 2010; Robertson, 2012). Evidence of harassment, bullying, threatening behaviour, coercion, and favouritism within university departments have been identified (Fletcher & Bryden, 2009).

Wider organizational and environmental issues can also contribute to bullying behaviors becoming accepted (Hutchinson, Vickers, Jackson & Wilkes, 2006). In reality, it can be very difficult to differentiate between the organizational and individual contributions to the issue of workplace violence (Ratner, 2006). In a time of nursing and nursing faculty shortage (Fontaine, Koh & Carroll, 2012), it is imperative that the violence in nursing academia be addressed.

Methodology

As part of a study on violence in nursing academia, we have explored the concepts of violence and power, incorporating the theoretical perspectives of Gail Mason (2002) who examined inter-personal violence and Michel Foucault (1977) who examined power. Mason’s work combines many of Foucault’s insights in her examination of violence; the commonalities and trends within these two perspectives were identified and explored. The development of an understanding of each author’s concepts supported the development of a theoretical framework. The framework was then examined to identify how its use could support the analysis of data for a critical ethnographic research study of horizontal violence in nursing academia.

Findings

Mason utilizes Foucauldian theory in her conceptualization of violence and there are some striking parallels between the way she conceptualizes violence and the way Foucault conceptualizes power. Both authors share common language. Both discuss power and how violence impacts and modifies behavior. There are similarities evident within the concepts and trends. Mason supports Foucault’s conceptualization of power as a productive process, and she builds on this in her theory of violence, which results in differences, some subtle and some more significant.

Foucault identified that power is not owned, but that it is exercised, and it belongs to no one, rather it permeates society. According to Foucault, the success of disciplinary power is grounded in its action on the body (1977). It functions by identifying and creating a hierarchy of acceptable and unacceptable behaviors which form individual subject positions. Disciplinary power is capable of functioning because of an internalization of modern discourse, resulting in “a perfect society in which power seeps into even the most intimate thoughts” (Perron, Fluet & Holmes, 2005, p. 539). Three techniques of control are utilized as part of disciplinary power to

train subjects to fit accepted norms. The first is hierarchical observation which results from the constant threat of surveillance leading individuals to monitor their own actions and behavior. The second is normalizing judgment through which modern subjects continuously monitor their own behavior, constantly judging it against the dominant societal discourse and determining what is or isn't acceptable behavior. The last, examination, combines hierarchical observation and normalizing judgment, and together these techniques function to shape individuals into certain types of subjects who conform to accepted discourse (Foucault, 1977).

Foucault uses the metaphor of the panopticon, an 18th century prison design, to describe the exercise of power and control in society, explaining that it is because individuals feel they are always under scrutiny that they behave in ways acceptable to society and compatible with the dominant discourse (McHoul & Grace, 1993). Just as the constant surveillance of the panopticon resulted in prisoners becoming docile subjects, so too do we become docile subjects through the technique of hierarchical observation. Nursing faculty is carefully monitored and judged by peers, students and superiors, and must conform to the organizational standards in order to meet tenure requirements, resulting in an internalization and normalization of regimes of truth.

For Foucault (1977) violence is always oppressive. It acts in a physical sense upon the body, inflicting physical harm to victims. Mason (2002) agrees that violence is oppressive. Violence constrains everyday life. Fear of violence will restrict activities; it can restrict options for victims or potential victims (Mason, 2002). Even the threat of violence can restrict and impact the way that victims will act and behave, affecting the way they experience their life. Violence shapes how victims resist and respond to violence, and violence affects how options are conceptualized. It is not only through personal experience of violence, the threat of violence itself can result in domination which makes violence oppressive (Mason, 2002). In these respects Foucault and Mason are in agreement.

Mason expands on this, arguing that we should also view violence through Foucault's concept of productive power. According to Mason, violence is an instrument of power, because it acts as a mechanism "through which we distinguish and observe" (Mason, 2002, p. 11). Mason explains that violence works its way into shaping how we view our knowledge and experiences. Violence and the threat of violence both have the ability to change our behavior, influencing how we are formed as subjects. Subjects are targeted for violence based on "hierarchical differences between certain bodies" (P. 10). These differences are viewed as a "threat to the social order" (Lucal, 2003, p. 515), and form individuals into subjects "worthy" of violence. Hence, even as an oppressive practice, violence impacts how we see ourselves. Knowledge of "who" we are, and "what" type of person we are takes place as a result, impacting actions, and informing subject positions (Mason, 2002).

The techniques of discipline which govern disciplinary power can be connected with Mason's concept of safety maps (2001; 2002). She describes safety maps as "ever-changing, personalized, yet shared, matrix of attributes and relations that individuals employ to make their way in public and private spaces" (p. 84). These maps result in the training of the individuals in the accepted discourse as a form of survival against potential violence. In the same way that normalizing judgment results in an internalization of common discourse, shaping personal behavior management, so too are safety maps created based on differences requiring monitoring and shaping. The various ways individuals are singled out as different are the reason individuals are placed at risk of violence in the first place. Mason (2001; 2002) explains that the adoption of some form of safety map within day to day activities and life becomes natural and second nature. The type of violence we believe we are vulnerable to will impact the specific way that our personal safety must be mapped out. In this way it is the forces of power, running like invisible threads throughout society, which create our subject positions and highlight our differences, resulting in the development of our sense of self. Safety maps are used to negotiate these positions (Mason, 2002).

Power provides us with the lens through which subjects identify themselves. Power can be found within all relationships; it is evident in all moments (Alex & Hammarstrom, 2008) and wherever power exists, "there is always resistance" (Perron et al., 2005, p. 541). Mason explains that violence, or the threat of violence, as an instrument of power, will shape and produce our interpretations, and which may result in outward changes such as behavior or dress, in a demonstration of resistance or to conform. How we adopt or reject different identities will impact how we "normalize" our behavior and the behavior of others (Mason, 2002). "Violence manifests at the weak points of domination, where power is in jeopardy....it emerges out of a struggle between power and resistance...it is an instrument for maintaining existing relations of domination and subjugation" (Mason, 2002, p. 129).

Integration of Theoretical Perspectives

By providing a lens to view violence as a productive process, Mason (2002) developed a way to conceptualize violence within Foucault's (1977) disciplinary power. Just as resistance against forms of power can work as a catalyst which brings to light the different methods used to maintain the status quo (Foucault, 1977), so too will resistance against forms of violence bring to light different methods used to maintain the status quo (Mason, 2002). Resistance becomes both an instrument of power and an instrument of violence. A subject is "thoroughly recognized and maintained to the very end as a person who acts" and as a result, who can also resist" (Foucault, 1982, p 789). By connecting resistance with power, resistance with violence, and power with violence, we create a dynamic cycle. How each of these interact and intertwine with each other will impact and shape dominant discourse, influencing subjectivities and differences.

“Power in all moments and in all relationships is changeable; it can be seen as dominant and repressive, also local, progressive, and capillary” (Alex & Hammarstrom, 2008, p. 170). The interconnectedness between power, violence, differences and resistance becomes evident. Each has the ability to manifest itself through the other given varying circumstances. As a result of this level of interconnectedness, there is a triad formed that works to shape the dominant discourse. This provides for the consideration that although violence and power will both shape and inform knowledge, acting as a productive process, there may also be times where violence, as an instrument of power, works in an oppressive manner. However no matter how violence and power are connected, and regardless of where resistance falls in this process, existing knowledge can be reinforced and new knowledge can be produced. In turn this knowledge will act to inform dominant discourse, subjectivities and differences, in a cycle which overlaps, with no beginning and no end. A visual depiction of this process is provided in figure 1.1.

Figure 1.1 Integrated Framework



Implication

Using this integrated framework to examine power and violence will provide for greater understanding of the impact and relevance of violence and power within nursing academia, and deeper understanding of the forces which influence them. What are the statements that violence makes? Unearthing these statements will allow us to identify the influences which enable the enactment of violence in academia. Looking at violence in relationship with other specificities, for example position within the department (part time/full time, full/assistant/associate professor), tenure process, race, and/or gender is expected to lead to a deeper understanding of the relationships between individuals and groups. What factors are evident which result in someone being considered outside the dominant discourse and what is the relationship between violence and the construction of these differences? Examining the experiences of academics through a lens of difference will expose factors which enable the enactment of violence in academia. How do power and resistance work in conjunction with violence to inform this discourse and is there a discourse which has enabled violence to become part of the dominant discourse within nursing academia? If a discourse exists which perpetuates and maintains violence, it must be identified. What is acceptable behavior? What are the specific knowledge regimes, formal and informal, which result in the dominant discourse that determines acceptable behavior, and how are these demonstrated, individualized and normalized? “When humans are rendered recognizable as certain types of individuals we assume responsibility for modifying and constraining our behavior and our sense of self so as to conform to normalized expectations and conventions” (Mason, 2002, p. 20).

Conclusion

It has been suggested that violence has become normalized in nursing (Hutchinson et al., 2006) and when “normalization of the abnormal occurs, violence has begun to achieve its objectives” (Munck, 2008, p. 11). Power is diffuse and invisible, operating in society in complex networks (Foucault, 1982). The concepts of power and violence, and the way they interact with dominant discourse, can be used in order to identify if they are being used to keep faculty in line. Overt and covert violence must be exposed. If we accept that all behavior within cultures, including organizations and professions, is governed by rules and norms then it is vital that the use of violence and power in negotiating and enforcing these rules be considered (Hutchinson et al. 2006). Violence must be recognized as a form of behavior that informs knowledge and makes a statement about those it “objectifies” (Mason, 2002, p. 43).

"We must actively critique the kinds of discourses that facilitate and maintain violence" (Mason, 2002, p. 62). A critical examination of power and violence within university organization practices, and in relationship with the culture of nursing and nursing academia may lead to identification of methods to enable a culture shift to one of greater caring and support for faculty and students. Using this integrated framework to examine power and violence will provide for greater understanding of the impact and relevance of violence and power within nursing academia, and deeper understanding of the forces which influence them. This knowledge will have implications for future research on violence, and it may inform how workplace violence is viewed and managed in the workplace. This framework may provide the structure required to increase awareness and understanding of power and violence within other contexts and geographic locations.

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Learning objectives

Participants will...

1. be able to describe the nature of workplace violence in academia and explain the social/cultural work environments that contribute to workplace violence in academia.
2. identify the purpose of integrating the concepts of power and violence into a theoretical framework.
3. Have sufficient knowledge to explain the influence knowledge, resistance and differences have on the power/violence dyad.

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Gender performativity in nursing: The misuse of discipline and power to construct the ideal nurse

Paper

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Perspective: Research

Keywords: Power, discipline, nursing, male, education, Foucault

"I think there was a requirement to adapt to a certain behaviour, a certain mindset... I started with ten males in my first year, the number of people who graduated from that, there were three....you're failing 70% of one sub-group, it to me ...it doesn't sort of fit" Doug

Introduction

Given its religious and military roots, the western nursing profession relies on fairly stringent discipline and training in order to prepare nurses for today's workplace (Mackintosh, 1997; MacPherson & Stuart, 1994). Students are expected to embody nursing ideals and values, as well as uphold strict standards of practice and ethical principles. This paper discusses some results of a Canadian doctoral study, in which 16 current and former male nursing students (and 4 female current and former students) described their experiences within the nursing education system at the university level. This research sought to explore the concept of gender performativity as it relates to the construct of the ideal nurse and the experiences of male students within this socialization process. Interviews show that this socialization approach toward a (gendered) ideal can result in the misuse of power and discipline, particularly in relation to male students. This environment perpetuates the need to conform and meet the expectations attributed to the construct of the ideal nurse. For a male within the education system the results of this process can be demoralizing, marginalizing, and even devastating.

Power: Theory and Impact in Nursing Education

Foucault defines power as a relation that can be both repressive and productive, with the aim of turning subjects into useful and productive members of society (Perron, Fluet & Holmes, 2005). The fundamental motive of utilizing power is to regulate behaviours and practices within a structure (Foucault, 1995). However, the use of power can also repress and dominate, resulting in subjectivities that may be taken as natural or predetermined, but are in fact constructs of the exercise of power (Widder, 2004). When the use of power results in a (female) gendered entity that does not resonate with male students, they experience frustration, stress and a sense of not belonging.

"I felt like I was in the wrong place...I don't know, just kind of felt hopeless and confused about what my role is" Brad

The productive exercise of power, particularly disciplinary power, results in the creation of "docile bodies". A docile body is one that can be subjected, used, transformed and improved (Foucault, 1995). It is not necessary to have complete standardization of the body, but only to ensure behaviours and thoughts fall within an acceptable, normalized range. The purpose of this creation is to increase productivity and create a body of subjects who work with the desired techniques and efficiency that is needed, for a specific task. It melds domination and aptitude to increase capacity and obedience (Foucault, 1995). Power is not only restrictive but also plays a productive role in constructing institutionalized routine practices. This power is not meant to be merely a controlling force but is used to govern institutional life and meaning for the members of this institution. This results in a hegemonic way of thinking and doing that regulates day to day practices and routines and defines the meaning of life within the institution (Mumby & Stohl, 1991). The establishment of practices and routines, through the use of power, is used to set standards for acceptable behaviours. In nursing these standards are based in traditional female characteristics attributed to the ideal nurse. Inability to conform to these standards can result in the exercise of power and discipline.

I felt like students weren't supported, it was either you fit into the program or you don't... there's this end goal and you have to do what they say to be able to get there." Did the end goal have a particular look to it? "Oh yes, it was totally a female nurse in a hospital doing bedside nursing." Karen

Norms, for example, are a key feature of the successful and effective government of individuals. Norms are based on knowledge, which establishes comparative ideals designed to manage and categorize individuals (Perron et al, 2005). When combined with partitioning, which distributes individuals within a defined space with the purpose of monitoring their behaviours, it transforms a heterogeneous mass of disparate individuals into an orderly ensemble of subjects onto whom disciplinary measures can be applied. The purposeful containing and distribution of individuals to specific areas within a designated space, such as classrooms, labs, and clinical settings, goes further to ensure surveillance and control (Perron et al, 2005). In the context of nursing education

these measures are seen in the need for students to conform to schedules, dress codes, codes of behaviour and the learning of precise nursing techniques. The result is power being exercised over all aspects of individuals' lives, rather than their body alone (Foucault, 1995). Control over students is substantially experienced by male students, whereby the need to conform and meet predetermined expectations related to behaviour, dress and skill performance is amplified and extends beyond the experience of female students. In the case of male nursing students, this critique encompasses every aspect of their performance, including their motive for entering the profession.

"In clinical teachers kept a closer eye on the male students in comparison to the females at first...just to kind of see where we were coming from." Jeff

The primary goal of training of individuals is to create a machine, moving together with other bodies to achieve a desired outcome, not necessarily in unison but in concert, understanding each one's role and moving efficiently and harmoniously towards a pre-determined end. To achieve this level of training, the use of disciplinary power is required. Disciplinary power is simultaneously individualizing and totalizing, focusing on both the individual and groups. Nursing training operates through the education of large groups of students to become nurses, to be productive members of the healthcare community. However, simultaneously this training is working to socialize individuals, moulding them into skilled and competent professionals who conform to the construct of the nurse, as the profession and society envisions it. This process of disciplined training is socializing the student nurse to meet a female gendered ideal; thus the system is designed to meet the needs of the female majority.

"If you have a minority of males in a majority of females, you teach the majority, and unfortunately the minority sometimes just has to conform and adapt. I think it's that conforming and adapting that can be very difficult"
Doug

Foucault (1990) also discusses sovereign power, which involves obedience to the law of a central authority figure. Metaphorically, the sovereign figure has power of life and death. This metaphor can be used in the context of nursing and nursing education. One such sovereign figure is the College of Nurses under which nurses attain and maintain their licence. If a nurse breaches the standards of practice or "laws" delineated by the College, s/he is subject to punishment, up to the revocation of his/her licence to practice (or metaphorically, professional death). The same can be true in nursing education: if the student fails to conform or meet expectations the authority figure within the school has the power to fail the student. There is a need on the part of the instructor to establish this perception of sovereign power over the students. This is necessary for the socialization process to proceed and acceptance of the construct to occur.

"They feel that there's a need to make an example of someone to sort of assert their power or their dominance over a group....they pick someone that they feel they can take advantage of without significant repercussions"
Doug

Discipline; Theory and Impact in Nursing Education

Power is the structural determinant of identity formation within an institution, because discipline produces specific kinds of subjects. Though at times invisible, power continues to be present and exercised through the implied discipline and threat of sanction. Various forms of sanction including segregation, disparaging remarks and increased surveillance are often reported by male nursing students as a result of an inability to conform to the desired (female) identity.

"I felt like I was kind of discriminated by my profs it just sort of came across that they didn't want me there. In front of the entire class, she called me heartless for no reason" Brad

Methods used to discipline are often closely related to the acquisition and dissemination of knowledge within the institution (Deacon, 2002). In Foucault's view (1990) this is made possible through the gathering of knowledge about subjects' performance measured against established norms. In the context of nursing education, knowledge is acquired through examinations, performance reviews, direct observation, review of student journals, and quizzing. If a student's performance falls below expectations, it triggers a series of measures to facilitate the student's progress (one-on-one meetings, counselling, learning contracts, remedial lab activities, etc.). These measures exemplify an intensification of disciplinary power intended to realign a subject with expected norms. In this study, male students report a disproportionate use of such disciplinary techniques and perceive being expected to perform at a superior level to female students, only to be considered to meet minimum expectations. *"I felt like they were trying to get me to drop out, but without failing me. Because they didn't have any grounds to fail me. I did not get the marks I deserved, I had papers reviewed by other profs and they would have given me 92 but I got 62"* Brad

Discipline is a highly effective way of exercising power because it does not rely on coercion or oppression. Students are willing participants in the education process as they seek the learning of new behaviours so they can become nurses. They thus accept educators' expertise and authority, their own status as students and the need to conform and self-regulate.

One of the tenets of a nursing program is the concept of students as self-directed learners. This aspect is stressed to students, and their ability to internalize this objective is seen as a sign of professionalism. Achieving this objective is not only a criterion for success but in actuality perpetuates discipline: through self-direction students learn to regulate themselves, assess their own performance, identify learning needs, and take responsibility for

their learning. However male students report receiving contradictory messages regarding self-evaluation and reflection. In institutions where participants had trained, one evaluation component revolved around identifying and discussing ones' feelings, particularly as regards clinical experiences. However, these reflections may be judged and ranked based on gender influenced expected responses, which may not be congruent with male students' emotional responses.

"They push for males to express themselves. Okay, well, now I express myself and I'm being penalized for it. It just wasn't the feelings they wanted to hear. I was failed because of it" Doug

The establishment of self-governance within the student population leads to the decreased need for professors to maintain direct supervision at all times. Students internalize rules, norms and standards and therefore come to exercise power over themselves in order to successfully complete the program. Self-monitoring continues outside of classrooms and clinicals. Behaviours are internalized to such an extent that they shape students' behaviours at home and elsewhere. According to Foucault (1995), decentralization of power is integral to its discrete and ubiquitous operation. The government of individuals is achieved by the dissemination of various messages, directives and policies regarding proper ways of living one's life or taking care of oneself. Such messages penetrate each individual in such a way that they become internalized:

external imperatives are internalized as private interests (...) The practice has become habit, a practice of the self perpetuated not by the dictates of external imperatives but by the individual's habits of everyday life (Petersen & Lupton, 1996, pp. 70–71).

The ongoing awareness of being monitored by peers, managers and patients contributes to the desire to conform to expectations. There is a sense of constant supervision and training that results in control over individuals' activities and, to a large extent, thoughts. Discipline is meant to discriminate between that which is desirable and that which is not, bringing the "deviant" behaviours back to normalcy. The use of punishment through normalizing judgement allows for the process to compare, differentiate, hierarchize, homogenize and, perhaps, exclude (Foucault, 1995, p. 182).

"My palliative patient didn't want a bath, he was too tired so I opted to negotiate with him that we would do a partial bed bath...I was told by my clinical instructor that that's not acceptable....it was not discussed again that day. I showed up the next day and was told I was not safe to provide care... I spent 8 hours that day folding laundry.... I was so hopeless, I felt powerless....I was so embarrassed" Doug

This need to normalize and conform is felt at an enhanced level by male students who are being asked to adhere to norms that are constructed for a female majority.

"I would say to make it through nursing school, you have to kind of be compliant..... women have a tendency to be more docile and... generally speaking, to be more accepting of what is said. Men maybe have a bit stronger personality, more of a male characteristic to get into conflicts and confrontation...maybe that could contribute to why they would succeed less, not as well as a female. I always tried to stay clear of confrontations with the instructor, they mark you and there is some subjectivity to the assessment" Jeremy

These two procedures, observation and judgement, come together through the use of examination. Examination results in an exercise and reminder of power, all the while delineating the individual's ability to perform at a normalized standard. Various methods of discipline assist in ensuring a sense, on individuals' part, of belonging or being a part of an important institution. In various institutions, these include mandatory uniforms, set meal/break times, specific expected behaviours, standardized procedures and methods of documentation. All of these means of discipline form part of nursing education and socialization. Male students have identified that they are ill prepared for such disciplined environment, particularly as it relies on a gendered ideal.

"It was huge eye-opener how strict it was. I had no idea it was going to be so extremely strict and rigid...if your late for class, your locked out...if you hand in assignment late often you get a zero....if you come late for clinical you get sent home and you could end up failing. I couldn't sleep before clinical I was so worried...it's just a really stressful experience" Jeff

Conclusion

Within a nursing program the principles of self-governance and internal discipline are stressed in both theoretical content and clinical practice, making them pivotal in the socialization to practice. Students are socialized into professional standards, and the notion that deviation from set behaviours outlined within the standards can lead to reprimands, in the form of discipline. For students discipline may be overt in the form of failure but it may take the form of subtle use of power to govern, mould and create "docile bodies". Nursing students may well perceive a sense of constant supervision and evaluation of their performance. While the therapeutic, political and ethical benefits of self-regulation, professional governance and discipline are important, there remains a possibility of misuse of disciplinary, observational power within nursing educational settings. For males attempting to integrate a female gendered profession the (mis)use of discipline and power is seen as an attempt to set an example, enforce norms and potentially eliminate those who are unable to conform and do not fit the construct of the ideal nurse.

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Acknowledgements

Thanks to the Ontario Graduate Students Scholarships that have assisted in the funding of this research.

Learning objectives

Participants will...

1. have an understanding of the psychological damage done to male nursing students through the socialization process experienced within a nursing program.
2. learn an example of the misuse of discipline and power within the educational environment to attain gender performativity and the socially constructed ideal nurse.

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Understanding underpinnings of acts of violence against polio workers: A case study of Pakistan

Paper

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Perspective: Policy

Keywords: Polio workers, Workplace violence, Target killing, Occupational safety, Community health workers, Pakistan.

Background and context

Workplace violence is a threatening, worldwide public health problem and is one of the most complex and dangerous occupational hazards faced by health care workers working in hospital or community based setting in today's health care environment (Mc Paul & Lipscomb, 2004) (Pinar & Pinar, 2012). A 1994 British study estimated that health care workers had 1 in 200 chances of major injury from violent client i.e. health care recipient each year (Hinson & Shapiro, 2003). The real size of the problem is only tip of the iceberg. Community health workers are at greater risk than others. It has been found that violent threats and incidents are commonly made towards public health field workers (Joann M. Schulte, Nolt, Williams, Spinks, & Hellsten, 1998). Not surprisingly, staff who work directly on the frontline are more vulnerable to episodes of physical violence from general public (Hinson & Shapiro, 2003). Violence can range from verbal assault to physical, psychological or emotional and sexual. However in most severe cases episodes of violence can result in loss of life of health care worker.

Pakistan has been a victim of violent conflicts since its inception. These conflicts vary in nature including sectarian conflicts, ethnic and linguistic conflicts, religious and political conflicts, conflicts over provincial autonomy etc. (Zehra, 2012). The cases of targeted killing of health workers in Pakistan are reported very frequently. Especially polio workers have been targeted at irregular intervals in the past (Gulland, 2012). Targeted polio worker killings in Pakistan are making headlines both globally and nationally. In 2012, after polio transmission interruption in India, it was believed that by making significant programmatic improvements the remaining three endemic countries i.e. Pakistan, Nigeria and Afghanistan can achieve polio free status. However, targeted killing of polio vaccinators in Pakistan, ban on polio vaccine by Taliban commanders in Waziristan and dismantling of national structure for managing polio eradication came out as a challenge and threat to global health and more significantly health care provider's safety (Donaldson, et al., 2014). Violence against polio vaccine workers, particularly the killing of female workers in Karachi and Baluchistan signifies need for urgent reprogramming of Pakistan public health approach (Khan, 2013).

This article examines the current situation of militant's violent act against polio workers in Pakistan. The paper highlights foundations and magnitude of the act of violence along with complexities. Recommendations for macro-level intervention that involves incorporation of information technology tools are proposed, and implications for government are addressed.

Methodology

Case Study Description

Pakistan is one of the three countries where polio is still categorized as endemic viral infection (CDC, 2006). In 2011, Pakistan became the global epicenter of polio, with more cases than any country in the world (Owais, Khowaja, Ali, & Zaidi, 2013). October 2011 report on an Independent Monitoring Board (IMB) of the Global Polio Eradication reveals that "Pakistan's progress now lags far behind every other country in the world. Without urgent and fundamental change, it is a safe bet that it will be the last country on earth to host polio" (Donaldson, et al., 2014). In 2013 Pakistan has been the major contributor to confirmed cases of polio as compared to Nigeria and Afghanistan. As per WHO, Pakistan recorded 91 cases of polio last year, up from 58 in 2012. In 2014, 54 children have been paralyzed by polio in a country which is four times high as rest of the world and nine times high as at this time last year (Donaldson, et al., 2014). Polio eradication Campaigns have suffered major obstructions because of severe resistance and violence from community i.e. from refusal, verbal threat, kidnapping and more significantly to killing or loss of life.

In December 2012, militants murdered 9 polio workers in Pakistan and the killing has continued into 2013 with death toll of more than 40 people including health and police guards have been killed during anti-polio immunization campaigns (IED blast injures lady health worker, 2013) (Khan S. , 2013) (Polio vaccination workers shot dead in Pakistan, 2012) (Gunmen kill police officer protecting polio workers in Pakistan, 2013) (Walsh & Khan, 2013) (Closser & Joama, 2013) (Fetene & Sherani, 2013). Workers going door to door for delivering polio vaccine have been abducted, beaten and shot, faced physical harassment and assassination, and have been targets of bombing at health centers. The episode of violence against vaccination workers has increased over past year. These fatal attacks on polio workers have drawn attention of many concerned

authorities including government and non-governmental agencies regarding safety and security of polio workers. Human rights commission of Pakistan (HRCP) condemned these killings and demanded arrest of perpetrators. Furthermore, WHO has called off their campaigns as a result of these killings (Burhan & Hasan, 2013). However, sadly it can be said that despite all efforts the issue of overcoming violence act towards polio workers is not sufficiently handled over the period of past two years and to date vaccinators lives are threatened.

Findings

It is not known precisely who is behind the attacks on Polio workers or why they have been targeting this specific group of healthcare workers (Abimbola, Malik, & Mansoor, 2013). However, it is widely thought that the action against polio workers may be driven by three major reasons i.e. (1) Militant groups perceive vaccination campaigns as a cover for spying as was the case when Central Intelligence Agency (CIA) used a fake Hepatitis B vaccination campaign to hunt Osama bin Laden. (2) Misconception about polio drops leading to infertility and (3) Religious and social perspective that mainly focuses on religious Fatwas that strongly discourage women to go and work in field. The factors that have aggravated this particular scenario include mainly the element of deception and covert data collection that had led to mistrust upon medical community.

Vaccination program as cover for spying: The primary objective behind these violent acts is understood as to stop the house to house movement of polio workers, who some terrorist groups suspect of carrying out surveillance activity to identify wanted persons (Abimbola, Malik, & Mansoor, 2013). Polio workers began to face violent resistance from militants after it was revealed in 2011 that CIA had used a Pakistani Dr. Shakil Afridi to run a fake Hepatitis B vaccination program in Bilal Town at Abbottabad to obtain DNA from Osama bin Laden's suspected hideout (Heidi, 2012) (Bin Laden death: 'CIA doctor' accused of treason, 2011) (Abimbola, Malik, & Mansoor, 2013) (Closser & Jooma, 2013) (Gulati, 2013) (Deonandan, 2012). Although, the CIA has acknowledged that the Hepatitis-B campaign was implemented for the reasons unrelated to public health however actual injections were real and can therefore it is argued that this campaign should be considered a valid public health intervention (Ukman, 2011). On the contrary, the report suggests that the duplicitous nature of the vaccine's delivery did not allow for provision of the follow-up dosages required for proper conferral of immunization against Hepatitis-B (Chambers, 2011). Therefore, distrust of people over vaccination campaigns endangers safety and life of the healthcare worker.

Myths associated with Polio vaccine: The second major reason thought behind the attack on polio workers is perception by certain groups in community that USA was using immunization campaigns to sterilize the Muslim population and deter the will of God (Khan S. , 2013). This myth started after the September 11 attacks. In Pakistan, low literacy rate and health disparities further strengthen misconception that lead to mistrust upon public health policies. It has been declared by Taliban that vaccination programs are western ploy to render Muslims sterile by alluding to the fact that it was receiving foreign financial assistance. Based on this programs' funding was then taken over by Pakistani government with the assistance of the Bill and Melinda Gates Foundation (B&MGF) however, the cases of violence has not been decreased even after this change (Gulati, 2013). Another misconception is that the polio vaccine contains materials forbidden by Islam, such as alcohol and pig's blood (Shackle, 2013).

Religious and social perspective: Religious and social perspectives are also of equal importance here. Low acceptance of female healthcare worker in field and negative perception of these female workers as being hired by western agencies and being involved in un-Islamic or anti-Islamic activities, had led to general resentment amongst communities. In tribal areas of Pakistan, gender roles for men and women are strictly defined and each individual is expected to adhere with their role and behavior associated with either gender. In tribal regions of Pakistan role of women is restricted to traditional child bearing and rearing, domestic and familial responsibilities, whereas men are expected to be the bread earners and they take part in social, cultural and religious activities outside home (Zehra, 2012). With these stereotypical ideas the communities do not easily accept the presence of women in field as these are considered as western concepts which are associated with western agendas with a motive to ruin the social foundation of the communities.

Implications and Recommendations

The literature suggests that violence can no longer be seen as an individual issue rather it must be viewed in terms of structural problem requiring action from organizational level on a number of fronts. Violence cannot be totally prevented but the risk of violence and its negative impacts on the individual can be reduced with carefully considered planning and swift action following a violent event (Hinson & Shapiro, 2003). Therefore following recommendations are made:

Providing assurance: In past public health activities especially vaccination programs have already suffered from public distrust. The use of a public health activity under false facades undermines significantly the validity and effectiveness of international public health endeavors (Deonandan, 2012) and it has also disrupted community trust upon healthcare workers badly. Concern has been voiced in international public health community about the damage that this operation has done to the effectiveness of real public health campaigns, current and future. It is time for agencies and governments to declare that health and development programs will no longer be used as cover for violent or subversive adventures (Deonandan, 2012).

Providing safety to health care workers: All healthcare workers have right to work in a safe working place. The safety of healthcare workers should deserve same priority as patient safety (Pinar & Pinar, 2012). Therefore first we must insist on zero tolerance of violence against health care workers in any setting either community or hospital. In order to keep the hope of eradication alive by not endangering lives of healthcare workers, the government must ensure security to health workers and recognize the available local health workers in order to raise community access and compliance to the service significantly (Burhan & Hasan, 2013). Close monitoring of anti-polio immunization campaigns and security of workers is essential to ensure accountability. The worker carrying out campaign against polio must be secured and provided good transport facility (Bhootrani & Tahir, 2012).

Clarifying misconceptions: Pakistan needs to instill motivation, dedication, honesty and trust between healthcare providers and the community (Khan S. , 2013). It is therefore strongly suggested that efforts should be made by government to clarify misconception at community level by using strategies of dialogue. The government should seek assistance from religious scholars for eliminating false misconceptions that would help counsel the mindset of the masses (Burhan & Hasan, 2013). Driving a campaign against fundamentalist forces propagating negatively against polio and attacking polio workers by use of electronic and print media, religious scholars, clerks and teachers can also be done (Bhootrani & Tahir, 2012). Public awareness is a key for getting acceptance and compliance that can diminish fatal attacks on polio workers. The strategy for public awareness can be frequent seminars, symposia and walk. In addition, special teaching program and sitting with family to aware them about polio and its transmission might help getting acceptance from community (Bhootrani & Tahir, 2012). Furthermore, health workers in tribal areas can cite Quran versus that encourages the care of child and reach out local religious leaders for support. (Kulger, 2013)

Inculcating ownership: Steps should be taken to ensure that locals see polio eradication as a social problem and start taking ownership of its campaign. Forceful reinforcement, involvement of coercion and military strategies might not be right approach to handle this sensitive issue. Rather working directly with community leaders and members to clarify myths about polio vaccination can help stabilize this situation.

Use of information technology tools: Introduction of better tools by incorporation of information technology like monitoring through SMS and global information system (GIS) needs to be implemented to determine accurate coverage and fake campaign identification at early level.

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Learning objectives

Participants will...

1. be able to identify the current issue of violence over polio workers in Pakistan.
2. be able to demonstrate understanding of complexities and reasons of violence act.
3. be able to discuss strategies for overcoming this issue.

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Implicit attitudes towards violence: Relations with aggressive and social behavior, and treatment implications

Paper

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Perspective: Research

Background and context

Attitudes often play an important role in the onset of behavior, including violent behavior. In attitude research, a differentiation is often made between explicit (or conscious) attitudes and implicit (or unconscious) attitudes. Explicit measures of attitudes include self-report questionnaires and are assumed to be predictive of behavior under conditions in which both sufficient cognitive resources and the motivation to act according to the explicit attitude are present. If these conditions are not met, individuals tend to show impulsive behaviors that are not in line with their explicit attitudes, but more related to their implicit attitudes.

Methodology

In our study, we investigated if implicit attitudes towards violence, which were assessed by means of an Implicit Association Test (IAT), were related to measures of psychopathy, aggression, and socially adaptive behaviors in a sample of forensic psychiatric inpatients (N = 110).

Findings

Results indicated that there was a significant positive relation between attitudes towards violence and antisocial psychopathic tendencies. Furthermore, it was found that negative implicit attitudes towards violence were significantly associated with prosocial behavior, coping behavior, and the level of moral reasoning. These results suggest that relatively positive implicit attitudes towards violence may be implicated in the formation of antisocial behavior, while negative implicit attitudes towards violence may have an inhibiting effect on aggressive and antisocial tendencies.

Implications

Implications for clinical practice will be discussed during the presentation. In our opinion, implicit attitude change may be an important treatment goal for the prevention of violent behavior in various situations in which patients are unable to control their impulsive behavior. Special focus will be on the treatment environment that can have an important and maybe even crucial contribution in changing aggression-related implicit attitudes.

Learning objectives

Participants will...

1. have an understanding in which situations violent behavior is guided by implicit cognitions and less by explicit cognitions.
2. learn strategies to adjust implicit attitudes toward violence in forensic patients.

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Policy of discrediting of medical community in Georgia from Soviet era to nowadays to redaction-team

Poster

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Perspective: Policy

Abstract

The witch-hunt on medical doctors has its historical roots in Georgia and began in the late fifties of the 20th century, in Stalins' Soviet era. The criminal cases were launched against the group of Soviet doctors who had been accused plotting to murder of some Soviet leaders. After arresting a group of prominent soviet doctors a campaign against medical doctors spread to the whole country. It started after the death of one of the Soviet leaders Andrei Zhdanov, who was the major perpetrator of the Great Terror. After cardiac complains, he was transferred to the sanatorium, where he died. Possibly his death was the result of an intentional misdiagnosis. Only after the death of Stalin, the new Soviet leadership stated a lack of evidence and the case was dropped. Soon after, the case was declared to have been fabricated and the victims were rehabilitated.

The second wave of violence on doctors started in Brezhnev's era of stagnation. In Georgia in Shevardnadze's epoch slogans used by media for estimating medical misdiagnoses became very popular. A campaign was directed against doctors who took money from the patients due to the low salary of the medical personal. These doctors – the “bribe takers” – were denounced by the mass communication media.

The last wave of violence on doctors started several years ago, at the period of Independency, soon after the “Rose Revolution” and reached an unprecedented level. Every day mass communication media was broadcasting to the country, that many patients had died due to doctors' mistakes, without any professional commission's discussion of medical cases. Several famous professors, and ordinary medical doctors, were arrested. A “noisy” series of arrests on doctors were provoked by authorities, in order to further compromise the doctors and diminish the protests of the medical community during the period in which public hospitals were privatized. In the last years the situation has changed, but the inflicted damage to the medical profession is irreparable. As patients and their relatives have lost much trust in medical professionalism it is hardly surprising that doctors are confronted on a daily basis with aggression, distrust, and sometimes with threats of prison and death.

Implications

The medical community of Georgia needs policy changes to restore the trust of the population in the medical profession and thus to assure that persons of the young generation will enter this profession.

Learning objectives

Participants will...

1. have an understanding that a government's policy of distrust of the medical community may lead to the decline of the quality of the medical care of the country, especially in developing states.
2. will acknowledge that the National Medical Staff Association must be involved in attempts to restore the trust of the population in the medical profession.

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Qualitative evaluation of a role play bullying simulation

Paper

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Perspective: Research

Background and context

Novice nurses are at high risk of bullying victimization within two years of starting nursing practice. These behaviors negatively impact novice nurses' ability to practice safely and productively; therefore, efforts need to be enacted to reduce the adverse impact these negative behaviors have on novice nurses. The purpose of this study was to examine a novel role play simulation designed to prepare nursing students to manage the bullying behaviors they will encounter as novice nurses.

Methodology

A qualitative descriptive design was used to evaluate the bullying intervention implemented for this study. The role play simulation intervention was delivered to two classes of senior nursing students on two college campuses. Sixty-five full-time pre-licensure baccalaureate of science nursing students participated. After delivering the intervention, all students were invited to participate in a focus group session to discuss their experiences as learners during the simulation. There were no exclusion criteria. Sessions were audio-recorded and transcribed verbatim. Transcripts were analyzed using Colaizzi's procedural steps in phenomenological data analysis including line-by-line coding and clustering significant statements into themes. The data were managed using NVivo 10. Qualitative rigor or the determination of trustworthiness (comparable to validity and reliability in quantitative studies) was performed as described by Lincoln and Guba criteria.

Findings

Eight students participated. Seven participants were White and one was African-American. The primary language for all participants was English. The mean age of students was 35 years old and ranged from 23 to 45 years old. Fifteen nodes were derived from the data and clustered within four themes. Theme 1 was "The Experience of Being Bullied" and reflected the bullying the participants experienced during their lives. Theme 2 was "Implementation of the Program" and reflected the effectiveness or recommendations for improvement of role play simulation. Theme 3 was "Desired Outcome of the Program" and reflected the knowledge attained from the intervention. Theme 4 was "Context of Bullying in the Nursing Profession" and reflected the dichotomy of being victimized vs. advocating for their future patients as practicing nurses.

Implications

Role play simulation was an effective and active learning strategy to diffuse education on bullying in nursing practice. Bullying in nursing was identified as a problem worthy of incorporation into the undergraduate nursing curriculum. To further enhance the learning experience with role play simulation, adequate briefing instructions and comprehensive debriefing are essential. Further research is needed to correlate the knowledge of managing incidents of bullying to the application of this knowledge in nursing practice with novice nurses.

Learning objectives

Participants will...

1. be able to state the prevalence of bullying against nurses in the United States.
2. Be able to evaluate a bullying role play simulation.

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Health care practitioners who harm their patients, clients and communities: Sex, lies and violence

Workshop

Eric Hickey

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Perspective: Practice

Background and context

Changes in health care delivery brings additional focus on the quality of such care and the potential for abuses to occur. From malpractice to looted bank accounts, to rape by fraud, suicides, and homicides, medical doctors, nurses, orderlies, dentists, psychologists, psychiatrists, chiropractors, social workers and other health care practitioners are not exempt as perpetrators. As in many professions the majority provide requisite services with little risk to the public.

Methodology

This workshop examines the psycho-social and behavioral characteristics of those health care professionals who use their positions to prey upon patients, clients and their communities. A global overview of health care professionals who sexually exploit, defraud, physically and/or emotionally harm patients is presented. Several cases studies are examined and a psycho-behavioral profile of those who abuse their patients is discussed. Best practices for protecting clients and patients will be discussed and evaluated.

Learning objectives

Participants will...

1. To educate practitioners to the harm perpetrated by some practitioners.
2. To help practitioners recognize potential abuses.
3. To remind practitioners of ethical, professional and moral boundaries between patients, clients and communities.
4. To identify best practices for protecting patients and clients against potential abuse.

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Using Failure Mode Effects Analysis (FMEA) to analyze aggression and violence risk on the health care campus

Poster

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Perspective: Practice

Background and context

With one of the largest inpatient and outpatient behavioral services in the Midwest, University of Minnesota Health found itself challenged with increasing number of episodes and severity of outcomes against staff by patients. To further analyze the risk of aggression and violence towards staff from patients, we undertook an Failure Mode Effects Analysis to identify areas where we were most vulnerable and to identify solutions to reduce those risks.

Because the risk of patient and family aggression and violence is not limited to behavioral patients, we decided to conduct two FMEA, one focusing on the behavioral patient and one focusing on patients and families in non-behavioral inpatient and outpatient areas. Included in this FMEA were both pediatric and adult populations.

Failure Mode Effects Analysis

The FMEA was first used in the 1950s to analyze systems' malfunctions in the military. The FMEA was adopted by healthcare as a proactive way to identify potential malfunctions in healthcare processes. Because of the proactive nature of our inquiry, we saw the FMEA as a way to review processes that might lead to increasing aggression and violence in patients.

For the Emergency Department and Behavioral Areas, the FMEA focused on following the patient through the point of contact with the facility through his or her discharge. Major processes reviewed included initial contact and triage, behavioral screening, decision to admit, admission, integration into the therapeutic milieu, anticipation of discharge, and actual discharge. Included in these processes were sub-processes such as decision to pursue commitment and other legal proceedings, which are potentially volatile times.

For non-behavioral areas, the FMEA process was altered to focus on situations that tended to pose the greatest risk for harm and then rating those times using an adapted scale for risk to staff (versus risk to patients).

Once a situation or process step was identified, it was stratified as to potential severity of harm, frequency of occurrence, and ability to detect. Based upon stratification, opportunities for intervention were identified.

Findings

While actually physical attacks occurred in the behavioral area, we found non-behavioral areas had far more occurrences of verbal aggression and attacks, as well as presence of weapons and risk of stalking. Staff in clinic areas are most vulnerable to presence of weapons and stalking by patients. Transitional care and acute rehabilitation units are particular vulnerable to having items thrown, especially from patients with traumatic brain injury, post-stroke, and other cognitive disorders where staff believe they must tolerate the behavior because the patients can't really help themselves. The greatest areas for violence toward staff occurred when setting limits on patient rights or behaviors, delays in care, and not meeting expectations of care.

Implications

Being able to identify areas of greatest risk allowed for identification of interventions to prevent aggression and engage in early de-escalation of patients who posed highest risk for violent encounters that would lead to severe harm to staff.

Learning objectives

Participants will...

1. understand the use of FMEA to identify high risk areas for staff harm as a result of patient/family aggression or violence.
2. identify ways FMEA could be used to evaluate one's own facility's vulnerability to staff harm from patients/families.

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Examining the phenomenon of workplace violence in healthcare

Poster

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Perspective: Research

Background and context

The purpose of this pilot research project was to examine actual and feared workplace violence (WPV) events among hospital employees in a rural southeastern medical center.

Methodology

A descriptive design with a convenience sample of employees who presented themselves to the Employee Health Department for annual wellness exams were surveyed over a three month period. All hospital employees were eligible to participate. The surveys were administered to evaluate the actual, physical, and nonphysical violent events as well as the fear of those future events. Sample size consisted of 62 employees. Of this sample, 40.3% were licensed providers consisting of both licensed RNs and PNs. The remaining population consisted of a mixture of non-licensed health care providers. Out of the surveyed participants, 26% were employed in high-risk areas. Areas included emergency room, behavioral medicine unit, and medical surgical units.

Findings

Data were compiled into a dataset and analyzed using SPSS. Kruskal Wallis statistics were performed in order to analyze differences by unit worked on violent events at work and fear of future violent events at work. There was a significant difference in unit worked and the actual physical violent events. Items on both tools were significantly different between unit worked and the actual non-physical events. There was also a significant difference between unit worked and several threatened physical violent events, including threats of physical violence, threats with weapons, seeing co-workers threatened, and hearing about co-workers being threatened. Finally, there was a significant difference in unit worked and the fear of future violent events. In addition to looking at actual violent events in the workplace, researchers were also interested in the employees' perception of fear of future violent events. Participants also reported the fear of future violent events and non-physical violence events. While 14.5% reported fear of experiencing WPV, 18.1% indicated they were fearful of being unable to prevent a violent confrontation if faced with one.

The researchers found an interesting phenomenon that was reported by participants. While most participants reported that they did not fear experiencing WPV; on the other hand, respondents did indicate that they were fearful of being unable to avert a violent confrontation. This has led the researcher to examine the potential disconnect that may exist among employees and workplace related violence.

Implications

According to the Bureau of Justice, estimates for workplace violence cost 4.2 billion annually. In the US, workplace violence occurs at an alarming rate of 1.5 million incidents per year with two-thirds of these occurring in healthcare settings. Although WPV remains on the forefront of a global health concern, this study suggest there is a disconnect that exist among employees' fear of WPV and their ability to manage violence. In light of the recent widespread health care tragedies within the national arena, it is now more important than ever to take a proactive stance in policy and practice rather than a reactive one.

Learning objectives

Participants will...

1. recognize the incidence and impact of the negative outcomes associated with workplace violence.
2. understand the actual and feared violent events at work in a clinical setting.

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Has the decentralization strategy curbed workplace violence in psychiatric care settings in South Africa?

Poster

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Perspective: Practice

Background and context

Mental illness is very prevalent in South Africa, due to many factors, such as civil strife, urbanization, community violence, drug abuse and unemployment. Yet, the country lacks many of the necessary resources, policies and guidelines needed to execute an effective mental health promotion strategy. In South Africa, workplace violence in psychiatric facilities is a major issue. In order to curb workplace violence and improve mental health care, the government of South Africa deinstitutionalized psychiatric care by relegating it to the primary health care setting.

Methodology

The study analyzed the major studies done in South Africa which focused on violence in psychiatric care facilities; and the available government policies and guidelines for the prevention of violence in the psychiatric care settings.

Findings

Available data showed that in the context of workplace violence in psychiatric care setting, the goal of deinstitutionalization of mental care services is yet to be fulfilled due to several factors, such as lack of trained health professionals, brain drain, communication gap between managers of care facilities as well as the historical/cultural context of South Africa. In other words, in spite of the existing measures, workplace violence is still rampant in psychiatric facilities in South Africa and both the services providers and consumers are badly affected.

Implications

There is the need to evaluate the implementation of the government strategies, policies, and guidelines developed to curb workplace violence in psychiatric care settings in South Africa so as to develop a realistic intervention strategy.

Learning objectives

Participants will...

1. be able to explain the strategies currently being used to limit the occurrence of workplace violence in psychiatric facilities in South Africa and the limitations of the strategies;
2. learn about recommendations on how to prevent/control workplace violence in psychiatric facilities in South Africa based on an analysis of the current policies/guidelines.

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The dark side of nursing homes: When staff commit inadequate care, abuse and neglect

Paper

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Perspective: Research

Keywords: Elder abuse, neglect, inadequate care, residents, nursing home, staff.

Introduction and background

In Norway, the municipalities are responsible for providing care for older adults. In January 2013, about 221,000 people were 80 years or older in Norway (1), and 15% of them were living in institutions. Such institutions include nursing homes, homes for older persons and sheltered housing. This study covers nursing homes only. Norwegian nursing homes provide 24-hour skilled nursing care under the supervision of a physician. Only a few Norwegian nursing homes are private, the rest is public and run by the municipalities.

Studies show that inadequate care, also referred to as abuse, violence, neglect or maltreatment, are not isolated acts, but a part of daily life in nursing homes in many countries (2-7). Different approaches and methods have been used in the effort to describe and quantify the phenomenon, and its complexity has been discussed by several authors (8-10). The lack of consensus in definition and theoretical approaches is still a problem in this field of research.

Older residents in nursing homes are particularly vulnerable and exposed to abuse and neglect because they are more or less dependent on their caregivers owing to chronic illnesses, especially those with cognitive and behavioral problems (11-13).

Although studies of the quality of care have shown that the care provided in institutions for older persons in Norway is mostly of a high standard (14, 15), studies have proved that inadequate care also occurs in Norwegian nursing homes (16). In general, and especially in a Norwegian context, we have had limited knowledge of abuse and neglect in nursing homes. There has not been, as far as we know, a larger study focusing on nursing homes that has included all types of inadequate care studying the relationship between inadequate care and factors such as facility characteristics, staff characteristics, and relational factors such as resident aggression and conflicts between residents and staff. Therefore, in addition to descriptive statistics, as frequencies and mean values, we found it interesting to test a model for the probability to commit inadequate care, abuse and neglect including 11 independent variables.

In this paper we have chosen to present an overview of the frequency and types of inadequate care, abuse and neglect reported and committed by the staff, as well as showing how resident aggression and conflicts between staff and residents increase the probability of inadequate care, abuse and neglect in nursing homes.

Definition

A broad definition of inadequate care has been selected: "Inadequate care results from the presence of unmet needs for services or assistance which threaten the physical and psychological well-being of the individual" (8, p.25). This definition includes unmet needs for food, shelter, clothing and supportive relationships, as well as the need for freedom from harassment, threats and violence. Other unmet needs may be assistance in the activities of daily living, such as going to the toilet, dressing, eating and taking medication (8). Inadequate care therefore encompasses a variety of actions which can be harmful to the residents of nursing homes. In order not to erroneously devalue how serious the acts actually can be, the concepts abuse and neglect are also used, as subsets of inadequate care. Abuse is defined as: "Actions of a caretaker that create unmet needs for the elderly person", such actions includes theft, isolation, threats, use of restraints, battering, sexual abuse, punishment and withholding food, clothing, or privileges to enforce behavior, and neglect is defined as: "The failure of an individual responsible for caretaking to respond adequately to established needs for care" (8, pp. 21-22). The WHO report on violence and health states that: "Regardless of the type of abuse, it will certainly result in unnecessary suffering, injury or pain, the loss or violation of human rights, and a decreased quality of life for the older person" (17, p.126).

Methods

Data were obtained from a cross-sectional survey conducted in one county in the middle of Norway including nursing staff (registered nurses, licensed practical nurses, and nursing aides) (n=616) from 16 nursing homes. The response rate was 79%.

Five items on the questionnaire were related to residents' aggressive behaviour towards staff, e.g. have residents ever thrown objects at staff? Spat at staff? Pinched, beat, or scratched staff? There were nine items on the question about conflicts between staff and residents in direct care-giving situations, and not directly related to care-giving activities, e.g. when residents refuse to eat, refuse to wash or dress, refuse to go to the toilet, claim that they are robbed, bother other residents, or want to run away.

Twenty items were related to staff behaviour (inadequate care, abuse and neglect); the respondents were asked to report how often they had committed the acts listed in the questionnaire (see Table 1 for complete list of items).

Descriptive statistics were calculated for committed acts of inadequate care, abuse and neglect, this is presented in Table 1. To investigate what factors that influence the probability that staff will commit acts of inadequate care, abuse and neglect, we conducted a logistic regression model for each of the types of abuse (emotional, physical and neglect as the dependent variables) and included 11 independent variables (location, size, staff density, staffs' age, education (two variables), experience, job satisfaction, resident aggression, care related conflicts, and non-care related conflicts). All variance inflation factors (VIF) were below 5. A significance level of .05 was used for all statistical tests, and SPSS version 17 was used for the data analysis.

Results

All in all, 87% of the nursing staff reported that they had committed at least one act of inadequate care, abuse and neglect, but most of them reported that this had happened once a month or less. There was no time limit for the reporting so this can be acts that happened a long time ago. Therefore, it is probably more interesting to see what the staff reported to happen more often than once a month (Table 1); 12% reported that they had neglected oral care, 7% had ignored a resident, 6% delayed required care longer than necessary, 5% had restrained/held back a resident, 3% admitted to have used diapers to prevent toilet visits, more than 2% had prohibited resident from using the alarm, 2% reported that they had talked disrespectfully to a resident, 2% said that they had given medication without prescription, and 1% admitted that they had threatened a resident.

The full description of the developing of the logistic regression models and the results are presented in our resent manuscript (18). In this presentation, we will focus on the relational variables, i.e. resident aggression and conflicts between staff and residents as predictors of the different types of inadequate care, abuse and neglect. We found a significant relationship between inadequate care, abuse and neglect of an emotional character and the independent variables resident aggression ($p = .000$), and non-care related conflicts ($p = .008$). If resident aggression increases, the probability for inadequate care of emotional character also increases ($OR=2.15$) and if conflicts in non-care related situations increase, the probability for inadequate care of an emotional character also increases ($OR=1.50$).

There was also a significant relationship between inadequate care, abuse and neglect of a negligent character and the independent variables: resident aggression ($p = .015$), care-related conflicts ($p = .012$), and non-care related conflicts ($p = .000$). The probability of inadequate care of negligent character increases when resident aggression increases ($OR = 1.96$), when care-related conflicts increases ($OR = 1.67$), and when non-care related conflicts increases ($OR = 1.92$).

In addition, we found a significant relationship between inadequate care, abuse and neglect of a physical character and the independent variables resident aggression ($p = .000$), and care-related conflicts ($p = .034$). The probability of inadequate care of physical character increases when resident aggression increases ($OR = 3.66$), and when care-related conflicts increases, inadequate care of physical character increases ($OR = 1.40$). The results show that residents in Norwegian nursing homes are exposed to different types of inadequate care, abuse and neglect, and that resident aggression and conflicts between staff and residents are important contributive factors to such. The extent confirms that these are not isolated acts, but a common part of life in nursing homes. Even though the most commonly reported acts are of emotional and negligent character and not seen as so severe, there is enough proof that residents in nursing homes are exposed to unnecessary suffering owing to inadequate care, abuse and neglect committed by staff.

Table 1: Distribution of committed inadequate care (n=616)

	Never		Once a month or less		Once a week or less		More than once a week	
	n	(%)	n	(%)	n	(%)	n	(%)
Emotional								
Scolded a resident	528	(87)	70	(12)	5	(1)	1	(0.2)
Entered a resident's room without knocking	190	(32)	288	(48)	76	(13)	50	(8)
Threatened a resident with punishment	580	(96)	21	(4)	3	(1)	0	(0)
Made fun of a resident in front of others	591	(98)	13	(2)	2	(0.3)	0	(0)
Talked disrespectfully to a resident	517	(86)	82	(14)	3	(1)	3	(1)
Prohibited a resident from using the alarm	488	(80)	109	(18)	9	(2)	1	(0.2)
Used diapers to prevent toilet visits	483	(80)	103	(17)	14	(2)	3	(1)
Neglect								
Did not wash a resident who needed washing	486	(81)	101	(17)	15	(3)	2	(0.3)
Omitted giving a resident enough food	537	(89)	66	(11)	2	(0.3)	1	(0.2)
Delayed required care longer than necessary	274	(45)	295	(49)	25	(4)	9	(2)
Ignored a resident	338	(56)	226	(38)	27	(5)	11	(2)
Inadequate treatment of wounds or injuries	547	(91)	54	(9)	2	(0.3)	1	(0.2)
Neglected oral care	226	(38)	311	(52)	51	(9)	15	(3)
Did not change diapers when needed	480	(79)	110	(18)	14	(2)	1	(0.2)
Physical								
Held a resident hard	470	(78)	124	(21)	8	(1)	1	(0.2)
Gave medication without prescription	551	(91)	45	(8)	5	(1)	3	(1)
Restrained/held back a resident	412	(68)	167	(28)	16	(3)	10	(2)
Pressed the nose in order to force the resident to open his or her mouth	600	(99)	6	(1)	0	(0)	0	(0)
Tied down a resident	536	(89)	55	(9)	6	(1)	6	(1)
Financial								
Taken money or valuables from a resident	607	(100)	0	(0)	0	(0)	0	(0)

Discussion

Conflicts predict different types of inadequate care depending on whether the conflicts are directly related to care-giving activities or not. Previous research has also indicated that different types of abuse may have different correlates (19). Aggression from residents was found to be related to all types of inadequate care, abuse and neglect, a finding supported by other studies (20, 21). In accordance with other findings (22-25) aggression from residents is a reality for the majority of nursing home staff. When discussing the relationship between aggression from residents and inadequate care, one has to take into consideration the interactive nature of these acts. On the one hand, studies have shown that behavioural disturbances among residents in nursing homes may be a direct consequence of staff behaviour (26, 27). On the other hand, inadequate care, abuse and neglect may be viewed as a response from staff to aggression from residents (28). Caregivers have identified agitation from residents as one of the most challenging behaviours and agitation can be experienced as frightening (29).

According to our main study (18), conflicts between staff and residents in non-care related situations happen frequently, which is in line with another study (6). This increases the probability of acts of a negligent and emotional character, but not acts of a physical character. A typical situation which was reported in an earlier study showed that conflicts occur when residents want a great deal of attention (16). Does lack of time, lack of adequate staffing or worn-out or stressed staff leads to conflicts or, furthermore, do staff intentionally neglect residents?

Staff reported in our earlier study that conflicts often occur during helping with personal care (16). Taking the high number of residents suffering from dementia into consideration, one can easily understand that misunderstandings occur e.g. owing to cognitive decline and mutual communication problems (23). The view that staff can trigger aggressive behaviour and provoke conflicts has some support in research. One study

identified physical assaults on caregivers by individuals with dementia (27), and found that certain caregiver behaviours e.g. confrontational forms of communication and failure to alert residents to an impending action were frequently immediate antecedents of assaults from residents during personal care.

Conclusions and final remarks

In many countries, there is still a lack of awareness regarding inadequate care, abuse and neglect in institutions for older persons. Recognition of the phenomena is the first step toward change, but it needs to be followed up by actions. Even in countries where this has been an ongoing debate for many years, there is still a gap between existing knowledge and legislation made to protect older persons from being exposed to inadequate care, abuse and neglect while they should be safe in nursing homes. Lack of a common definition, appropriate measurement methods, and theoretical framework for understanding the phenomena, is no doubt a challenge to researchers and practitioners. However, even without a consensus there is enough evidence that inadequate care, abuse and neglect occur in institutional settings, and thus, actions should immediately be taken to stop this unworthy behaviour when caring for nursing home residents.

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Learning objectives

Participants will...

1. will have knowledge of the frequency and types of inadequate care, abuse and neglect committed by staff in nursing homes.
2. will learn that resident aggression and conflicts between staff and residents increase the probability of inadequate care, abuse and neglect in nursing homes.

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An inquiry into the injuries sustained by security guards at a level 1 trauma hospital

Poster

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Perspective: Research

Background

Hospital security guards are tasked with protecting the safety of healthcare personnel, visitors to the hospitals, and patients. They are called on to help control violent situations and are thus at a high risk to sustain violence-related injuries, but little is known about the protective and risk factors for injuries to hospital security guards.

Method

Qualitative and quantitative analyses were performed on three existing data sources from an urban 462-bed Level I Trauma Center in the Midwest: the security officer narratives, occupational health department data, and the patient electronic health records.

Findings

There were 19 reported injuries over the course of a year, with an additional 300 violent incidents reviewed from that year. Most of the violent incidents that involved security officers occurred between 8pm and 4am, with a greater proportion of the officer injury events taking place in the psychiatric departments. Of the 317 incidents reviewed, the officers used a tool of law enforcement (TASER and/or handcuff) on 11 occasions. There were 11 patients injured during the violent incidents, 4 of which occurred with the use of a tool of law enforcement. Security officers are at a high risk for violence-related injuries in the hospital, with most injuries in this group being blood and body fluid exposures and strains and sprains. Staffing and patrol patterns and can be optimized when the location and timing of violent incidences are known.

Learning objectives

Participants will...

1. appreciate that hospital security guards are underrepresented in the occupational health literature, though they bear a relatively high incidence of assault-related injuries.
2. learn where and how security officers may be at highest risk for injury and that further investigation into this phenomenon is warranted.

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Economic costs of aggression in closed, long-stay psychiatric wards in the Netherlands

Poster

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Perspective: Practice

Background

The prevalence of aggression in acute and forensic psychiatric wards is extensively researched and associated with high costs. However, 67% of Dutch psychiatric inpatients reside in long-stay care facilities of which research is scarce.

Objective

We aimed to estimate the incidence rate and economic cost of aggressive incidents in closed long-stay psychiatric wards in the Netherlands.

Methods

The incidence rates in three closed long-stay psychiatry wards were estimated using a sampling method. To estimate time spent on incidents a researcher recorded aggression related activities of staff members in real-time. Incidence rates and time invested per incident in 4 aggression categories (i.e., verbal aggression, physical aggression towards objects, self-harm and physical aggression towards others) were aggregated to yield the personnel costs of aggression in closed long-stay psychiatric wards.

Results

Average incidence rates of aggressive incidents were 112 incidents per patient per year, and 65, 12, 8 and 27 per patient per year for the 4 aggression categories respectively. Average staff time spent was 81, 79, 224, and 336 minutes per incident for each aggression category, respectively. This amounted to a mean of €78 per incident, €8800 per patient annually, and a total of € 176.000 per year per closed long-stay ward (assuming 20 patients).

Conclusion

Incidence rates of aggressive incidents on closed long-stay psychiatric wards were higher than those of acute and forensic wards in earlier research. Real-time collection of data may prevent underreporting of incidents. The nurses' workload due to aggression in this complex group of inpatients is associated with substantial economic costs.

Learning objectives

Participants will...

1. recognize the prevalence and economic burden of aggression in closed, long-stay psychiatric wards.
2. learn a model to estimate the economic burden of aggression in their own institutions.

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Chapter 3 - Strategies and initiatives which enhance cultures of safety

Enhancing homecare staff safety through reducing client aggression and violence in non-institutional care settings

Workshop

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Perspective: Organisational

Keywords: Safety, non-institutional care settings, patient violence, policy development, interventions

Abstract

Client violence and aggression towards social in non-institutional care settings is pervasive, with studies finding that clinicians practicing in this arena experience higher rates of client violence than in any other field. This workshop examines this phenomenon offering organizational intervention strategies that may effectively decrease the prevalence and severity of such incidents.

Background

Home health care workers experience one of the highest rates of client violence than any other career field [1,2]. Hospitals and clinics have policies and protocols to enhance employee safety in institutional settings. However, the industry is emphasizing providing medical and psychosocial care to clients in non-institutional settings, outside of the safety nets established within hospitals and clinics [3,4]. Consequentially, greater numbers of healthcare workers are providing services in patient private homes, increasing the potential risk to staff safety and well-being. Home healthcare workers will be less effective when working in dangerous environments, experience greater probability of compassion fatigue, decreased job satisfaction and decreased commitment to the organization. Additionally, violence to home health workers has been shown to result in a decreased quality and quantity of services provided to the patient served at home.

Serving as a continuum of coordinated extended care services, non-institutional health care settings provide medical services outside of formal institutions such as hospitals and nursing homes and typically include home health services, hospice services and in home respite programs. The term the 'lone worker' has been utilized internationally to define the healthcare provider who works independently with limited supervision and without close geographic proximity to colleagues [5]. For these lone workers, verbal abuse is the most common form of patient aggression, estimated to be perpetrated on anywhere between 33%-87% of home care staff [6]. Prevalence of actual or threatened physical assault against staff is estimated to be between 17% and 74% [7]. Research abounds supporting the assertion that risk of staff experiencing such incidents is heightened when working in non-institutional care settings [8].

Interventions

While research on patient violence and aggression towards healthcare providers in non-institutional care settings remains in its infancy, the literature has begun to examine practices for reducing patient violence against lone workers. Evidenced-based practice are yet to be determined, however, three distinct categories of intervention are beginning to show promise for decreasing prevalence and severity of incidents: ensuring accurate incident reporting and removing barriers to reporting, staff education regarding accurate predictors and indicators of patient aggression and violence, and utilizing thorough and accurate risk assessments prior to conducting visits.

The first category of intervention which has a critical role in decreasing severity and frequency of patient violence and aggression is obtaining accurate incident reporting and removing existing barriers which prevent staff reporting incidents [8,9]. Patient violence and aggression towards healthcare staff is severely under reported [10]; this creates both difficulty measuring the phenomenon and consequential lack of ability to devise interventions to address the safety concern. Franz et al. (2010) assert that 'systematic research of the causes and consequence of aggression and violence towards employees in the health care system are still being neglected' (p. 52) and that without accurate frequency and prevalence statistics effective prevention and policies are hindered [1].

While clinicians and scholars are beginning to examine the reason for this, evidenced based best practices do not yet exist, as existing studies have significant limitations. Of the few mixed-methods studies in the literature, a quasi-experimental mailed survey of homecare staff found that staff perceptions of safety are enhanced through accurate reporting [11]. The Hutchings study however had a low response rate, with a greater number of staff completing posttest than pretest, raising questions regarding the validity of findings. MacDonald & Sirotych [9] reviewed underreporting of incidents of client violence among social workers through a randomized mail questionnaire. However, the study lacked discrimination between institutional and non-institutional care providers and settings. The sole randomized controlled trial located in the literature, conducted in Sweden over a decade ago by Arnetz and Arnetz [12], suggests that that accurate reporting of violent incidents not only increases staff awareness but also increases staff confidence. This study, however, acknowledged that the intervention group was at onset at a greater risk for client violence and the authors report a limitation of loss of follow up with the intervention group. The authors assert that as incidents are accurately reported, staff perception of well-being and ability to react to the incident is greatly enhanced. Incident reporting forms, such as the Violent Incident Reporting Form (VIF), do exist, however they lack research supporting that use of particular tools or forms is evidenced based.

The second category of intervention which has demonstrated success decreasing prevalence and frequency of patient aggression and violence is education and training for clinical healthcare staff [13,14,15,16]. The education of non-institutional lone healthcare workers on predictors and indicators of patient violence and aggression has been found to be an effective intervention. The literature and scholarly research is saturated with studies identifying patient risk factors for aggression in institutional settings, however research in this area continues to be lacking for factors predicting aggression towards lone workers. For example, Amore et al. conducted a study in Italy of an inpatient psychiatric unit to determine factors and indicators for patient violence which utilized the Overt Aggression Scale (OAS). The authors note that predictors of patient violent behavior include patient demographics such as gender, socioeconomic status and marital status: unmarried males of lower socioeconomic status present a higher level of risk than other demographic groups. A noted shortcoming of application of the authors is that the application of instrumentation (Overt Aggression Scale) and study findings have questionable generalizability to non-institutional care settings and other service populations: the study was conducted within an inpatient psychiatric hospital. Fazzone et al. examined the predictors of client violence in the non-institutional care setting and found that the client's community characteristics, time of staff visit, and personal characteristics of the clinical care staff were predictors of client violence. Communities with high crime levels and visits conducted during nighttime hours also presented higher probability of client aggression and violence. McPhaul et al. add to the discussion of risk level based on setting, reporting that overcrowding and long waits for services increase probability of client aggression. These predictors are supported by a study conducted by Galinsky et al., adding that the type of service being provided to the client also may predict patient violence and aggression; those healthcare workers providing hands on care in patient environments are more likely to experience aggression or violence than those staff not providing hands on care, regardless of institutional or non-institutional care setting¹⁶. Another predictor of patient aggression was the field of the clinician: geriatrics, mental health and nursing fields have higher risk of patient assault than other fields [17].

Thus while research on predictors of patient violence and aggression does exist, there is not yet a clear evidence base for non-institutional care settings. Furthermore, while inpatient predictors have been studied and are beginning to be explored in the non-institutional care setting, there is a significant and paucity of information on how to best train clinical healthcare staff working in non-institutional care settings about these red flags.

The third theme that has been demonstrated to enhance the ability of healthcare providers and agencies to develop programs which more adequately prepare staff providing services is the development and utilization of accurate and thorough risk assessments⁷. Use of risk assessments has been found to be another essential for reducing violence against the lone worker. Lundrigan et al. [18] assert that "risk assessment is an integral part of any program that promotes occupational health and safety" (p. 404) and that development and utilization of such tools enhance staff safety. Hutchings et al.¹¹ found that risk assessment tools and agency safety procedures reduce the risk to homecare staff and increase the safety of social workers and nurses providing home care. Macdonald et al. [19] summarize the necessity for risk assessment tools in their qualitative study, reporting that "ensuring safety in the home care sector requires a coherent body of research to inform practice and policy, a process which begins with requires accurate assessment of risk (p. 234)." Examples of existing risk assessments instruments include the Western Health Risk Assessment Screening Tool (WHRAST), Home Visit Risk Scale (HVRS) and the Workplace Violence Safety Climate Scale (WVSC). The WHRAST, introduced by Lundrigan et al. [18] and validated by Hutchings et al. [19], was designed to be conducted prior to non-institutional care setting staff visits to establish a level of risk which would then result in specific policies or procedures to decrease probability of patient violence or aggression towards homecare staff. Despite the mixed-methods

quasi-experimental study conducted to validate this tool, the authors determined that the risk assessment tool continued to leave staff with the perception that there were too many unknowns to have confidence in their safety. The study was further limited due to low response rate of participants [11]. The HVRS and WVSC were both introduced in a study by McPhaul et al. [15]. While the study found the instruments to be both reliable and valid, the study was limited to a small sample size (n=130) and was limited to a small geographical region, questioning the generalizability of findings to other settings and geographical locations.

Policy Solutions

While three potential interventions are supported in existing literature, a best practice evidenced based guide remains lacking. It is therefore suggested that individual providers and agencies offering clinical healthcare services in non-institutional care settings establish evaluation criterion for selection of a policy for which meet two goals: development of a transdisciplinary approach to understating client violence and aggression, possible through understanding the social indicators which are predictive of client violence and aggression in non-institutional care settings, and establishing and developing procedures and policies which will decrease the occurrence of such incidents.

Successful achievement of these goals must include relevant stakeholders in the selection and development of the policies, as any selected policy will require staff adherence for implementation making it is critical to have buy-in of individual healthcare providers and agency administrative staff (Bardach, 2012). Additional criteria for selection of a policy option include legality, political acceptability, administrative ease and robustness and improbability of the policy (Morse & Struyk, 2010).

Implementation of the first intervention, ensuring incident reporting will aid in the development of an understanding of client violence against lone workers only if done in a manner which allows for collaboration of the various disciplines engaged in providing healthcare in non-institutional care settings. The VIF is one suggested means of incident reporting; however there are concerns regarding the administrative burden of this option. Political acceptability of this option also raises concern, as the literature suggests that underreporting of incidents is prevalent in the health care field. Staff must be trained in the administration of this tool and incentives and education will be required to ensure compliance. This option has good potential as long as the agency instating this policy remains open to a dynamic dialogue with providers to adapt the instrument to ease staff use. One legal issue that arises with the implementation of incident reporting procedures is that the agency initiating the policy must develop a method of data collection and processing that ensures protected health information is not disclosed or misused in the process of incident reporting.

The second viable intervention which could be developed into agency policy with ease is providing staff education on predictors of patient violence and aggression. However, as no current training programs are currently evidenced based for achieving the desired goal of decreasing client violence towards the lone worker, this intervention would require each individual healthcare agency serving non-institutional clientele to develop a staff education program that will meet the policy objective. Staff could be mandated to participate in this training, however this may not be adequate to ensure adoption. Incentives such as continuing education credits could be offered to increase probability of staff cooperation and ultimate adoption of the desired practices. There are no identifiable legal concerns with this option. However, the effects of the specific type of training and education offered to meet the proximal and distal goals of this policy option have not been clearly identified in the literature. Additionally there arises the potential for internal validity issues with this policy option, and the burden will lie with each agency to develop a staff education program that will meet the policy objective.

The third available policy intervention is for agencies to incorporate and utilize risk assessments prior to conducting healthcare visits by lone workers. Utilization of risk assessment tools as a policy option to enhance healthcare staff safety in non-institutional care settings is well supported in the literature, and multiple options exist for which risk assessment instrument to use. However, no single instrument is currently supported as the best approach. No identifiable legal issues arise with this option; however there are concerns with political acceptability of this option, primarily due to the reluctance of healthcare staff to take on additional paperwork tasks which present a time burden. With this in mind, adherence to utilization of selected risk assessment instrument may be enhanced through engagement of stakeholders in the selection of specific risk assessment.

Analysis

Conducting a cost-effectiveness analysis allows for these three potential policy solutions to be compared using a systematic procedure to determine which policy or program may provide the greatest benefit and effectiveness at the least cost [20]. The monetary costs for implementation of incident reporting procedures are easily identified: purchasing the permission to utilize existing reporting tools and cost associated with staff resources for improvement and adaptation of incident reporting form. Non-tangible costs include the staff time and resource allocation required for completion of incident reports. The costs for staff education are also similarly divided into monetary and non-monetary costs. There will be significant up-front costs associated with developing an educational program and salaries for staff educations and staff salaries during training. Opportunity costs and compliance costs also arise with this option, as staff productivity will be decreased during training time, participating in education program which is non-revenue producing versus time spent

seeing patients. Should implementation of risk assessments be selected as the policy option, there will be similar upfront costs with purchasing permission to utilize an existing risk assessment instrument or staff resources for development of agency specific risk assessment tools. The non-monetary and intangible costs associated with this option similarly include staff time as well as potential staff resistance to the added burden of additional paperwork requirements.

Regarding the net benefit of each policy option, each policy would meet the proximal and distal goals as outlined previously. Tangible benefits of implementation of incident reporting forms include the development of prevalence statistics and accurate data for agencies. Intangible benefits with this option include increasing staff awareness of patient violence and aggression. Selection of staff education as the policy of choice offers more intangible benefits, to include increased staff education and knowledge as well as increasing awareness of potential prevention techniques. Implementation of risk assessments prior to conducting client visits in non-institutional care settings offers both tangible and intangible benefits. Tangible benefits include compliance with Joint Commission mandates and furthering the goals of agencies regarding providing safe working environments for employees. Intangible benefits include increased staff safety and consequential increased productivity and staff effectiveness.

Discussion

The research suggests that home healthcare workers experience high rates of client aggression or violence. These statistics transcend discipline boundaries, affecting home health aides, nurses, psychologists, social workers, chaplain, physicians and other direct care staff. Social indicators which may predict patient violence include the service setting, client diagnosis and demographics as well as provider demographic. The research reviewed highlights predictors of patient aggression and violence within various settings, staff demographics and patient diagnoses and demographics, which indicates that regardless of the specific case, risk assessments and agency policies and procedures are necessary to ensure workplace safety for home care staff. An added finding of this review is a review of the social, organizational and personal consequences of staff experiencing patient aggression and violence, including decreased staff efficiency, well-being and decreased quality and quantity of health care being provided. One limitation of this analysis is that there is a paucity of controlled studies in the literature to suggest that particular tools and assessments are more effective than others in reducing the incidence of violence against lone workers.

Three distinct policy options have been highlighted as a means to combatting this public policy issue and a value-matrix has been offered to allow policy makers the opportunity to explore the feasibility of implementation for each option, as well as associated costs and benefits of each policy option. The need exists for further research, particularly that which focuses on home healthcare staff safety and the development of policies and procedures to decrease the probability of occurrence. While there are studies which explore these constructs, explanatory and randomized controlled studies are greatly needed to further the ability to predict and explain client violence towards home health care staff. In doing so, organizations and individuals providing care in non-institutional care settings may further the goals of The Joint Commission to enhance human development goals of providing safe workplace environments. Further policy research would then be indicated to collect both qualitative and quantitative data through sampling and surveys. This would then allow for the prevalence of incidents of client violence and patient aggression to be studied and then policy research on performance measurement could examine the effectiveness of implemented policies.

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Learning objectives

Participants will...

1. appreciate that the development of an interdisciplinary approach to understanding the prevalence of client violence and aggression, highlighting the social determinants of this phenomenon and the impediments to staff safety in non-institutional care settings.
2. be able to identify the social indicators predictive of patient violence, and thereby allow for interventions which may effectively decrease the prevalence of such incidents.
3. recognize established risk assessment tools utilized in non-institutional care settings to predict patient aggression and violence.

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An Educational video for newly hired graduate nurses working in hospital setting to promote workplace violence knowledge understand and strategies for prevention

Paper

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Perspective: Education and Training

Introduction

Workplace violence is a serious problem facing many newly hired professional nurses nationwide. Unfortunately, workplace violence is not limited to new nurses; senior nurses are just as vulnerable. The purpose of this project was to create an educational video for newly hired graduate nurses working in a hospital setting to promote workplace violence knowledge, understanding, and strategies for prevention. According to Booth (2011) one in three nurses will leave their position due to workplace violence. Nurses, especially graduate nurses, are vulnerable to workplace violence. Therefore it is incumbent on the health care facility to take workplace violence seriously and to educate all staff. An ideal place to start educating nurses about workplace violence is in nursing school and to continue to re-enforce it once they are hired into the health care setting. In prospective this can provide nurses with the knowledge, tools and support of their organization around the gravity of and strategies to prevent workplace violence.

The Prevalence of Workplace Violence

Workplace violence among nurses is not a new phenomena. Unfortunately both new nurses and experienced nurses have been victims of or witnesses to aggressive attacks (Thomas, 2010). Findings from the review of nursing and health related literature indicate that workplace bullying affects nurses worldwide. It is estimated that in the United Kingdom, 44% of nurses are victims of bullying (Dellasegaa, 2009). Finnish nurses reported a high incidence of bullying and an estimated 500 newly employed New Zealand nurses experienced interpersonal conflict (Dellasegaa, 2009).

Graduate nurses are in demand to help with the ongoing issue of nursing shortage. However, instead of solving the issue, nursing students and newly hired graduated nurses are in fact contributors to the nursing shortage because of dissatisfaction of their work experience resulting in a premature exiting from the profession - simply due to workplace violence (Thomas, 2010). Longo et. al. (2011) maintained that although several factors affect nursing retention rates, the factor needing the most attention is the workplace environment.

Destructive Effects of Workplace Violence

Safety should be the priority when it comes to nurses and patients; otherwise destructive activities and behaviours can occur in the workplace. King-Jones (2010) reported that some nurses react to workplace violence by working harder to fit in and to maintain the status quo: to make other nurses respond to them positively. Workplace violence can influence the person negatively – physiologically and psychologically, as well as have behavioural impacts on the individual. The consequences of workplace violence can include, but is not limited to, being labeled as a troublemaker; fearing loss of career advancement opportunities; fearing job loss; and experiencing psychosomatic symptoms such as nervous tension, headaches, eating disorders, sleep disturbance, and onset of chronic illness (Murray, 2009).

Workplace Violence Education

Health care providers are responsible for acting in a professional manner and have the right to expect fair and equal treatment from their colleagues (Longo, 2010). It is imperative that nurses demand safe working environments; free from any type of workplace violence. Research has indicated that workplace violence education serves as a powerful tool to address and reduce destructive workplace behaviours (Longo, 2010). Workplace violence education can improve general communication skills, making communication more effective; can introduce and reinforce zero-tolerance policies; and can offer strategies to employees with regards to how to handle those who are demonstrating disruptive workplace behaviours (Longo, 2010). Therefore having the right tools to educate nurses, for example, an educational video can be beneficial because it can create opportunities for meaningful discussions. Newly hired graduate nurses would benefit and senior nurses would be reminded.

Methodology

An educational video called “Workplace Violence Among Nurses” was developed. The educational video took place in a hospital setting in Toronto, Canada. The voluntary participants were five registered nurses, two personal care assistants and one ward-clerk. Four advanced nursing professionals, who consented to participate voluntarily as expert content reviewers, evaluated the workplace violence educational video for newly hired graduate nurses.

Development and Evaluation of the Educational Video

The educational video was developed in order to create discussion, to allow for dialogue and to problem solve around the given scenarios, and to allow viewers to reflect on their experiences as well. Follow up discussion would include whether or not the issue was solved appropriately and if not, would allow participants to explore alternative solutions. Furthermore, other likely or common scenarios could be discussed along with possible resolutions.

The video was divided into four different scenarios, each one covering a different topic. The video starts off with all four scenarios of workplace violence incidences summarized. Point form notes on how to resolve workplace violence conflict are outlined. Then the four scenarios are shown again, this time with the resolution dramatized.

Once the educational video was complete it was then hand delivered to the four content experts with a recruitment letter explaining the purpose of the project and an evaluation tool. All four content experts completed the evaluation tool and the results were anonymously collected within 10 days from distribution of the package.

The evaluation tool consisted of five measures including organization, readability, applicability, usefulness and adherence to best practice guidelines. A four point Likert scale was used to rate each measure indicating whether the content expert: 4 – strongly agree, 3 – agree, 2 – disagree, or 1 – strongly disagree with the given statement(s). Each measure of validity was also accompanied by an open-ended question providing the opportunity for content experts to add further comments and suggestions.

Results indicated that all four content experts “strongly agreed” that the educational video is well organized, readable, useful and adhered to Best Practice Guidelines (BPG). The educational video was considered to be a highly effective and useful educational tool on the issue of workplace violence among nurses in a hospital setting. Recommendations for the video, in addition to the 4-point Likert score, identified several themes. Expert one, stated that the video was “overall well done”, suggesting that for “clarity” the recommendations were to have the written points be in a larger fonts with longer time to read each point. Expert two commented that the video clip was logical and clear, the incidents were cleverly enacted and made it easier for the viewer to ‘get the picture’ right away without using too many words. Again, a recommendation was suggested for “clarity”, which was to add a line on the screen stating that viewers should refer to resources available from their organization or professional licensing college. Overall this video was viewed as “useful”, nicely done and more organizations should have this on hand for new employees entering the workforce. Expert three enjoyed the setup of the video clip, indicated that it was “nicely organized”, “useful, and very appropriate”. For “applicability”, specifically with regards to incident III, it was suggested that instead of when the registered nurse goes to the change nurse and she says “I’ll speak to her”. Instead, it was recommended that she say, “Have you spoken to Cindy, shall we speak to her together?” A second suggestion was to have the manager offer to speak to both of the nurses to solve this issue instead of the unit manager changing the shift as Cindy requested. The Final comment was: “Overall a beautiful job! Well done!” Expert four, enjoyed each scenario, indicated that having a title “i.e. Incident I” followed by resolution strategies made it “well organized”. Under the “readability” section, comments were to increase the fonts and the time for the slide to be visible, as it is relevant information and should be highlighted. Under “clarity”, the comment was that in Incident IV resolution the volume was low and the viewer was not able to hear the dialogue properly. Overall the video was rated as “excellent” specifically for “increasing awareness about workplace violence and providing strategies to manage those situations is applicable to healthcare”.

Implementation of the Video

When the video was completed it was then shown to a group of staff nurses, where various discussions were developed, questions were asked and meaningful dialogues started. Some of the staff nurses felt this never happens in the unit while their colleagues felt the complete opposite. One nurse stated: “It’s worse in the unit than what is presented in the video.” Throughout the discussion the video brought an awareness of the different types of workplace violence that is happening among nurses and as result created a positive change. The nurses now felt that they are not alone, that some of their colleagues also felt bullied. In time, the awareness gained from the educational video facilitated some form of team building or belongingness and, with further discussions; they felt stronger and were reminded of the importance of teamwork. Any act of bullied behavior was pointed out by the nurse and as a team the nurses were much more supportive of one another. This is a positive change because now nurses are not only caring for patients but for each other as well. Nurses need to continue to care for each other. With clear intolerance of workplace violence; nurses will care about their profession, each other and their patients in a healthy and professional manner (Broome & Willams-Evan, 2011). As Thomas (2010) stated, Healthy workplace environments begin with promoting a positive attitude among experienced and senior

nurses toward nursing students otherwise, nursing recruitment and retention is threatened, as is the future of the nursing profession.

Implication for Advanced Practice

Understanding and recognizing the value of workplace violence and prevention strategies is critical for all healthcare professionals' well-being and for their patients' health goals. Advanced Practice Nurses (APNs) must be knowledgeable and competent in empowering all employees in clinical and community settings with regards to ensuring a healthy workplace. APNs, nursing managers and physicians should adopt and re-enforce 'zero-tolerance' for any types of violence in the workplace. This process can easily be implemented when it comes to educating nurses about workplace violence. Education is an essential strategy to combat workplace violence. Education is further enhanced by the use of multimedia presentations such as the "Workplace Violence Among Nurses" video.

Recommendations

The educational video can be implemented in various healthcare settings. Measuring the outcome of knowledge gained can be completed by the use of a pre- and post-test. Also, the development of a workplace environment assessment tool could be implemented along with the educational video. Doing so would empower healthcare providers and create a positive outcome towards patient care and safety. Due to the inevitability of turnover in staff in the various units, it is essential for the manager or Advance Practice Nurse to regularly revisit the issue of workplace violence, ensuring that everyone brings positive change to the unit. Creating an educational tool is half the work while the other half is to maintain a positive attitude and change negative influences. Mitigation and evaluation tools can be created to evaluate the satisfaction of the staff nurses in the unit which will assist in understanding the positive change in the nurse's attitude and, in return, to the unit as a whole. The evaluation and mitigation can be done annually or biannually. If the evaluation reveals positive results it would mean nurses are satisfied with the team dynamic and are able to deal with the workplace violence they might encounter. If the evaluation reveals negative results it may mean that more education or possibly a different strategy needs to be created to re-enforce the initial positive change.

Conclusion

It is imperative to implement educational strategies, such as the use of the educational "Workplace Violence Among Nurses" video, perhaps in conjunction with oral presentations, case studies, mentorship and various other methods to create a forum for discussion and awareness among nurses. The limitation of an educational video is that it is problem focused, specifically based in a hospital setting, and thus, may not apply to community settings. For future practice it is important to educate using a visual multi-media approach to create a positive dialogue for change. After all, the best positive change is when nurses come up with solutions and ideas themselves rather than having a top-down approach towards enforcing change that they may not believe in. Viewing the workplace violence educational video is not enough. Further tools such as evaluation and mitigation to maintain a safe environment for all nursing staff must be included. In addition, re-enforcing an awareness of workplace violence annually is important so that it does not occur again. It is crucial to stop the cycle of violence in the workplace and to promote positive change. Nurses, managers and Advanced Practice Nurses must recognize, instead of ignore, the obvious and must take action instead of continuing to expose newly hired graduate nurses to hostile workplace environments.

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Learning objectives

Participants will...

1. realize the necessity that stopping the cycle of violence in the workplace and to promoting positive change is of high priority for the advance practice nurses, managers, nurses and all health care providers.
2. appreciate that the exposition of newly hired graduate nurses to hostile workplace environments must be recognized and that appropriate action must be taken.

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Learning and performance outcomes of mental health staff training in de-escalation techniques

Workshop

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Perspective: Research

Background and context

De-escalation techniques are a highly recommended therapeutic intervention for the management of violence and aggression. They are taught as part of mandatory training for all UK National Health Service staff. Despite this, little is known about the effectiveness of this form of training.

Aims

A systematic review was conducted to

- evaluate the effectiveness of this form of training,
- identify moderators of effectiveness,
- identify data relating to the acceptability of interventions.

Methodology

The review process included: an exhaustive literature search, eligibility screening of results, data extraction, quality appraisal, and data synthesis.

Findings

The search process identified 37 empirical studies evaluating the effectiveness of training interventions. There were 34 Cohort Studies, 3 Case Control studies, 0 RCTs and 0 qualitative studies. 7 studies provided acceptability data. 1 study was rated as strong, 17 studies as moderate and 19 as weak in quality.

Effectiveness

The strongest impact of this form of training is on participant confidence to manage aggression. A further consistent finding was that improvements in de-escalation performance can be observed and objectively measured after training. However, these improvements were limited to artificial training scenarios. There was little evidence of measured improvements in de-escalation techniques impacting on safety outcomes in practice. No strong conclusions could be drawn about the impact of training on assaults, injuries, containment and organisational outcomes due to a) low quality evidence and b) conflicting results.

Moderators

This review identified no evidence that age, occupation, level of experience and gender are reliable predictors either of the impact of training or of de-escalation performance.

Acceptability

The data were consistent in terms of the positive value participants attached to the training. However, there were a number of recommendations to enhance quality including: increasing the frequency of training, a stronger emphasis on the use of role play and on training all members of the multi-disciplinary team together.

Implications

High quality research innovations are needed to address the lack of clarity around the effect of this intervention. This should include the development of evidence-based interventions for evaluation in feasibility studies measuring both de-escalation performance and transfer to enhanced clinical and organisational outcomes.

Conclusion

Training staff in non-physical conflict resolution represents a substantial and costly proportion of National Health Service mandatory training. It is assumed that this training may improve staff's ability to de-escalate violent and aggressive behaviour. There is currently limited evidence to suggest that this form of training has this desirable effect.

Learning objectives

Participants will...

1. understand of the quality of existing research evidence on this topic.
2. have knowledge of the evidence of effectiveness.
3. be able to discuss future research and practice developments in this area.

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Bullying and incivility in nursing: A work place reality

Paper

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Perspective: Practice

Abstract

Historically, bullying was associated with school children, however, recently this phenomena was spilled over to the nursing work place. A current study by Johnson and Rea, 2009 showed that 27% of nurses had experienced work place bullying in the last six months by their managers or charge nurses. Moreover, incivility is contagious epidemic with fast spreading throughout the work place that affects employees on all levels. According to the current literature, more than 60 percent of employees were directly exposed to work place incivility the rest affected indirectly (Leekley 2012). Furthermore, nursing literature revealed that bullying and incivility were associated with burnout, job dissatisfaction and turnover.

With the advance in technology and the growing use of social networking such as Face book and Twitter a new dimension has been added to the incivility behavior in work place which negatively impacts the productivity, retention, satisfaction and employees morals. Health care managers should address this issue using education, and other strategies to reduce such negative impact on their employees.

The purpose of this paper is to explore the negative impact of incivility and the inappropriate behavior on the work place and the impact of such behaviors on employee's productivity, morals and strategies to prevent the occurrence of such behaviors.

Learning objectives

Participants will...

1. understand the impact of work place incivility on nursing productivity and morals.
2. identify effective strategies to deal with incivility among nurses in work place.
3. Have ideas on how to develop policy to reduce the incidence of work place incivility and violence among nurses.

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A training course in aggression management for nursing students: Its aims, contents and benefits

Paper

Johannes Nau

Perspective: Education and Training

Keywords: Aggression; violence; staff in distress, nursing student; aggression management, coping with aggressive behavior

Background

The nursing profession has one of the highest assault risks compared to other professions (International Council of Nurses - ICN, 2007). Managing patient aggression is therefore a challenge for nurses, especially for nursing students since they are mostly young and less experienced. Experts recommend staff training to prevent and manage aggressive situations with patients or their relatives. However, in many countries this subject is not covered in pre-registration nursing education. Experts stress the necessity to design programs adjusted to the special needs of the target group and target setting (National Institute for Clinical Excellence (NICE), 2005). This implies that we need a “tailor-made” training course designed for specific situations in the education of nursing students. Thus a special training course for nursing students was developed and evaluated. It includes about 24-26 hours of training and has been in use since 2008 in several schools of nursing in Germany.

The main focus of this article is on the discussion about the usefulness of such training programs. Therefore scientific evaluation will be combined with anecdotal evidence from up to 35 courses within the last 5 years. The scientific focus will show results of the developmental stages of the course e.g. in which way the confidence in managing aggressive behavior will be influenced, what impact it has on the performance in deescalating aggressive behavior and last but not least whether the confidence influences the performance.

Development of training intervention

The training was developed in the following steps:

1. Focus group interviews with nursing students
Twelve nursing students participated in semi-structured interviews. Data were evaluated by qualitative content analysis. They showed that managing patient aggression is a general challenge for nursing students and is not confined to psychiatric settings. Specific problems of beginners became evident. General issues were addressed like controlling causes of aggression, interpreting aggressive situations, dealing with the aggressive patient, coping with stress, and organizational issues. The conclusion was: Nursing students need preparation and training in handling patient aggression. They should acquire knowledge about aggression, awareness of contributing problems and factors, self-confidence in dealing with aggressive situations, assertiveness and empathy while communicating with patients and relatives and the ability to cope in a healthy manner. In addition the safety policy of hospital placements should be examined for their appropriateness in supporting nursing students (Nau, J., Dassen, T., Halfens, R., & Needham, I.; 2007).
2. Development of a first version of a training course for nursing students and evaluation after four courses
Based on the results of interviews and on evidence of core-curricula (NHS Security Management Services, 2005; Oud & Walter, 2005; Zarola & Leather, 2006) a new curriculum was developed. This first version was evaluated in respect of aims, content and impact on self-confidence after using it with four groups of students with 15-19 participants each (Nau, Dassen, Halfens, & Needham, 2007) and led to the (tentative) final version.
3. Establishing a final version
After evaluating the results the following core-curriculum and methods were established (Nau, Halfens, Needham, & Dassen, 2010):
Lectures: Definition of aggression (APA, 2000); Current theories and their limitations; Assault cycle; Impact of stress hormones; Phases of aggression; Post trauma support; Attribution theory; Just World Hypothesis (Lerner); Safety culture.
Group work: Sharing personal experiences about aggression (Cohn, 2004); Coping with perceived aggression
Skills training: Self-awareness; verbal, para-verbal and nonverbal communication skills; body language; Danger zones/spatial safety zones; Non-provocative intervention; safe posture; variations of non-provocative release; Escape from body holds, choking, and biting; Self-awareness; Verbal, para-verbal and nonverbal, non-physical de-escalation; Communication skills; Body language.

This version of the training course was subject to further investigation

Methods of training evaluation

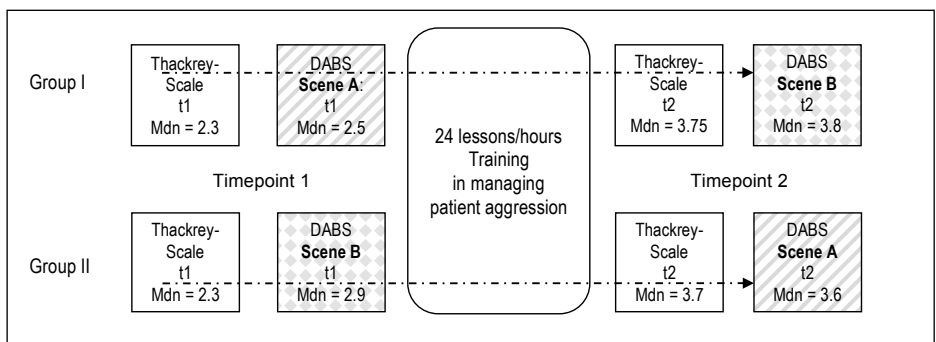
In a 'pretest–posttest within-and-between-group design' nursing students encountered two scenarios (A or B) with simulation patients.

1. Thackrey's confidence in coping with patient aggression scale was used before the training, immediately after the training, and in some courses after two weeks in practical placement. The instrument and its German translation have demonstrated the capacity to monitor change on a short-term and a long-term basis (Needham et al., 2005c; Thackrey, 1987). The original instrument is a one-dimensional, 10-item scale demonstrating a high degree of internal consistency and precision. The German scale scores from 1 to 5 with high scores denoting greater perceived confidence. The German translation of the instrument produced equivalent psychometric results to Thackrey's original scale which is in English.
2. Performance was tested by using the Deescalating Aggressive Behavior Scale (DABS) (Nau, Halfens, Needham, & Dassen, 2009). Mean values and statistical significance tests were computed to compare the results. DABS is a 5-point Likert scale using only 7 items and employing a strongly agree to strongly disagree format. Cronbach's alphas of 0.87 and 0.88 indicated good internal consistency irrespective of rater group. A Pearson's r of 0.80 confirmed acceptable test–retest reliability, and interrater reliability. Intra-class Correlation 3 ranging from 0.77 to 0.93 also showed acceptable results. The effect size r of 0.53 plus Cohen's d of 1.25 indicates the capacity of the scale to detect changes in performance. (Nau, Halfens, Needham, & Dassen, 2009).
3. Correlations were computed between confidence in coping with patient aggression and performance in managing aggression

Using a 'pretest–posttest within-and-between-group design' nursing students of six educational levels (six classes, 10th–28th month of nursing education, $n = 65$, mean age = 22) were investigated at two time points. Each time point evaluated self-assessment of confidence and immediately afterwards expert's assessment of performance (Figure. 1). Therefore each participating class was divided into two groups. Both groups received the same training, but group I began with pre-test performance test 'Scenario A' and ended with the post-test using scenario B while group II started with scenario B and got post-test scenario A. In order to create an almost realistic environment they were sent one by one into the room. The students agreed on not discussing the scenarios with other participants.

The differing types of pre- or post-test stimuli in interchanged sequence allowed to compare identical scenarios managed once in the untrained and once in the trained study condition (between group design). A within-group design made it possible to reveal changes in performance concerning each participant. Before starting the performance the students assessed their confidence. This self-assessment was repeated afterwards.

Figure 1: Research design



The performances were first videotaped and then evaluated by de-escalation trainers using the DABS. Therefore the video scenarios were blinded and randomly distributed on five DVDs whereby every DVD was rated by three raters. Thus 15 raters were involved. All these raters had received a one year training program for consulting and training of aggression management by Nico Oud and colleagues (Oud & Walter, 2005). The participants knew nothing about self-assessment values and pre- or post-test condition. Because of the non-parametric statistics medians were computed. Statistical significance of change was evaluated using Wilcoxon signed-rank test (differences within groups) and Mann-Whitney-test (differences between groups). The sensitivity, specificity of the Thackrey-Scale and its predictive value for identifying poor and good performance were also computed. The scales' neutral midpoints (score of 3.0) were used as cut-off point.

Results

Both scales, the self-assessment scale of confidence and the rating of performance, showed a significant improvement of group medians after aggression management training. In group I self-confidence in the post-test (Median = 3.75) was significantly higher (Wilcoxon signed-rank test) than in the pre-test (Median = 2.3), $Z = -4.94$, $p < 0.001$, $r = -0.87$. Quite similar were the results in group II (Pretest Median = 2.3, Posttest Median = 3.7), $Z = 5.02$, $p < 0.001$, $r = -0.87$. Analogously, comparisons of identical scenarios (type A or B) managed by trained and untrained students showed that trained students had significantly more self-confidence and performed significantly better: a score of 3.0 indicates 'neither good nor poor'. In scenario A the DABS scores increased from Median = 2.5 (untrained group I) - Median = 3.6 (trained group II), $U = 93.0$, $p < 0.001$, $r = -0.71$ (Mann-Whitney-test). In situation B the performance improved from Median = 2.9 (untrained group II) - Median = 3.8 (trained group I), $U = 193$, $p < 0.001$, $r = -0.55$. (Mann-Whitney-test) (Nau, Dassen, Needham, & Halfens, 2011).

Discussion

The findings provide some evidence that training is suitable to enhance nursing students' de-escalating performance and students with the highest need of improvement benefit the most from participating in a de-escalation management training course.

Although significant statistical results suggest that improved performance is closely related to training we must consider whether the statistical significance is of clinical relevance. After training the group mean did not reach the 'good performance' score of 4.0. However, prior to the training only 8 students scored higher than 3.6, whereas afterwards 49 students scored 3.6 or higher. To achieve a score of 3.6, for instance, no more than three criteria were allowed to be judged 'neither good nor bad', and contemporaneously four criteria must have been judged 'good'. Especially in view of the particular meaning of each criterion (Table 1), this suggests that offering the training is justifiable. Further health research from around the world pertaining to physical injuries and psychological responses following exposure to aggression highlights the need for preparation and support when it comes to the safety and health of all staff members (International Labour Office - ILO et al., 2002, Needham et al., 2008). Then, clearly, nursing students should not be excluded from this.

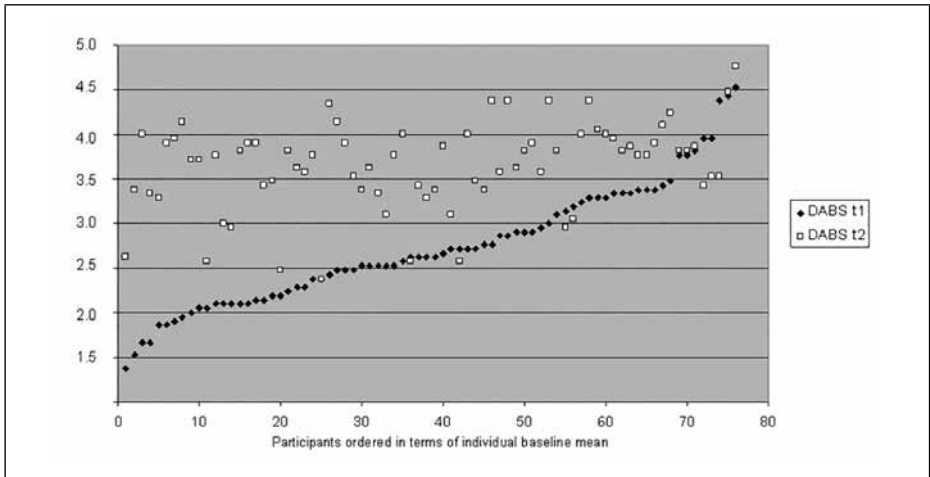
Table 1: De-escalating Aggressive Behaviour Scale (DABS)

Students' behaviour towards client
1. Valuing client
2. Reducing fear
3. Enquiring about client's questions and anxiety
4. Providing guidance to the client
5. Working out possible agreements
6. Remaining calm
7. Risky*

* Absence of risky behaviour is recoded in the direction of best practice

The student nurses neither started at the same pretest value, nor progressed at the same rate, nor showed identical learning results. Results showed that some students had already performed well. This is noteworthy because they had not attended training before. Apparently they succeeded in informal learning in a way that should also be investigated but this was not in the scope of this study. However, this study shows that, despite a general pattern of progress, some students did not improve their performance and – surprisingly – some showed weaker performance after training (Figure 2). Nevertheless, the results generally suggest that trained persons are more likely to develop their skills. Figure 2 also points out that even skilled people may not always succeed in de-escalation. This could mean that de-escalation of a new unknown situation will always remain a challenge – even if training was provided.

Figure 2: Individual DABS post-test score (t_2) related to pre-test score (t_1): 3 = neither good nor bad behavior



It may be that development of competence may occur by maturation. However, an inspection of the nursing students' age and their duration of previous nursing education showed no relationship on how these factors may influence their baseline values. This suggests that students' performance does not improve naturally and that it is possibly erroneous to assume that they will learn aggression management on the job (Nau, Halfens, Needham, & Dassen, 2010).

Given the benefit of such programs and the worldwide problem of aggression (International Council of Nurses - ICN, 2007), the question "Should we implement a course like this for our nursing students?" may become "How can we implement further hours of education into our curriculum?" Although it was not strictly the focus of the investigation, some remarks on the topic may be useful. The staff of the nursing school participating in our project reported that they had conducted an evaluation of the curriculum to identify topics which had changed and were no longer necessary. These outdated curriculum contents were substituted by aggression related topics. If the constraints of legal or school policies do not allow new topics to be established in this way, we suggest additions to existing modules or school subjects covering, for example, health sciences, psychology, or – depending on the verbal skills required by the curriculum – communication skills.

This study is subject to certain limitations. Due to practical constraints – the limited number of available participants and costs – we were not able to use a control group. However, other studies (Nau et al., 2009a, Needham et al., 2005, Thackrey, 1987) have provided some evidence that maturation is not to be expected without a training intervention. Alternatively we chose a design using two groups with interchanged pre- and posttest stimuli to monitor changes. The chosen design revealed a striking comparison of trained and untrained behaviour with highly significant differences ($p < .001$).

The situations students were requested to master were somewhat artificial. The students knew in advance that they would be surprised at some point. They knew that they will encounter a simulation patient and that a researcher will be in the room to videotape the situation. These conditions may have distracted the students. However practical and ethical considerations made it impossible to conduct such an investigation in a real clinical setting. Nevertheless, the students attested later that the simulation patients performed realistically and that when they became engaged in the simulation they were not distracted by the recording procedure.

The evaluation of the videos could also be biased because of the use of 15 rater-experts in 5 groups. Some rater triplets could possibly have been more or less accurate and less rigorous or indulgent in its judgment than another. Additionally the number of raters per DVD could be considered small. However, all five rater triplets judging the differing 30 or 32 video scenes of a particular DVD revealed congruently statistically significant ($p = .02$) performance improvement.

Up to now more than 35 trainings were given in the way described above. Evaluation of its impact via group discussion at the end of the pre-registration nursing education reveal following issues:

- Students value the participation in aggression management courses
- Students perceive it as a problem, that the staff in general hospitals and nursing homes is less trained or not trained in managing patient aggression. Thus they lack in role models
- If no refresher courses are offered the achieved contents and competencies may be forgotten.

- It is not sufficient to train students in managing difficult situations. In addition healthcare institutions should implement preventive measures in the organization
- Especially the fact that the majority of health care institutions do not provide a policy regarding violence prevention and de-escalation management should be made to an important content of the preparation of students for their practical placements

Conclusion

Improvement in dealing with aggressive situations does not occur of its own accord. This is shown by consistent results of low baseline, visible in all groups at different stages of nursing education without intervention. This investigation provides evidence that a training program in aggression management can positively affect students' confidence and performance in de-escalating aggressive patients. Aggression management training is able to reduce distress and to improve nursing students' performance in de-escalating aggressive behavior. This adds clinical benefits for patients, relatives and students.

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Learning objectives

Participants will...

1. be able to appreciate that a special training for nursing students is able to support nursing students' self-reported capacities to manage patient aggression - solely because the nurses perceive a significant reduction of distress and discomfort when facing aggressive patients hence it is worth to offer the course.
2. Learn that aggression management training is able to improve nursing students' performance in de-escalating aggressive behavior. This adds clinical benefits for patients, relatives and students.

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The quantitative impact of nonviolent crisis intervention training on the incidence of violence in a large hospital emergency department: A quality improvement study

Paper

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Keywords: Hospital violence, nursing violence, violence incidence, violence training, workplace violence conceptual framework

Perspective: Practice

Background

The National Institute for Occupational Safety and Health (NIOSH) defines workplace violence as “violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty” (National Institute for Occupational Safety and Health [NIOSH], 2002, p. 1). Emergency department (ED) and mental health staff incur greater risks of workplace violence than staff in other areas (Gillespie, Gates & Berry, 2013). Nonviolent Crisis Intervention (NCI) training may help staff diffuse violent situations, increasing the quality and safety of patient care (Gates, Gillespie, & Succop, 2011).

Conceptual Framework Requirements for a QI Violence Study

A conceptual model was needed to support a Quality Improvement (QI) study. Violence-related attributes were identified and grouped from the literature. The attribute groups are outlined here. The magnitude of a violent event is its severity or its frequency of occurrence if the violence is repetitive (May and Grubbs, 2002; Mooij, 2012; Tyrer et al., 2007). People involved in healthcare workplace violence (patients, family members, staff, etc.) are actors. Future refinement may need to differentiate aggressors from victims. These attributes were identified and described by Ben Naten, Hanukayev, and Fares (2011), Pai and Lee (2011), and Winstanley and Wittington (2004).

Background Factors

Background factors which influence how a violent event occurs are called influences. These factors are:

- Staff behaviors and training, described in detail by Cahill (2008).
- Social factors such as drugs and alcohol use (May and Grubbs, 2002; Ferns, 2006; Luck et al., 2008), or socio-demographic factors such gender, age or ethnicity (Ben Naten et al., 2011).
- Psychological factors such as frustration due to long wait times (May & Grubbs, 2002; Crilly et al., 2004).
- The nature of patient illness/injury and prescription side effects (Ferns, 2006).

Manifestation

The manifestation of a violent event: Verbal/threatening behaviors, or physical attacks on victims. Both are consistent with NIOSH (2002). The dimensions (magnitude, actors, influences and manifestation) formed a new acronym and name for the model. The resulting MAIM conceptual framework is shown in Figure 1. The attributes circled in dashed lines were isolated for the study.

Local problem and QI study

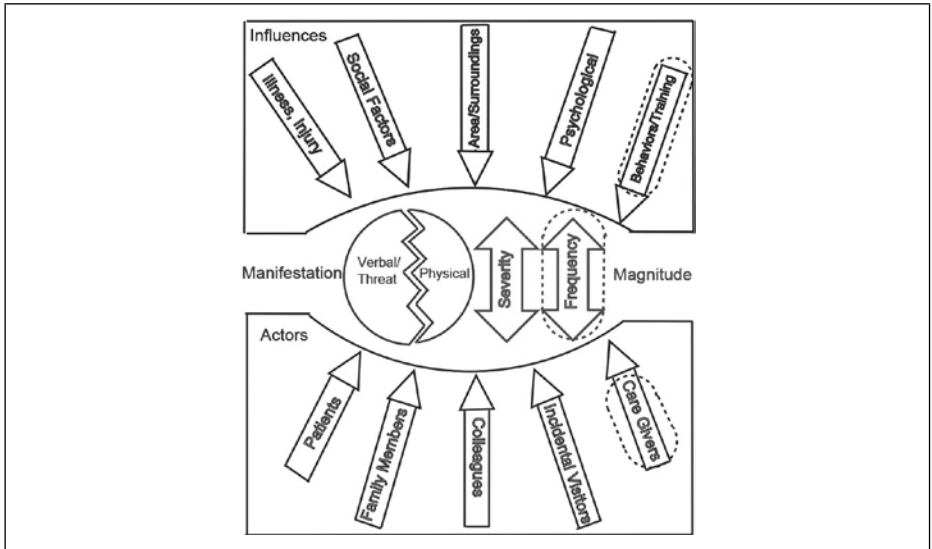
At the study setting, patient care is interrupted when frustrated or combative individuals confront staff. When violence occurs or appears imminent, staff declare code purples via the public address system, initiating urgent security team responses. In mid-2011, concerns about employee morale and safety spurred an NCI training investment. All employees were eligible to attend the training. A QI study began in late 2012 to evaluate the effectiveness of the ongoing training investment. The study focused on the ED, as the majority of code purples occur there. The study evaluated NCI training impact on ED code purples, and the training investment in terms of cost versus benefits.

Methods

A single-phase observational study occurred over a one-year period. The study began on November 1st, 2012 and ended on October 31st, 2013. The setting was the primary ED of a 304-bed acute tertiary care hospital with

over 75,000 ED patients/year. All employees were offered NCI training. Physicians (non-employees), were excluded due to regulatory restrictions.

Figure 1. The MAIM conceptual model.



Methods

A single-phase observational study occurred over a one-year period. The study began on November 1st, 2012 and ended on October 31st, 2013. The setting was the primary ED of a 304-bed acute tertiary care hospital with over 75,000 ED patients/year. All employees were offered NCI training. Physicians (non-employees), were excluded due to regulatory restrictions.

Planning the intervention and the study

At the study start, 42% of the ED staff were already NCI-trained. The study analyzed the impact of ongoing NCI training on monthly ED code purples. The hospital security team provided weekly code purple reports. The ED reported monthly on hiring and training. Security-based reporting avoided violence under-reporting, widely documented in violence studies (Ben Naten, Hanukayev, & Fares, 2011; Gacki-Smith et al., 2009; Gates et al., 2011; Medley et al., 2012 and Sato, Wakabayashi, Kiyoshi-Teo, & Fukahori, 2013). The reporting method also avoided the Hawthorne effect (i.e., changes in staff behavior induced by their awareness of the data being collected; Leonard, 2008; Mayo, 1933). The accounting department provided volume data.

If effective, NCI-training would reduce monthly code purples. Expected confounding factors were the psychiatric patient mix (Gillespie et al., 2013), staff turnover/experience (Cahill, 2008; Sato et al., 2013), staff gender mix (Ben Naten et al., 2011), and ED wait times (Gates et al., 2011; Gillespie et al., 2013). The variables analyzed were: Percentage of cumulative NCI-trained staff by month; Percentage of staff completing NCI training each month; Code Purple events per ED visit per month. The expected confounding variables were: Percentage of monthly ED psychiatric patients; Percentage of male versus female staff; Average monthly ED wait-to-greet times; Percentage of staff who left employment in the current month, previous month or the current 60, 90, 120, 150 and 180 day periods. If no significant negative correlation were found between cumulative NCI training and code purple incidence, additional training variables were to be examined: Percentage of staff completing NCI training in the current month, the previous month, and the current 60, 90, 120, 150 and 180 day periods. IBM SPSS Statistics version 22 was used to analyze the data. Correlation analysis used Pearson's r . Linear regression determined the incremental impact of NCI-training on monthly code purples.

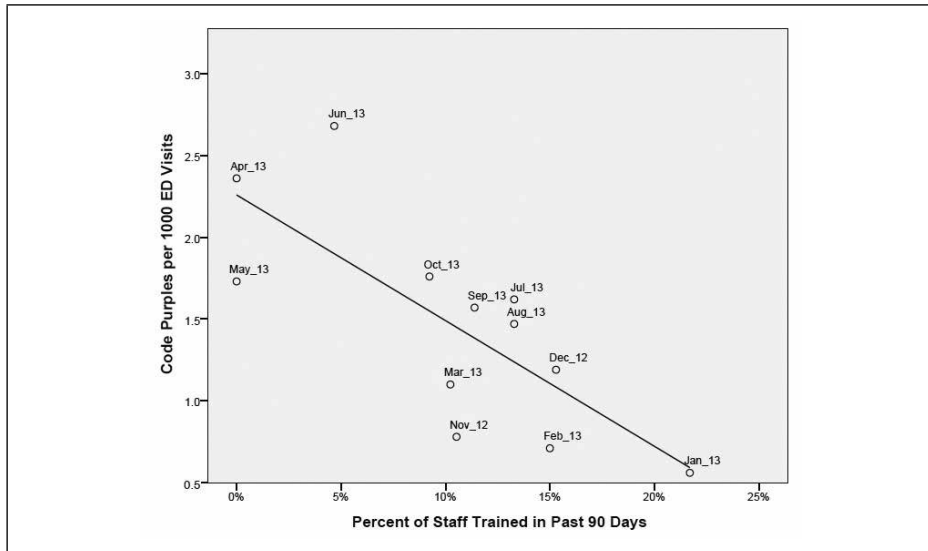
Results

During the study 111 code purple incidents occurred across 76,246 ED visits; a mean rate of 1.46 events per 1,000 patient visits. Monthly incidences varied between 0.56 and 2.68 events per 1,000 ED visits.

- **NCI Training for ED Staff:** The percentage of trained staff increased from 42% (n=104) to 75% (n=109) over the study period. The percentage varied throughout the study due to hiring versus attrition.

- **Code Purple Incidence Versus NCI Training:** Code purples were expected to decrease as progressively greater percentages of staff were NCI-trained. This did not occur. Further study was needed. Additional study found a strong negative highly significant correlation between code purple monthly incidence and the percentage of ED staff NCI-trained within 90 days ($r = -0.756$, $p = 0.004$). The regression plot for the relationship is shown in Figure 2.

Figure 2. Regression plot. Code purples versus percent ED staff trained in past 90 days



Another strong, highly significant correlation emerged between monthly code purples and the monthly percentage of ED psychiatric patients ($r = 0.824$, $p = 0.001$). A moderate significant correlation also surfaced between monthly code purples and the percentage of staff turnover within 90 days ($r = 0.594$, $p = 0.042$). Analysis also identified significant negative correlations between monthly code purples and both the 120-day and 150-day percentages of NCI-trained staff. Correlations were nearly as strong as the 90-day figure. No correlations were found between percentages of NCI-trained staff and code purples for periods greater than 150 days. A partial Pearson's r addressed the psychiatric and 90-day turnover confoundings as control variables. A strong negative Pearson's value ($r = -0.675$, $p = 0.032$) persisted between code purples and the percentage of staff trained within the past 90 days. The partial linear regression formula provided by SPSS was: $y = (6.02)10 - 19 - (4.52)10 - 3 x$.

Discussion

When greater percentages of staff were NCI-trained within 90-150 days, monthly code purples decreased. This contrasted with increases in code purples as more staff were trained overall. To further assess the training impact, the 90-day NCI-trained staff percentage replaced the cumulative NCI-trained staff percentage as the independent variable.

Limitations

The patient population was not standardized for illness/injury, age, gender, or race. The monthly percentage of ED psychiatric patients was tracked as a possible confounding, however. The possibility of increases in code purples due to staff awareness and greater focus on violence prevention and intervention subsequent to NCI training was not addressed. Benefits of training completed before the study were not considered. The QI study was limited to the ED. Further study may determine how findings apply to other areas.

- Interpretation/Cost/Benefit: Correlation and regression findings show recent training appears to lower the incidence of monthly code purples. Details follow below.
- Effect timing: The correlation implies that NCI training has a temporary (90-150 days) effect on code purple incidence. A lack of correlation for periods greater than 150 days may infer training benefits erode within six months. Semi-annual training may strengthen code purple reductions.
- Intervention benefit: Based on the partial regression slope, a one percent increase in NCI-trained staff within the current 90 day period mapped to 0.0452 fewer code purple events per 1,000 ED visits. In aggregate, the

NCI training impact avoided 33.7 code purples, a 23% decrease from the projected number of code purples had NCI-training not occurred.

Code purple cost: Most work-related violence studies only reflect costs associated with physical injuries, as injuries are more readily defined and measured (McGovern et al., 2000). Additional impacts may contribute to the cost of violence. Assaulted staff may suffer emotional effects even if no physical injury occurs (Gates, Gillespie, & Succop, 2011). Table 1 lists potential impacts.

Table 1: Potential cost contributors to code purple events

Impact Area	Cost Component	Reference(s)
Employee Impact	Decreased productivity due to adverse impacts on employee morale	NIOSH (2002)
	Employee burnout	Winstanley & Whittington (2004)
	Post-Traumatic Stress Disorder (PTSD)	Pai & Lee (2011), Inoue, Tsukano, Murakoka, Kaneko, & Okamura (2006)
	Cost of recovery time if injury occurs	US Department of Labor (BLS), 2013
	Cost of medical treatment if injury occurs	US Department of Labor (BLS), 2013
Patient Impact	Quality of care	Medley et al. (2012), Gates, Gillespie, & Succop, (2011)
Security cost	Cost of security to manage code purples	Event/ Facility specific
Facility Impact	Damage to facilities or equipment	Event/ Facility specific
General liability	Risk/Cost of Litigation	Event/ Facility specific

Cost versus benefit

Despite the lack of available data to support cost models, the health care industry continues to call for workplace violence reduction. Ultimately, the question needing answered becomes: Is investing 0.77% of annual payroll (16 of 2080 hours per staff member) worth mitigating 23% of the workplace violence risks?

Conclusions

The benefits justified the training costs. Although the implied erosion of benefit outside 150-days was surprising, no prior literature or studies stated or implied that benefits derived from one-time NCI training were permanent. Semi-annual training may yield further reductions in workplace violence. Subsequent studies in this field are recommended to initiate with normalized expectations regarding the implied short and long term effects of NCI training.

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Learning objectives

Participants will...

1. have an understanding of how to evaluate the cost versus benefits of a nonviolent crisis intervention training curriculum.
2. have an understanding of the need for reinforcement nonviolent crisis intervention training to occur on a repeated periodic basis.
3. be able to enumerate several statistically significant confounding factors associated with the incidence of violent events in a US hospital emergency department.

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“Not worth the paper”: How hospital nurse managers in the United States discuss anti-bullying policies

Paper

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Perspective: Research

Keywords: workplace bullying, nurses, managers, hospitals, policies

Background

While physical violence has been identified as a problem faced by hospital nurses, in Anglo-American cultures more nurses experience workplace bullying (Spector, Zhou, & Che, 2013). In the United States (US), prevalence rates for workplace bullying have been reported to be around 30% (Berry, Gillespie, Gates, & Schafer, 2012; Johnson & Rea, 2009; Simons, 2008). This is concerning as the presence of workplace bullying contributes to an unsafe environment for both patients (Wright & Khatri, 2014) and healthcare providers (Nielsen, 2012).

Workplace bullying is commonly defined as a series of negative acts, which include social ostracism, attacks on a person's professional or personal reputation, and deliberate sabotage of another's ability to do their job through actions such as withholding vital information (Einarsen, Hoel, Zapf, & Cooper, 2011a). Workplace bullying, unlike other forms of workplace incivility or conflict, is characterized by an imbalance of power between the target and the bully (Einarsen, Hoel, Zapf, & Cooper, 2011b). As a result of this power imbalance, it is difficult, if not impossible, for targets of bullying to resolve the problem on their own (Lutgen-Sandvik, 2006). Consequently, to resolve bullying, targets need assistance from others within their organization. While targets report they often turn to their managers for assistance, they also report that managers are often unwilling or unable to resolve incidents of bullying (Gaffney, 2012; Namie & Lutgen-Sandvik, 2010). On the other hand, managers report they feel they have an obligation to respond to complaints of bullying, but they do not always feel their efforts are supported by the organization (Lindy & Schaefer, 2010).

Currently in the US there are no mandates stating that organizations need to address workplace bullying (Yamada, 2011). However, in 2009 The Joint Commission, the regulatory agency responsible for accreditation of hospitals in the US, issued a directive which required hospitals to address disruptive behavior. While this document never specifically mentions bullying, this directive has been interpreted as requiring hospitals to address bullying (Johnston, Phantharath, & Jackson, 2009). To date, there is no information on whether hospitals have implemented policies that help managers understand and respond to workplace bullying. The aim of the study which is reported here was to explore how hospital nursing unit managers talk about their organizations' policies, and whether they find them useful. The goal was to gain some understanding why managers do not appear to be helping targets, and how this situation could be amended.

Methods

This descriptive, qualitative study took place in the Pacific Northwest region of the United States. Fifteen hospital nursing unit managers, who were recruited via purposive sampling, were interviewed. During the interviews, managers were presented with policies from their organization, which were obtained from the human resource department of the organization (n=3), the organizations' publically available web site (n=2), or from the participants themselves (n=2). In total, 14 documents, from 6 of the 7 organizations in which participants worked, were analyzed. After presenting the policy documents to the managers, they were asked the following questions:

- Tell me about this document, is it something that you are familiar with?
- How often would you say you refer to it?
- How about other people who work here, have you ever heard anyone else talk about it?
- Are staff aware of this document?
- How useful is this document in providing an understanding of bullying behaviors?

Interviews were audiotaped, and transcribed verbatim by a professional transcriptionist. Data was analyzed using thematic analysis (Braun & Clarke, 2006).

Findings

There were three themes that were identified: Not worth the paper, This is my Bible, and Never seen it. These will be discussed below.

Not worth the Paper (7/15; 47%)

In this theme managers were familiar with the policies but felt they were not useful. They described the policies as just “words on paper” (Participant 6), “very vague” (Participant 10), and “it means very little” (Participant 2). They said the policies could be interpreted differently because they were vague, which meant that staff often got away with bullying. In addition, managers felt the policies were not useful because they didn’t adequately describe bullying. As one of the managers said, “they outline what you’re supposed to do, but there are so many variables to bullying” (Participant 9). Within this theme, there was also disagreement with the way behaviors were labeled in the policies. As one manager said of her organizations policy, which was labelled “Fitness for Duty”,

“if you want to put a thing [policy] like that, for bullying, then put one out. Explain what it is. And not fluff around, you know? I like direct language. Works much better.” (Participant 2)

Additionally, participants said the policies were not useful because they did not give concrete guidance to managers, nor did they consider the possibility of union action. As one manager said, “in the union environment, it ultimately doesn’t matter [what the policy says]...at the end of the day, it’s our policy, but it still gets grieved” (Participant 10). The managers also said that because of the threat of union action, some managers were reluctant to enforce policies.

This is my Bible (5/15; 33%)

In this category, the managers said the policies helped them define bullying behaviors and discipline staff. One manager said that her policy listed the “whole laundry list” (Participant 9) of behaviors that constitute bullying, and that she used this list to point out to staff that “this is what you should do, and this is what you actually did.” Another said “this pretty much covers everything. Helps a lot” (Participant 1).

In this theme, managers described referring to the policies frequently, and using them to educate and discipline staff. One manager (Participant 7) described the policy as “my bible” and said she “highlighted” passages she refers to frequently. While this manager said the policy was very useful in her current efforts to discipline a staff member who had engaged in bullying, she went on to describe this process as one which had lasted over a year and had involved multiple grievances to the union; issues that other managers cited as reasons that the policies were not useful. Interestingly, some of the same policies which were deemed useful by some managers were described as not useful by others. Furthermore, policies which were labeled as “too vague” by some managers, were described as “general enough that you can really pinpoint issues with someone” (Participant 3) by others. Some of the participants said that because the policies were interpreted differently by different managers, enforcement was not consistent.

Never seen it (3/15; 20%)

When presented with their organizations’ policies, three of the managers said they were unaware of the existence of this policy. One said she had been to a recent workshop on disruptive behavior, and the policy, which was titled Disruptive Conduct by Staff, had not been mentioned. Another said she was unaware of the policy, and would “probably be looking for a little while before I found it,” (Participant 3), because she would not have thought to look for the words “disruptive conduct.” The third worked for the organization in which a policy was never obtained for analysis. This manager was unsure if one even existed.

All of the managers, even those who were aware of their organizations’ policies, indicated that the policies were not part of the general discourse of the organization. They said that other managers rarely referred to them, even when they were discussing problematic behaviors among staff. As one manager said, “[the policy] kind of sits in the policy book and it’s there...but we don’t take this out and give it to staff and say, here, would you read this, because this is how you’re expected to conduct your business” (Participant 12). Only two of the managers said they made sure their staff was familiar with the policies regarding behavioral conduct. The others said the staff were given this information in orientation, or would be able to find the policies “online anytime they want” (Participant 14).

Discussion

The findings of this study suggest that the mere presence of a policy does not mean that managers will be able to more effectively address bullying. Over half of the sample in this study said that they did not find their organizations’ policies useful. While it might be tempting to say that the policies were poorly crafted, some of the policies that one manager found useful, another said was not helpful. Other studies have also reported that organizational members have different and varied interpretations of policies related to workplace bullying (Cowan, 2011). To avoid this problem, organizations need to make sure managers understand the intent of these policies. They also need to seek feedback from the end users of policies to determine if and how they are being

used (Rayner & Lewis, 2011). Policies which are not widely seen as useful should be updated with input from managers and staff (Jian, 2007; Peirce, Rosen, & Hiller, 1997).

Finally, the findings of this study illustrate the point which has also been made by other authors, that successful policy implementation will only occur if policies are widely disseminated and discussed throughout the organization (Coursey, Rodriguez, Dieckmann, & Austin, 2013; Rayner & Lewis, 2011). In organizations, texts which are widely discussed influence action, and when policies are not part of the general discourse of the organization, organizational members may be subtly discouraged from enforcing them (Phillips, Lawrence, & Hardy, 2004). (Peirce, et al., 1997).

Conclusion

While this study was conducted in a limited geographic area with a small sample, and cannot claim to be generalizable, there are some things that any organization that wishes to successfully tackle workplace bullying can learn from the findings. First of all, organizations need to consult the end users (staff and managers) to make sure that policies that address bullying are meeting their needs. They also need to make sure that these policies are widely disseminated, that all members of the organization are aware of their existence, and know how to use them. These efforts should be an ongoing process, and should be incorporated into wider discussions on civility and respect in the workplace.

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Learning objectives

Participants will...

- realize that organizations need to make sure that managers are aware of policies which address bullying-type behaviors.
- appreciate that organizations need to make sure that managers can use the policies to address bullying-type behaviors.

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Implementation of Recovery Rounds in the prevention of restraint and seclusion

Paper

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Perspective: Practice

Keywords: Interrupted time-series, least restraint, seclusion, mental health, minimizing control intervention, recovery

Introduction

Ontario Shores Centre for Mental Health Sciences (Ontario Shores) is a teaching hospital specializing in comprehensive mental health and addiction services for those with complex serious and persistent mental illness. The facility, in Whitby, Ontario, Canada, has 17 specialized inpatient units and extensive outpatient and community services. Our recovery-oriented model of care places direct emphasis on effective communication and goal-setting with patients and families in order to implement a proactive and collaborative approach towards care. One goal is the early identification of alternative interventions for patients who may be at risk for restraint and/or seclusion (R/S) use and the proactive implementation of a management plan to minimize R/S as a preventative approach to strengthening the therapeutic alliance. Our Therapeutic Relationship Model guides clinicians in communicating with and promoting patients' strengths and goals for well-being while ensuring the least restrictive and least intrusive practices to support recovery. Ontario Shores' current focus is on enhancing staff knowledge, communication skills and attitudes in advancing a culture of excellence, quality and safe care.

Background

Control and containment measures, such as restraint, are often common first-line interventions within healthcare settings (Cowin et al., 2003; Foster et al., 2007; Kynoch et al., 2009) and they are often used in the treatment and management of disruptive behaviours (Sailas & Fenton, 2012). While restraint and seclusion is perceived to be warranted at times (Bigwood & Crowe, 2008; Joanna Briggs Institute, 2002), there is a growing literature indicating the potential counter-therapeutic effects of this practice (Borckardt et al., 2011). Presently, there has been a stream of guideline activity in countries, such as Canada, USA and UK, encouraging organizations to shift towards the minimization of restraint, whereby its use is to be a last resort when all other alternative interventions have been exhausted (National Offenders Management Services, 2013; MIND, 2013; Royal College of Nursing, 2013; College of Nurses of Ontario, 2009; Royal College of Nursing, 2008; National Institute for Clinical Excellence, 2005). This momentum emphasizes proactive, preventative approaches in the management of violence and aggression.

Evidence has linked the use of restraint to a number of adverse outcomes, such as the exacerbation of aggression, injury to staff or clients, increased costs, re-traumatization, rupture of the therapeutic alliances amongst staff and clients, physical injuries and death (Ashcraft & Anthony, 2008; Foster et al., 2007; Fisher, 2003; Mildred, 2002; Duxbury et al., 2011). Furthermore, the first Cochrane review assessing the effectiveness of the use of R/S compared to alternative approaches for those with serious mental illnesses concludes, "no controlled studies exist that evaluate the value of seclusion or restraint in those with serious mental illness...there are serious adverse effects for these techniques in qualitative reviews" (Sailas & Fenton, 2012, p.2). It has been suggested that the continued use of restraint and its efficacy must be questioned (Muralidharan & Fenton, 2012; Sailas & Fenton, 2012; Nelstrop et al. 2006).

Although there is a paucity of literature exploring the patients' perspective and experience in the use of R/S, extant evidence suggests patients do not view this practice as therapeutic. Soininen et al. (2013) found that following R/S patients felt R/S were 'hardly' necessary and that their opinions were not included in treatment planning. In Canada, the Psychiatric Patient Advocate Office (PPAO) reviewed R/S practices in a number of Ontario psychiatric hospitals (2001) and found that more than 50% of the patients stated that when they were restrained or secluded, they had not posed a threat to themselves or others, nor was there any confrontation with another. Additionally, once in seclusion or restraint, almost 50% said they did not know what was required of them to be released (PPAO, 2001). Other studies have indicated that being restrained can lead to feelings of anger, fear, panic, and sense of feeling dismissed (Bowers et al., 2012; Sequeira & Halstead, 2004; Bonner et al., 2002). This highlights the significance of trauma informed care and valuing patients perspective and experiences to recovery in mental health.

Despite the growing evidence that R/S are potentially counter-therapeutic, traumatic, unnecessary and can be life threatening (Curran, 2007; Duxbury et al., 2013), clinicians continue this practice. The use of restraint is

perceived to be one of the few options clinicians view as effective in managing violence and aggression, in the absence of a real evidence base (Cutcliffe & Santos, 2012). Staff need to be provided avenues for enhancing knowledge, communication skills and attitudes in advancing a culture of excellence, quality and safe care.

Ontario Shores has implemented "Recovery Rounds" as a mechanism to further support a recovery oriented approach to patient-care, by advancing a culture of least restrictive, least intrusive philosophies. The purpose of Recovery Rounds is to elevate the importance of R/S prevention and recovery-oriented care through witnessing of R/S events by senior staff. The Recovery Team is comprised of representatives from Senior Management (SM), Professional Practice (PP), Peer Support Specialists and the Clinical Ethicist. On a daily basis (during business hours) one member from SM, PP, Peer Support Specialist and Ethics attends all Codes indicating aggressive behaviour and the daily Unit Recovery Rounds. A schedule identifies the teams each day, ensuring a minimum of two members each day. Witnessing contributes to organizational change through oversight, accountability, timely communication, and the commitment that will surround every R/S event. It also provides an opportunity to work with teams to identify strengths as well as opportunities for improvement in R/S prevention techniques. Our aim was to study the effect of implementation of Recovery Rounds, implemented in November 2012, on incidents of R/S at Ontario Shores.

Method

Administrative data capturing incidences and durations of R/S over a 26 month period of time was subject to a segmented regression analysis. This allowed us to examine the effect of Recovery Rounds Implementation, as well as a change in trend (i.e. change in slope) prior to and following the Recovery Rounds implementation. Analyses were conducted on monthly seclusion and mechanical restraint incident counts and durations from October 2011 to November 2013 based upon an inpatient population of 339, making a total of 26 observations per analysis. In the segmented regression, 14 time points (months) were included prior to the Recovery Rounds implementation (intervention) and 12 points (months) included in the Post-Recovery Round period. The number of incidents, total hours, and mean number of hours per incident were examined in separate analysis. The Durbin-Watson statistic was used to test for serial autocorrelation among error terms prior to analysis.

The following linear regression model was used to estimate the pre-implementation trend, immediate change in incidence, and change in trend following implementation:

$$Y_t = \beta_0 + \beta_1 * \text{time} + \beta_2 * \text{intervention} + \beta_3 * \text{time after intervention} + \text{et}$$

Where Y_t is the outcome (i.e. number incidents, or total hours, or mean duration of incidents); time is a continuous variable representing time in months from the start of observations, intervention represents time before (intervention = 0) and time after (intervention = 1); and time after intervention represents a continuous variable, which was coded 0 before the intervention, and coded 1 to 12 afterward. β_0 is the baseline level if the outcome at time 0; β_1 is the monthly change pre intervention (estimates the pre-intervention or baseline trend or slope); β_2 is the immediate level of change at the time of intervention; β_3 is the change in trend (or slope) from pre- to post-intervention; et is random error that cannot be explained by the model. Two-tailed t-tests were used to compare each parameter with zero to determine if there were significant differences.

We also ran ordinary regression analysis on the total observations (all 26 observations) without consideration of the time of Recovery Round Implementation in order to examine any overall trends in reduction of incident number, total hours, and mean duration at Ontario Shores. These analyses were conducted to see if overall there has been a decrease in use of R/S, as this is a priority at Ontario Shores. All analysis were run using SPSS (version 7.0).

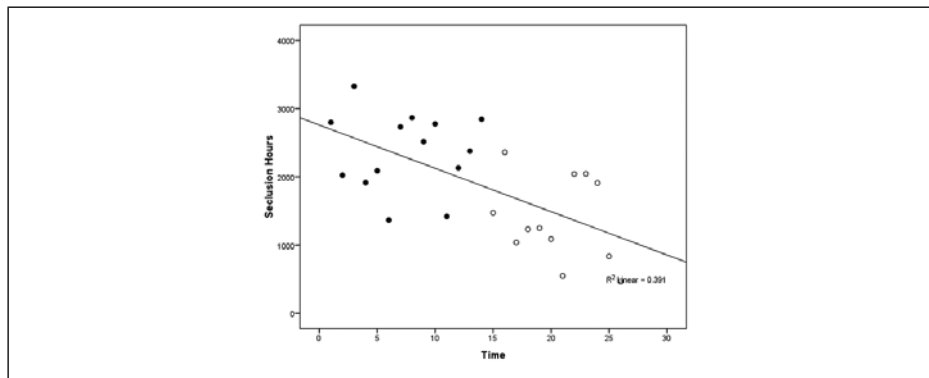
Results

The Durbin-Watson statistic showed no serious autocorrelations with all values near 2.0, thus it was not necessary to control for autocorrelations among adjacent months in subsequent analysis.

Use of Seclusion

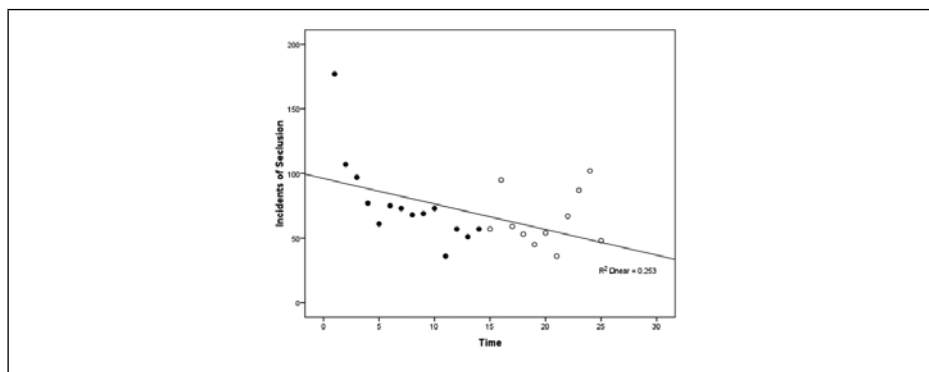
In the regression analysis that considered all 26 observations (see Figure 1), month significantly predicted total seclusion hours, $\beta = -63.48$, $t(24) = -3.92$, $p = .001$, with a decrease of 63.5 incidents per month (Figure 1). Month also explained a significant proportion of variance in total seclusion hours, $R^2 = .39$, $F(1, 24) = 15.41$, $p = .001$. Interrupted time-series analysis however failed to show a significant pre-Recovery Rounds trend, or change in trend or level at the time of Recovery Rounds implementation (at a significance level of $p < .05$). Total seclusion hours was therefore, found to be significantly decreasing across the 26 observations, however, the time-series analysis does not support that this was a direct effect of the implementation of Recovery Rounds but rather the cumulative or overall effect of recovery initiatives in general.

Figure 1. Total seclusion hours each month. A significantly decreasing trend was found, decreasing 63.5 hours per month.



In the regression analysis that considered all 26 observations, month significantly predicted total number of seclusion incidents, $\beta = -1.98$, $t(24) = -2.89$, $p = .009$, with a decrease of 2 incidents per month (Figure 2). Month also explained a significant proportion of variance in total number of seclusions, $R^2 = .25$, $F(1, 24) = 8.12$, $p = .009$. The Pre-Recovery Rounds trend was significantly decreasing ($t = -3.910$, $p = .001$), and interrupted time-series analysis did not show a significant change in trend in number of incidents of seclusion or level at the time of Recovery Round implementation (at a significance level of $p < .05$), though the trend change approached significance. The number of seclusion incidents per month therefore was found to be significantly decreasing overall, however, the time-series analysis results does not support that this is primarily attributable the implementation of Recovery Rounds but rather the cumulative or overall effect of recovery initiatives in general.

Figure 2. Incidents of seclusion each month. A significantly decreasing trend was found, decreasing by 2 incidents each month.



Interrupted time-series analysis did show a significant change in trend in mean duration of incidents of seclusions each month following Recovery Round implementation ($t = -4.42$, $p = .000$), with a post-implementation decrease of 0.5 hours/seclusion each month. The Pre-Round trend of hours of seclusion duration was significantly increasing ($t = 5.81$, $p = .000$) at a mean of 2.1 hours/seclusion incident each month. There was a significant immediate change in level of duration at the time of Recovery Round implementation ($t = -5.18$, $p = .000$) with the mean duration of seclusion incidents dropped by 22.5 hours/incident (Figure 3). Month did not significantly predict mean duration of seclusion incidents, $\beta = -.40$, $t(24) = -1.55$, $p = .134$, in the regression analysis that considered all 26 observations. Month also did not significantly explain the proportion of variance in mean duration of seclusion incidents, $R^2 = .09$, $F(1, 24) = 2.40$, $p = .134$. This suggests changes seen in average duration of seclusion incidents are a direct effect of Recovery Rounds implementation and not the cumulative or overall effect of recovery initiatives in general (Figure 3).

Use of Restraints

In the regression analysis that considered all 26 observations, month significantly predicted total mechanical restraint hours, $\beta = -20.14$, $t(24) = -2.17$, $p = .040$, with a decrease of 20.1 incidents per month (Figure 4). Month also explained a significant proportion of variance in total mechanical restraint hours, $R^2 = .16$, $F(1, 24) = .73$, $p = .040$. Interrupted time-series analysis however failed to show a significant pre-Round trend, or change in trend or level at the time of Recovery Round implementation (at a significance level of $p < .05$). Total restraint hours therefore is significantly decreasing at Ontario Shores, however, the time-series analysis does not support that this is a direct effect of the implementation of Recovery Rounds but rather the cumulative or overall effect of recovery initiatives in general.

Figure 3. Mean number of hours per seclusion from October 2011 to present. The arrow indicates the time of Recovery Rounds implementation (month 14). A significant upward trend in mean hours per seclusion prior to rounds of 2.1 hours per incident each month (A), a significant drop at implementation of an mean of 22.5 hours per incident each month (B), and a significant change in trend after the Recovery Rounds implementation, with a post-implementation decrease of an mean of 0.5 hours per incident each month (C).

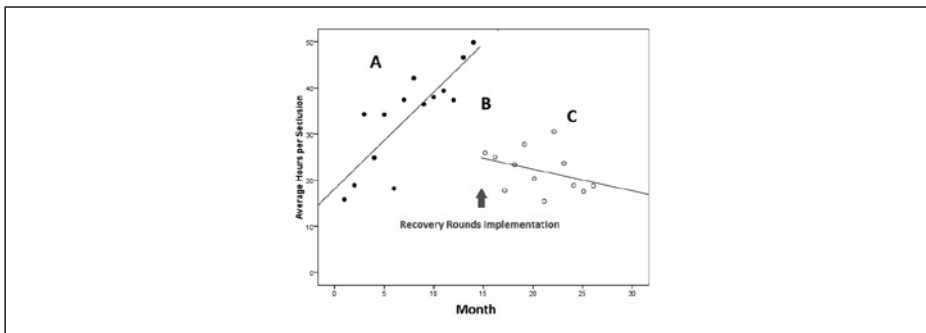
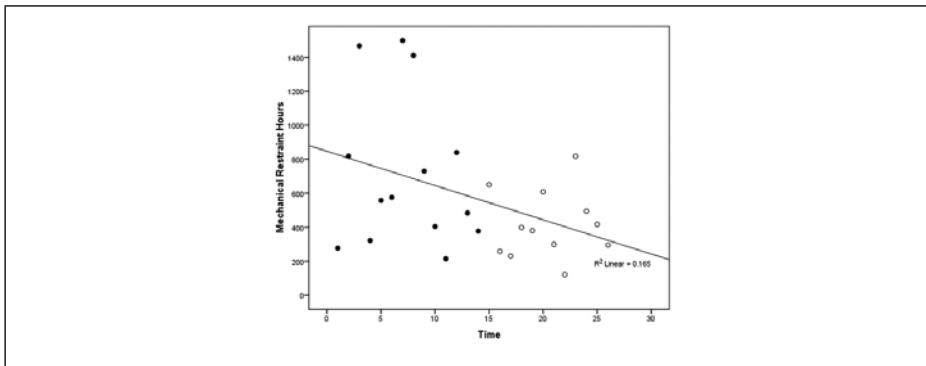
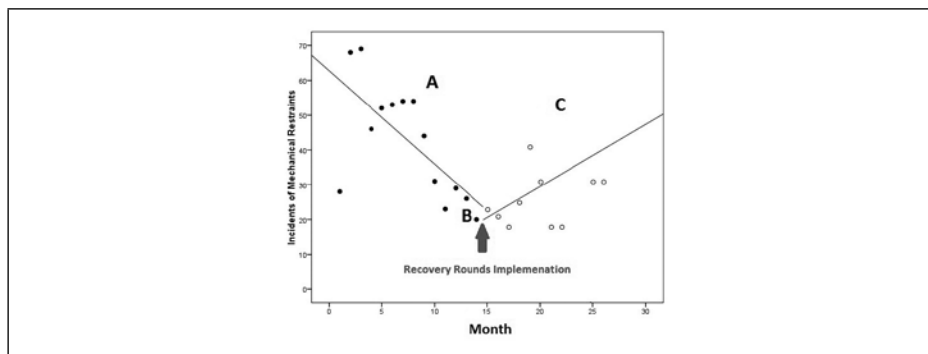


Figure 4. Total mechanical restraint hours each month. Significant decreasing trend was found, decreasing by 20 hours per month.



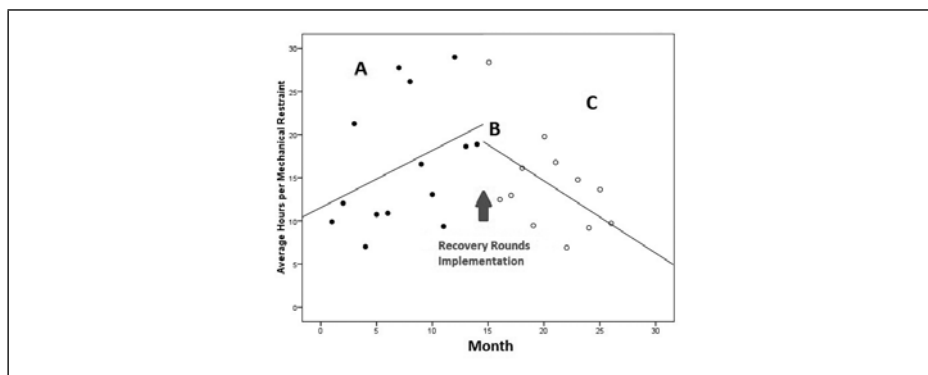
In the regression analysis that considered all 26 observations, month significantly predicted total mechanical restraint incidents, $\beta = -.93$, $t(24) = -2.42$, $p = .023$, with a decrease of 0.9 incidents per month. Month also explained a significant proportion of variance in number of mechanical restraint incidents, $R^2 = .20$, $F(1, 24) = 5.86$, $p = .023$. Interrupted time-series analysis showed a significant change in trend in number of incidents of restraints at the time of Recovery Round implementation ($t = 3.35$, $p = .003$), with a post-implementation increase of 1.8 incidents per month. Pre-Round trend was significantly decreasing ($t = -3.23$, $p = .004$) at a rate of 2.7 incidents per month. There was no significant immediate change in number of incidents at the time of Recovery Round Implementation ($t = -.62$, $p = .543$) (Figure 5). However, while the number of restraint incidents per month therefore are significantly decreasing at Ontario Shores overall, however the time-series analysis may suggest a shift over time after the implementation of Recovery Rounds (Figure 5).

Figure 5. Number of Incidents of Mechanical Restraints from October 2011 to present. The arrow indicates the month of Recovery Rounds implementation (month 14). A significant decrease in 2.7 incidents of mechanical restraints each month prior to rounds (A), no significant immediate change at implementation (B), and a significant change in trend post-rounds, with an increase of 1.8 incidents each month post-rounds (C).



Despite this, interrupted time-series analysis did show a significant change in trend in mean duration of incidents of restraint each month at the time of Recovery Round Implementation ($t = -2.249$, $p = .035$) (Figure 6). The pre-Round trend was not significant ($t = 1.60$, $p = .124$), and no significant immediate change was seen at the time of Recovery Round Implementation ($t = -.27$, $p = .787$). Month did not significantly predict mean duration of mechanical restraint incidents, $\beta = -.12$, $t(24) = -.70$, $p = .493$, in the regression analysis that considered all 26 observations. Month also did not significantly explain proportion of variance in mean duration of mechanical restraint incidents, $R^2 = .02$, $F(1, 24) = .48$, $p = .493$. This suggests that changes seen in mean duration of seclusion incidents are a direct effect of Recovery Rounds implementation and not the cumulative or overall effect of recovery initiatives in general. Mean duration of restraint incidents therefore has been impacted by the implementation of Recovery Rounds, decreasing 0.8 hours/incident each month (Figure 6).

Figure 6. Mean number of hours per Mechanical Restraints from October 2011 to present. The arrow indicates the month of Recovery Rounds implementation (month 14). No significant association between time and mean hours per mechanical restraint in pre-implementation period (A), no change in mean duration of per incident when rounds implemented (B), but statistically significant change in trend after Recovery Round implementation, with a decline of an mean of 0.8 hours per incident each month (C).



Conclusion

Overall, Ontario Shores' efforts to establish a recovery oriented approach to patient-care, through many initiatives, including minimization of the control interventions such as the use of R/S, has resulted in a reduction in total hours and incidents of seclusions (Figure 1 & 2 respectively) and seclusions (Figure 4 & 5 respectively) per month. Furthermore, the results of the time-series analysis demonstrate that Recovery Round Implementation has had an immediate and sustained impact on decreasing mean duration of seclusions (Figure 3) and mechanical restraint incidents (Figure 6). Implementing Recovery Rounds had an immediate impact, decreasing the mean duration of incidents of seclusion and restraints. Where there was a significantly increasing trend of an mean

of 2.1 hours/seclusion incident each month prior to Recovery Round implementation, immediately following implementation, the mean duration of seclusion incidents dropped by 22.5 hours/incident, and continued to decrease each month at a rate of 0.5 hours/seclusion each month. Similarly, a significant change in trend is seen in the mean duration of mechanical restraint incidents, with a post-rounds decrease of 0.8 hours per incident each month.

The results indicate that oversight, accountability, and timely communication, and commitment surrounding every restraint and seclusion event, through the implementation of Recovery Rounds, can effectively impact staff responses once seclusion or restraints have been used, but may be less influential to the reducing reliance on methods of control interventions by staff, as yet. Continued training and further advancing a culture of least restraints and seclusions, in order to continue to impact staffs' proactive responses in preventing violence and aggression will be necessary to provide staff with the tools to prevent reliance on control interventions. In addition to continuing to evaluate Recovery Rounds outcomes, segmented regression analysis can also be used to evaluate interventions, such as policy changes and educational interventions, implemented to reduce the use of R/S.

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Learning objectives

Participants will...

1. be knowledgeable about our Recovery Model of Care and appreciate our commitment to Trauma-informed practice as well as restraint and Seclusion prevention.
2. recognize our key communication activities, including Recovery Rounds, and be able to apply our Lessons Learned in your own areas of practice.

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Violence against physicians-an updated look at the strategies and initiatives introduced in Israel

Paper

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Keywords: Violence, physicians, Israel, initiatives

Perspective: Practice

Introduction

The risk of a health worker being subjected to physical and/or verbal violence in Israel continues. Israel has introduced a series of reforms over the last several years in an effort to combat this worrisome trend. Some of these were reported in our 2010 survey (Borow and Wapner, 2010): increased budgeting, legal bills, emergency hotline for victims of violence, media awareness, call buttons and others. The study showed that attacks over the ensuing years did drop; however, rates of verbal violence are once again rising, while physical violence has declined further. In this report, we revisit the situation three years later.

Background

Violence toward health care workers in hospitals and other medical institutions has been widely documented in recent years around the globe (Kowalenko et al. 2013; Kitaneh et al. 2012; Benham et al. 2011; Hahn et al. 2008; McPhaul & Lipscomb, 2004). Health care workers in the USA have an assault-injury rate nearly 10 times the workers in other sectors (Kowalenko et al. 2013). This figure indicates that although violence in the workplace is not a phenomenon unique to health care, medical personnel are exposed to violence at a far greater rate than the average worker. The reasons for this can be explained by a variety of factors, most due to patients' frustrations with the health care system. With rising health care costs, limited insurance coverage and an ever-growing manpower shortage in hospitals and clinics that results in overburdened doctors and longer waiting times, patients may channel their anger at the doctor. Violence against health workers in general, and doctors in particular, is especially dangerous, affecting not only the individual health worker but the entire quality of the working environment and, therefore, the quality of care received by patients.

Violence in the Israeli health sector

Several studies within Israel have identified the most common triggers for acts of violence in the health sector as long waiting times and dissatisfaction with the treatment provided. (Klein & Tauber-Borochov, 2012; Elroy et al. 2011; Carmi-Iluz et al. 2005; Landua 2004; Derazon et al. 1999). Such studies also support a multi-faceted approach to addressing the issue of violence in the health sector, including legislation, law enforcement and attention to situational factors such as overcrowding in waiting rooms and training of staff members in dealing with confrontational situations. Services provided to doctors after the attacks and increased public awareness of the issue are also vital elements. This balanced approach to tackling the issue of violence in the health sector has been echoed throughout the world (WMA 2012, 2008; ILO 2003; BMA 2003; ILO-ICN-WHO-PSI 2002).

Strategies and initiatives implemented in Israel

Both the Israeli Medical Association (IMA) and the Israeli Ministry of Health are aware of this growing problem and have been trying to deal with it by introducing a range of reforms.

Legislation

Stricter penalties for attackers: Following an alarming rise in the number of violent assaults against doctors in the workplace, the IMA initiated a proposed amendment to the Penal Code. The amendment, which was approved by the parliament in February 2010, raised the prison sentence given to those who attack emergency workers on duty- including, but not limited to doctors, nurses and paramedics from three to five years. The IMA is currently working on a revision which would extend this provision to include health workers working in non-emergency capacities as well.

A bill to prevent violence in health care: The Israeli parliament approved a bill initiated by the IMA, which was designed to combat the phenomenon of violence against doctors, according to the format adopted in England a few years ago. According to the new law, adopted in 2011, a person who intentionally physically or verbally attacks a doctor, nurse, or healthcare worker, or damages hospital or clinic property, will be warned that they may not be allowed to return to the same medical institution if the behavior is repeated in the future. If the warning did not help and the assailant commits another attack in the same institution within a year, the director

of the facility shall be entitled to prevent him from entering the institution for a period of three months (in the case of a verbal attack or destruction of property) or six months (in case of physical injury). However, the law contains an exemption stating that a person will not be denied the right to enter a medical institution in order to receive required medical treatment.

National Anti-violence Program

Although not an IMA initiative, Israel boasts a national program for the minimization of violence against healthcare personnel. Parties to the program, formed in August 2013, include the Ministries of Health, Justice and Internal Security. The IMA collaborates with the Ministries, the Israel Police and the State Attorney in order to design and implement a national plan for preventing violence against doctors and medical personnel. The program includes expanding the powers of security guards in hospitals, who currently have no enforcement authority. The intention is to legislatively grant security guards authority to detain an offender and intervene in any act of violence occurring in a medical facility. A guard that identifies a threat will be authorized to impede the incident in a manner in accordance with the law. Guards stationed in hospitals and clinics will also undergo a special training program. In addition, medical personnel will undergo training designed to prevent or reduce the likelihood of violence.

The national program also includes stress reducing measures in hospitals and clinics, improved transmission of information to patients awaiting treatment and the integration of technology based violence prevention measures.

Finally, the program aims to expand the deployment of specially trained police in hospitals. Two to four additional policemen will be placed regularly in 4-7 hospitals, and work in shifts. Currently a pilot program is in the planning stages.

The hospitals where security and police formations will be strengthened will be determined in accordance with statistical data analysis conducted in order to map the severity of the threats. In addition, the police and State Attorney have been taking a hard line against offenders and a supervisor in charge of dealing with violence against medical staff has been appointed in the police force. The supervisor works in coordination with the Ministry of Health.

Hotline against Violence

The IMA manages an emergency hotline (24 hours a day, weekdays and Sundays) for doctors who have been victims of violence, providing immediate advice and assistance. Representatives of the hotline assist in reporting attacks to the relevant parties (police, security officer, hospital management, doctors' committee) and provide professional assistance, including referrals to legal counsel if necessary. In extreme cases, a risk and personal security evaluation is conducted and protection provided to the physician. In 2011, the hotline received a total of 26 reports of violence as compared to 16 in 2012 and 26 again in 2013. The number of physical attacks did not change. There were nine reported incidents each year, although the number of complaints filed to the police decreased from 16 in 2011 to 10 in 2013. In any event, this clearly represents only a small fraction of the total cases of violence committed each year against health workers.

Work with international organizations

Because violence among healthcare professionals is a global phenomenon, the IMA proposed a statement to the World Medical Association on violence in the healthcare sector. The statement, adopted by the organization in October 2012, summarizes the issue and provides a list of recommendations for national medical associations to employ in order to counteract the phenomenon (WMA, 2012).

Recent Developments

Following the approval of two bills, and the establishment of guidelines for attorneys and police, there is an increased sense of actual guidance. However, the new legislation does not sufficiently reflect the situation on the ground; police do not always handle cases correctly, the State Attorney's office is still congested and their attitude towards attacks, although toughened in recent years, is not strong enough. For this reason, we asked the Ministry of Health to resume the work of the Inter-Ministerial Committee and this recommenced in August 2012. The IMA also contacted the head of security at the Ministry of Health and we are in the process of coordinating work with him to ensure that the policies of decision makers affect the doctors in clinics and hospitals.

Results

The extensive activities of the IMA and consistent pressure on the Ministry of Health have led to significant measures and considerable financial investment to reduce violence in the health sector. It is hard to say which, if any, of these activities and laws have had a direct effect on the number of incidents of violence in the health sector.

Number of reported violence attacks 2008-2012

Overall, violent attacks on physicians in Israel decreased between the years 2008-2012. This trend correlates with the anti-violence measures taken in this period of time, as discussed above. These figures follow the trend of reduction observed since 2003 – from 1,250 physical attacks in that year to 902 attacks in 2008 and 524 in 2010. However, in 2011 we witness a sudden and sharp increase in the number of reported attacks (752). The reasons for this increase are not sufficiently clear. It may be attributed to the long physicians' strike which took place that year, which may have caused dissatisfaction and tension among patients and their families. On the other hand, it could be that the massive campaign and the passing of anti-violence laws in 2010-2011 bolstered awareness and encouraged reporting without any real increase in violence level. In any case, the decline in physical attacks resumed in 2012 (700). Until 2008, verbal attacks in the health sector in Israel were not recorded. However, it can be seen that these are also on the decline, with the number of verbal attacks in 2008 reported to be 2,736, while in 2010 this was reduced to 2,004. Again, there is a sharp increase in 2011 (2,406 reports), but contrary to physical violence, it continued to rise in 2012 (2,750 reports), although still lower than it was in 2008. The total sum of attacks (both physical and verbal) shows the same pattern.

Conclusion

Despite the overall decrease in the level of violence, there is still a long way to go, as violent acts in the Israeli health service are still taking place. These findings suggest that in order to effectively tackle the issue of violence in the health sector a balanced approach, comprised of activity on several fronts, is needed. In addition, collaboration among various players, including government, the national medical association, hospital and general health services and the police is more effective than the individual efforts of any one party.

Further cooperation between governmental bodies, police and non-governmental associations such as the IMA is required to continue building successful policies and frameworks. Within the hospital and health care practices, more training is required for staff. In the public domain, the IMA will continue to encourage staff to report any violent events and will publicize efforts through internal mailings and through the media.

All in all, there is no escape from recognition that although we want our work to eradicate violence against physicians, only a state-level comprehensive plan may lead to a significant reduction of the phenomenon, and for that a dedicated budget is required. It is expected that in the long run the increased measures taken since 2010 will further contribute to a reduction in all types of violence. In particular, the joint efforts of the different government agencies mark a change in approach and assumption of collective responsibility for the problem that we hope will engender greater change.

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Learning objectives

Participants will...

1. appreciate that key parties must be involved in the development of policy and initiatives to reduce violence.
2. realize that campaigns to minimize violence must be initiated on different fronts and with diverse players in order to succeed.

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Identifying safety challenges among nurses in India: An international approach to facilitating change

Paper

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Perspective: Research

Background and context

According to the World Health Organization (2010) India has a need for approximately 2.4 million more nurses to fulfill its nursing workforce requirements. A low workforce capacity is associated with high infant and child mortality rates and poor health outcomes (WHO, 2010). Nurses in India often leave the country in search of better working conditions (Evans, Razia, & Cook, 2013). One study assessing student nurses' perceptions of nursing in India reported a majority indicated a preference towards practicing abroad and few were interested in practicing nursing at the bedside upon graduation (Patidar et al., 2012).

Methodology

An international collaboration between nursing faculty from the United States and India resulted in a photovoice research study to illuminate the perceived challenges of nursing among nursing students in Bengaluru, India. Photovoice, a participatory action methodology, uses photos taken by the participants to stimulate individual and group reflection about issues within a population (Wang & Buris, 1997). The acronym VOICE in photovoice stands for "Voicing our Individual and Collective Experiences" (University of Massachusetts, 2014, para 3). Photovoice uses a three step process including selecting, contextualizing and codifying to derive patterns among the population during critical group dialogue sessions. All group sessions were audio-recorded and researchers analyzed the transcripts and individual reflection narratives using qualitative content analysis methods described by Graneheim & Lundman (2004).

Findings

Night work and the nurses' personal safety, particularly while traveling to and from work alone after dark, were identified as perceived challenges of nursing in India. In addition, the students perceived challenges related to the nursing shortage and increased nurse to patient ratios as a threat to the nurses' physical and mental well-being. Insightful photographs taken by the participants and abstracted narratives will be highlighted in this presentation.

Implications

This work culminated in an art exhibit in which community stakeholders were invited. Participatory action research focuses on dissemination of findings to those individuals who are in positions to facilitate change and respond to the problem. Attendees included local hospital administrators, supervisors, physicians, a hospital ethics committee representative, nursing faculty and students. Through their work, participants were empowered to voice possible solutions to safety challenges including ideas about safe modes of transportation for nurses. Nursing has been identified as a profession that is essential to improving patient outcomes. Improving personal safety, physical and mental health is critical to recruitment and retention of the profession.

Identification of the perceived personal safety and health challenges of nursing as a profession in India sensitizes stakeholders to the issue and increases understanding of the professional and societal implication of the nursing workforce shortage. In addition, the dissemination of results to community stakeholders facilitated a conversation on strategies to improve conditions for nurses in India.

Learning objectives

Participants will...

1. recognize the problem of the nursing shortage in India and its impact on health outcomes.
2. understand the perceived safety and health challenges for nurses in India.
3. Be able to discuss strategies to improve the personal safety and health for nurses in India.

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Healthcare workers' perspective of violence prevention training and education

Paper

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Perspective: Education and Training

Keywords: healthcare violence, violence prevention, violence mitigation, training effectiveness, training applicability

Introduction

Violence in healthcare is a known problem and can happen to any member of the healthcare team (Gates, et al., 2011). It has been posed that healthcare workers are almost guaranteed to experience harassment or violence at some time in their career (Henson, 2010). The Bureau of Labor Statistics (2013) indicated violence in healthcare was over three times the rate of violence in all other private industries.

Recently, a six-hospital healthcare system in the Northwest instituted a workplace violence prevention and mitigation educational course. After looking through available data, it had come to the attention of leaders within the organization that violence was a problem within this specific health system. It was also brought to their attention that the health system was not following state laws in regards to violence prevention for healthcare staff. A comprehensive workplace violence prevention and mitigation training program was initiated in September of 2012 and is ongoing.

The six-hospital health care system had identified multiple safety issues. Zook (2012) analyzed the healthcare staff's workplace violence reporting data as well as worker's compensation data from January, 2008 to December, 2011. The greatest number of reported violent events was 193 in 2009 and the highest amount of compensation claims was over \$500,000 in 2008. Previous training had been a single PowerPoint slide with "tips for de-escalation" and a one-hour presentation by security officers on restraint application.

The analysis also took into account federal guidelines and state laws. The healthcare system had facilities in both Oregon and Washington, which had similar healthcare violence prevention laws (Safety - Healthcare Settings, 1999; Safety of Healthcare Employees, 2007). In order to become compliant with Oregon, Washington, and the Occupational Safety Health Administration's (OSHA) guidelines, the Management of Aggressive Behavior (MOAB®) course was selected. Upon initiation of the course, the professions with the highest identified risk of workplace violence completed the course. This included emergency department, security, and behavioral health staff. The course is ongoing and over 6,000 employees will participate in some aspect of the course.

Research Questions

1. How effective and applicable did healthcare workers find techniques taught in a violence prevention and mitigation training course?
2. What were the barriers to successful outcomes of violent events after implementing a comprehensive workplace violence mitigation program?

Hypothesis

Hospital healthcare workers who attended a violence prevention and mitigation course, and who have experienced verbal aggression or physical violence after the course, will have found the techniques taught applicable and effective if they had to utilize said techniques after taking the course.

Methods

The participants had completed the 8-hour MOAB® course from the inception in September 2012 to October 2013. The survey email presented the informed consent information and the receipt of an anonymous, completed survey indicated the participant consented to the survey as stipulated by the institution's review board approval. The mixed-method study survey contained questions asking demographic data, questions related to the participants' experience with the MOAB® course with yes or no answers, and Likert scale questions rating the MOAB® course. The last question of the survey was open-ended, allowing the participant to tell a story of a violent event and its outcome. The online survey was distributed to 1,109 participants. The number of completed surveys was 212 which resulted in a 19% response rate. In order to better address the research questions and hypothesis directly and limit the number of responses, the participants were asked to self-limit

their responses. The participants were asked to participate in the survey only if they had experienced a verbally aggressive or physically violent event after attending the MOAB® training course.

Results

Figure 1. Breakdown of participants' gender.

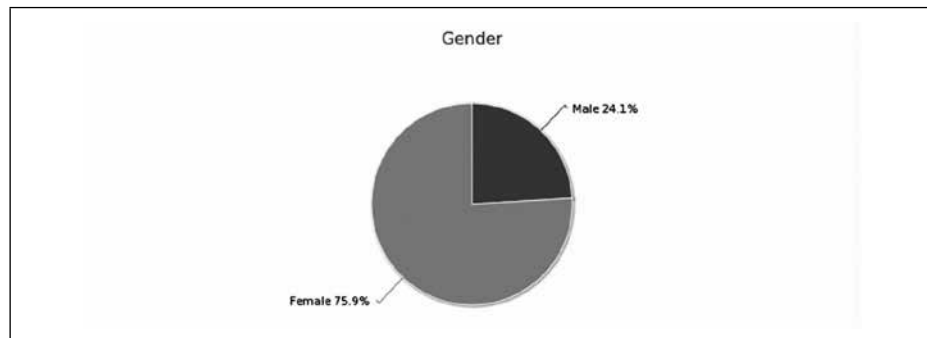


Figure 2. Breakdown of participants' age.

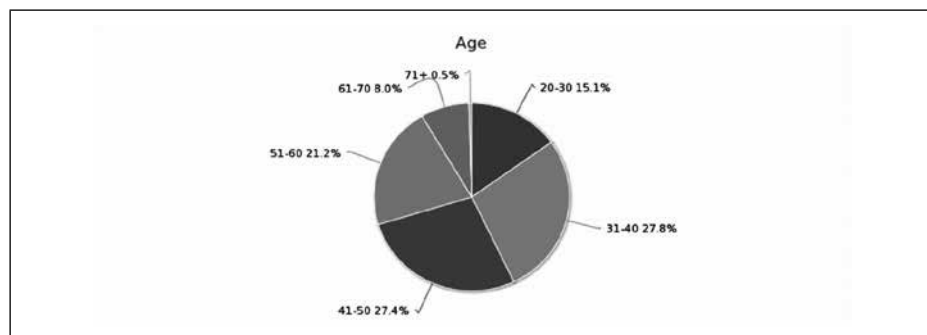
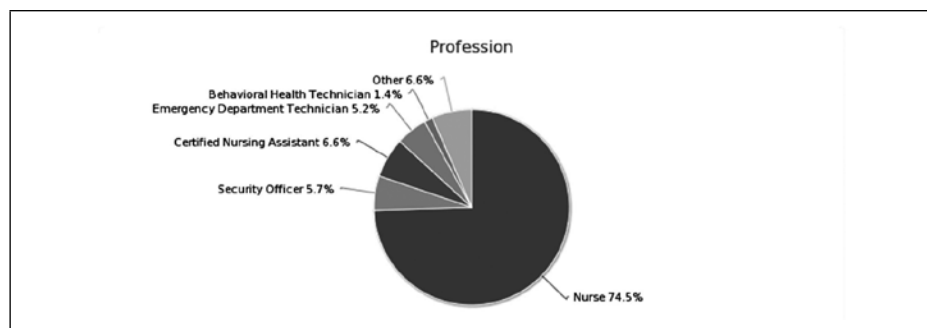
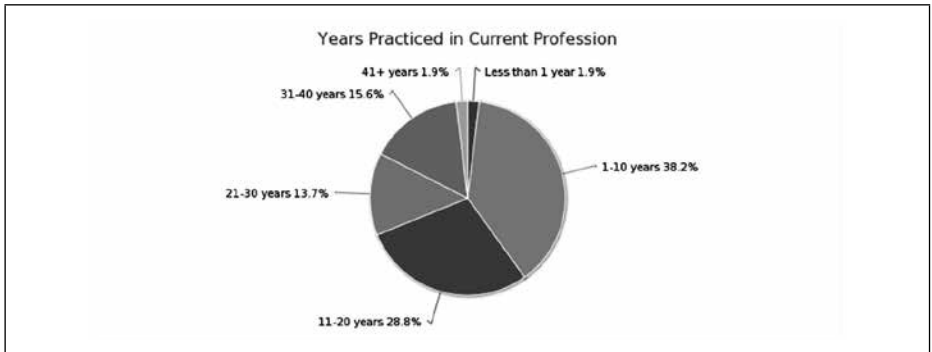


Figure 3. Breakdown of participants' profession.



Note: Other professions reported include: unit secretary, clinical assistant, resource specialist, clinic manager, respiratory therapist, social worker, pharmacist, surgical technologist, and a behavioral health therapist.

Figure 4. Participants' reported years practiced in current profession.



The healthcare staff participants provided their care at varying locations within the healthcare system. The two urban hospitals comprised the majority of the respondents; with 58 participants from a non-trauma hospital and 42 participants from the level 1 trauma center. Twenty of the respondents were from a pediatric hospital and 18 participants floated between hospitals within the health system. The three suburban hospitals accounted for 18, 14, and 41 participants respectively. Only one participant reported working at a non-clinical facility.

Figure 5. Participants' experiencing a physically violent event since taking the violence prevention course.

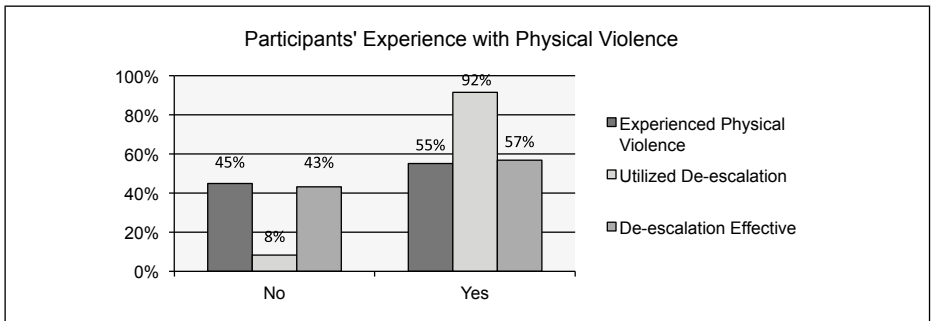


Figure 6. Participants' experiencing a verbally aggressive event since taking the violence prevention course.

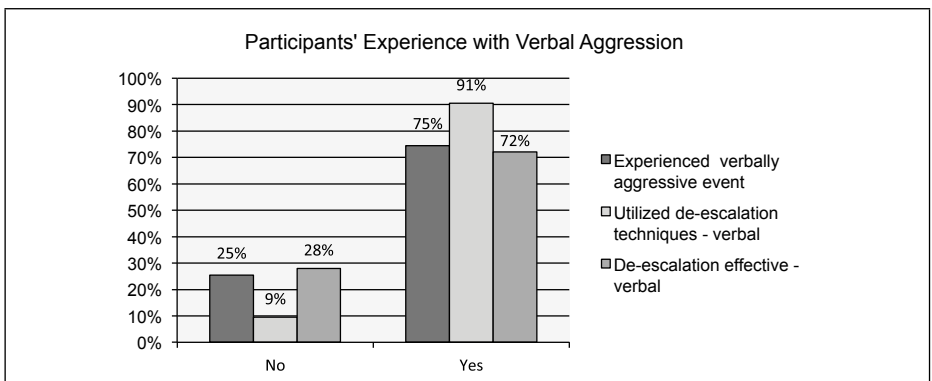


Figure 7. Participants' rating of verbal and physical de-escalation techniques taught in the violence prevention course.

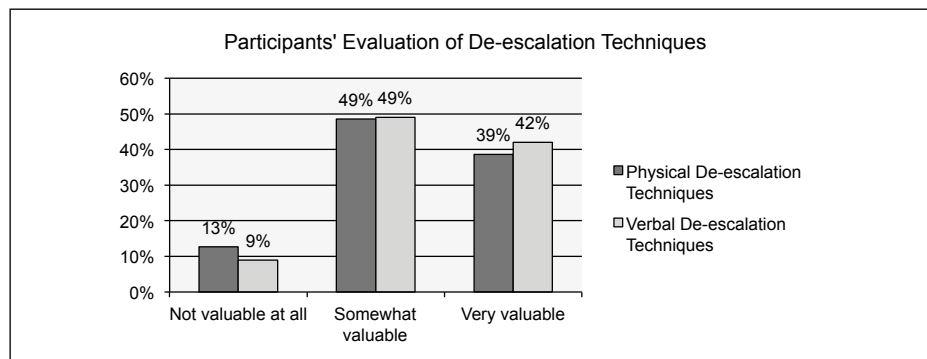
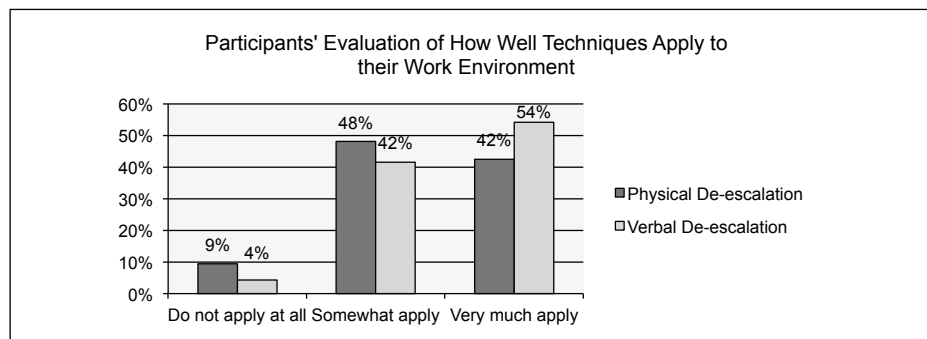


Figure 8. Participants' rating of how well verbal and physical de-escalation techniques apply to their work environment.



Participants were asked if they had changed their personal safety practices. The majority of the respondents reported that they had somewhat changed ($n = 127$; 60%). Some reported they had changed a lot ($n = 38$; 18%), while others reported no change in their safety practices ($n = 47$; 22%). Participants were asked if they had utilized any of the de-escalation or self-defense techniques taught to them outside of the workplace since participating in the MOAB® class. The majority of the respondents reported that they had not while 23% ($n = 48$) reported that they did utilize techniques outside of the workplace.

Figure 9. Number of aggressive events witnessed by participants within the previous month.

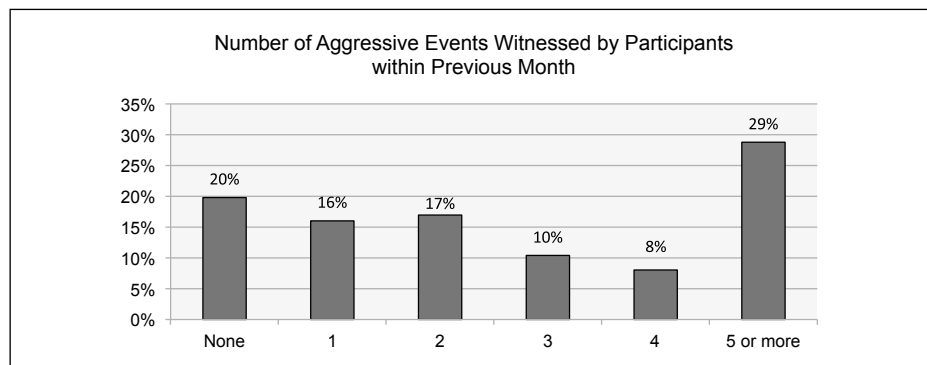


Figure 10. The number of aggressive events participants reported they were involved in within the previous month.

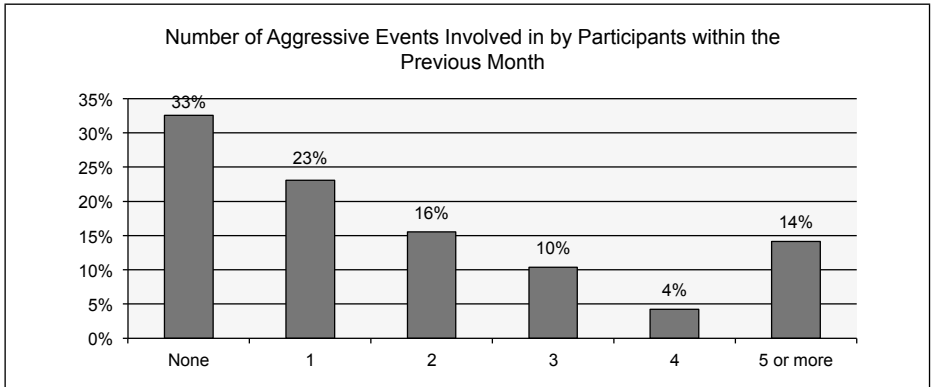
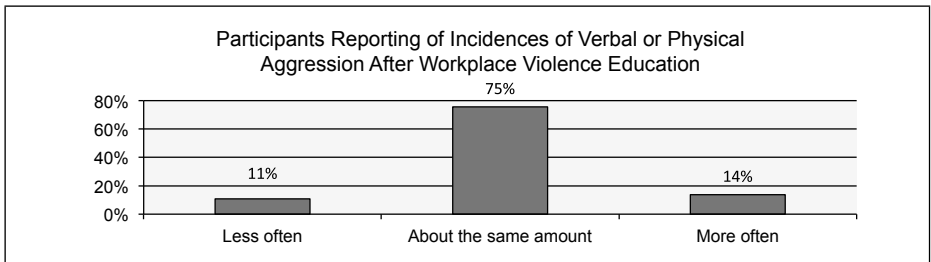


Figure 11. Participants' rating of how often they report incidents of physical or verbal aggression after the violence prevention course.



Qualitative analysis. Analysis of the participants' description of an event with its outcome after taking the violence prevention course was very telling. A total of 95 responses to the question were noted with 87 (41%) providing enough data for coding the responses into common themes. Some responses did not provide a descriptive story, but rather commented on being more confident in self-protection, noticing an increase in personal safety awareness, an increased concern to patient safety, and requesting further training or refresher courses. Other factors surrounding violent or aggressive events included law enforcement involvement, skills that were beyond the scope of the violence prevention course were required for the situation, criminal charges being filed against the aggressor, injuries occurring to staff, and a staff member as the aggressor.

Analysis

Gender. There was a relationship between gender and experiencing a violent event after taking the violence prevention class ($p = .035$; Cramér's $V = .279$) with an observation that 68.6% of males reported experiencing violence since training. Males also experienced verbally aggressive events (88.2%) more so than females (70.2%) since taking the class ($p = .009$; Cramér's $V = .229$). Males also tended to be involved in verbally or physically aggressive situations with 25.5% experiencing five or more events in the previous month ($p = .031$; Cramér's $V = .241$).

Years of practice. Participants with 21 to 30 years of experience witnessed five or more verbally or physical aggressive events in the previous month at 48%, while 75% those with less than one year of experience did not witness any aggression ($p = .018$; Cramér's $V = .199$). Most of the participants reported changing their personal safety practices somewhat after taking the course, with 75% those having over 41 years of experience not changing their safety practices ($p = .014$; Cramér's $V = .229$). When asked about experiencing violence since taking the violence prevention course, 100% of participants with less than 1 year of experience and 100% of those with more than 41 years reported they did not experience physical violence ($p = .015$; Cramér's $V = .258$). The remaining participants all reported experiencing violence.

Profession. The relationship between the participant's profession and if the participant had experienced a physically violent event showed that 100% of behavioral health technicians, 91% of security officers and 73% of emergency department technicians experienced violence since training ($p = .005$; Cramér's $V = .279$). Of security officers, 100% reported experiencing verbal aggression as well as 100% of behavioral health technicians and 91% of emergency department technicians ($p = .048$; Cramér's $V = .229$). When faced with verbal aggression, the majority of professions who reported utilizing de-escalation techniques were CNAs, emergency department technicians, and those in the "other" category at 100% ($p = .026$; Cramér's $V = .284$). Also notable was that nurses reported utilizing de-escalation techniques for verbal aggression at a rate of 92%, while both security officers and behavioral health technicians reported a rate of 67%.

Half of the security officers rated the physical de-escalation techniques as "not valuable" in conjunction with the majority of behavioral health technicians. A majority of CNAs reported the physical de-escalation skills as "very valuable", while the majority of nurses and those in the "other" profession rated the skills as "somewhat valuable" ($p < .001$; Cramér's $V = .276$).

When participants were asked how much they had changed their personal safety practices; CNAs ($n = 10$), those in the "other" category ($n = 10$), and nurses ($n = 98$) reported "somewhat" changing ($p = .039$; Cramér's $V = .212$). Behavioral health technicians and security officers reported the highest percentages of not changing safety practices at all at 67% and 50% respectively.

Security officers reported the highest number of aggressive incidents that they were involved in; with 58% reported being involved in 5 or more events within the previous month ($p < .001$; Cramér's $V = .229$). Behavioral health technicians reported being involved in 4 events (33%) and 5 or more events (33%) within the previous month.

Facility. Participants from all healthcare facilities reported experiencing verbal aggression since participating on the violence prevention course as shown in ($p = .041$; Cramér's $V = .263$). Workers at the Suburban 2 hospital reported experiencing physical violence the most (78.6%), followed by the Pediatric hospital (70.0%), the Level 1 Trauma and Suburban 1 hospitals (66.7%) and lastly those workers that float between facilities at 50% ($p = .029$, Cramér's $V = .271$). Participants who worked at the Level 1 trauma hospital reported witnessing the most verbal or physically aggressive events within the previous month at 48% ($p = .018$; Cramér's $V = .227$).

Discussion

There is much to do in the prevention of violence in healthcare. Future research could include training staff in different violence prevention courses, and following participants over time to assess effectiveness of training. Longitudinal studies could help to discover the effectiveness of training and recommended reinforcement of training. Development of violence prevention training that is clinically based, with less of law enforcement or military focus could help gain better engagement of clinical staff. Development of violence mitigation education specific to hospital units might be helpful, as each unit has special circumstances. Evaluation of the states that have enacted felony legislation for assaults on healthcare workers could provide insight to whether these laws are effective and help to discover their limitations. Development of a scoring, grading, or rating system for healthcare facilities could encourage best practices in violence prevention and maintain focus on the safety of healthcare staff.

Physician participation is crucial to the future lessening of violence in healthcare. The study's literature review showed that physicians were minimal participants in the planning, implementation, and evaluation of violence prevention strategies. It had been mentioned that sometimes the physician could be the instigator of aggression. Physicians are part of the healthcare team, and need receive the same violence prevention education and training as the rest of their team members. Although not well studied, physicians are not immune to violence.

Assessing the healthcare workers' perception of violence prevention training provides valuable insight to their buy-in to the course. If they feel that the training is applicable, valuable, and effective, it is possible that there could be better outcomes of aggressive events. An engaged and participatory staff is more likely to have successful prevention of aggression and violence. It cannot be stressed enough that evaluation of violence prevention training needs to be ongoing. Ineffective training can waste time, money, valuable resources, and possibly not mitigate violence in healthcare.

It is time to find out what does and does not work in the prevention and mitigation of violence in healthcare. Discovering which verbal and physical de-escalation techniques work best for aggression and violence would be helpful not only to healthcare, but to the general public. Assessing the implementation of various violence prevention programs could help to discover which programs have better success at reducing violence in healthcare. Violence in healthcare affects all workers, not just nurses. Although violence will not be eliminated, it could be significantly reduced through education and proactive measures.

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Learning objectives

Participants will...

1. be able to describe the strengths of violence prevention training and discover the weaknesses of violence prevention education.
2. be able to suggest improvements to healthcare violence prevention education.

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Translational models of workplace violence in healthcare: Interprofessional application

Workshop

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Perspective: Policy

Keywords: Translational Model, Workplace Violence, Healthcare

Introduction

There are many competing definitions and theories of workplace violence (WPV) and its components spread across professional literature in nursing, medicine, social work, law enforcement, judiciary, and business management.

Even those who work or do research in their profession's version of the WPV field struggle to understand the numerous issues and may not have a consensus on the use of terms and concepts. Imagine the difficulties when crossing professional and discipline communication lines on such complex matters. Yet, dealing with active WPV, and finding solutions to reduce future WPV, routinely requires interprofessional and interdisciplinary collaboration. WPV, such as threats, assaults and homicide (mega-violence), may be low in number when considering a typical workday's events, but they have high impact on individuals and the healthcare system when they occur. Lower level violence (micro-violence), such as workplace incivility (WPI), unreasonable expectations, offensive actions or words, or the lack of action or words are much more frequent than mega-violence. Micro-violence needs to be better understood as possible antecedents of mega violence. As such, reduction of micro-violence may present a needed opportunity to reduce mega-violence.

Since micro violence is more frequent than macro violence, primary prevention and perivention becomes a relevant opportunity in our daily work. Periventions are defined as timing and location interventions that would occur right before, during, and right after a potential or real violent event occurs. (Privitera 2011). Violence from patients, visitors and family, staff styles of interaction as well as organizational contributions to violence (Bowie 2011) are often socially and politically delicate to discuss. This may be due to numerous competing interests, vantage points and agendas involved (Tabone et al, 2011). Staff may fear they will be blamed and loose their job and tend to under-report incidents.

Translational science refers to a highly collaborative process of the translation of basic research findings more rapidly and efficiently into practice. It is multidisciplinary by nature and transdisciplinary in practice. Multidisciplinary refers to a primary discipline with other discipline specific experts used in a as required basis. Transdisciplinary refers to discipline specific experts with working knowledge of other disciplines roles. In this way a small number people can assess and respond to situations with knowledge that transcends their own formal training and broadens the ability to meet the complex needs that often underlie WPV. Interdisciplinary refers to discipline specific experts with knowledge of other disciplines' roles to facilitate collaboration, used regularly (Direnfeld 2009).

Translational models in WPV then, would help rapidly translate and present a wealth of basic research in WPV in ways that would be more understandable and thereby more usable across a broad array of disciplines and professionals. The goal would be to help these mixed professional groups converge on common understandings in the complexity of violence and its causes. The goal of using translational models would be to reduce the interprofessional communication, procedure and jargon differences that interfere with effective solutions ("Tower of Babel" phenomenon-Michalski and Privitera 2011). Sharing information that conceptually joins micro-violence with the potential for mega-violence outcome may align efforts across disciplines and professions for more coordinated and sustained impact. Sustained organizational attention toward reduction of frequent events is more likely to continue than sustained organizational attention toward reduction of low frequency events and behaviors.

Methodology

Translational models were designed to summarize and integrate major contributing factors to violence in order to more succinctly convey such concepts to organizational decision makers. The authors will present translational visual models to reduce excessive jargon and more clearly convey concepts which illustrate how WPV concepts may relate to each other. Relevant basic science and clinical science research will be used to construct derived concepts into these models.

Findings

There is a need to integrate the many existing pieces of research and clinical concepts of WPV in actionably useful ways. Excessive profession-specific jargon and procedures impedes the interprofessional communication needed to collaboratively work on WPV reduction. Much of the literature on workplace violence, for quality and reliability of scientific findings, focuses upon specific narrow realms of study that can control select variables. Though scientifically sound, their scope of application may be too narrow to be operationally applied. Other sources of findings might be derived from anecdotal reports and expert opinions. Three major realms of study in WPV include: 1) Substrate (the person), 2) the stimulus, and 3) the environment in which these exist.

Often, violence may come in a healthcare setting, fairly rapidly. Having an approach to more rapidly assess the escalating event requires an ability to synthesize the individual roles and interaction of these three realms. Models are necessary for ease of conveyance of concept.

- 1) Person.** The tendency to violence can be envisioned along a spectrum from high risk to low risk individual.
- a. In the high risk range, there are a number of contributing factors:
 - i. Aggression in an antisocial personality disordered individual that is instrumental, having a specific goal in mind.
 - ii. Medical and psychiatric conditions that alter the person's thinking due to illness that make their perceptions altered, e.g., delirium from medical causes, drugs, psychosis with paranoid delusions etc.
 - iii. Aggression triggered by past history of violence, PTSD
 - iv. Reactive aggression, e.g. in Borderline Personality disorder- with emotional sensitivity/dysregulation (Siever)
 - b. In the low range we might consider the average individual's risk. The concept of "the man on the Clapham omnibus" - a hypothetical average reasonable individual (ARI) used by English courts where it is necessary to decide whether a party has acted in the way that a reasonable person should. For example, this may be used in a civil action for negligence*. Using this ARI concept and judging behavior against such a reasonable person, we may now acknowledge and account for types of stimuli and/or environments that may raise the odds for violence if the situation were dire enough. This ARI concept helps open the conceptual door to organizational(environment) and stimulus contributions to violence.

The average reasonable individual concept becomes even more salient within healthcare settings, where self sacrifice and self effacement is taught in professional schools to healthcare staff. Recognition of when self sacrifice and self effacement have reached their reasonable limit is a dilemma to decipher both internally and external to the individual.

Incrementalism is a process by which small additive changes in procedures, regulation or policy from multiple sources can accumulate unbeknownst to the staff or administration. Increasing expectations on healthcare staff due to well-meaning regulations, law, political pressure, and insurance methods to lower usage of patient benefits add up to unreasonable levels. Yet, there exist no central "clearing house" to manage how far these expectations on staff should go.

Their sources are multiple. Expectations on healthcare staff in the cause of quality of care are not coordinated by any single entity, and each source has authoritative capital. Because the changes are incremental, their additive enormity occurs below detection and awareness, but raising the stress and coping challenges to individual staff. Reduced resilience to patient demands, less demonstration of compassion to patient needs results. This creates a negative experience for the patient on quality of care, at the point they need it the most (pain, fear of their disease, etc). Extensive literature is emerging on how these stressor factors on healthcare providers are contributing to medical error, poor quality of care, malpractice, poor patient satisfaction, but may be under-recognized by administrative leadership.

- 2) Stimulus.** The proclivity to induce violence can be envisioned along a spectrum from high range to low range stimuli
- a. In the high range stimulus, highly noxious stimuli, may exist that is likely to provoke a violent response, aggressive act that may require self protection, incivility mid range, to the low end of a benign statement that can be misperceived to no stimulus at all.
- 3) Environment.** Is the environment a protective factor to the interaction of person and stimulus to a mega violent outcome, or might it be an aggravating factor to the interaction of person and stimulus to a mega violent outcome? In this realm, organizational culture and philosophy can influence the outcome of interactions between persons and stimuli. Organizational and milieu contributions to violence are often ignored when much of the literature focuses on dyadic relationships involved in dispute, failing to capture the systemic environment.

A review of the violence theory literature was done to examine mechanisms of how smaller stimuli may progress to macro violence. A number of relevant theories were obtained. Those that relate to additive effects of stressors are The Frustration-aggression Hypothesis (Dollard 1939, Brennan 1998.); The Negative Affect Escape Model (Baron and Bell 1976.); and Excitation-Transfer Theory (Zillmann 1988). All of these theories would take

into account the environment of the individual(s) involved, and help us to make sense of the mechanisms of environmental contribution to violence.

The Frustration-aggression Hypothesis: aggression presupposes frustration, inability to achieve an intended goal. Frustration produces a potential for a number of different responses, only one of which is aggression.

The Negative Affect Escape Model postulates that increasing heat (as example of aversive stimulus) increases aggression when total negative affect experienced is in the low to moderate range (the fight response), but excessive heat decreases aggression when total negative affect gets too high (flight response).

Whether fight or flight response occurs depends on a number of factors that include how the person examines and controls feelings, and how they analyze the situation.

Environmental stressors: Arousal: hot, noisy or crowded places can raise physiological arousal.

Cognitive overload: If we receive too much stimulation/information from an environment we may not be able to think or function as well.

These can be from well intended regulatory requirements, or electronic medical record complexities (“friendly fire”). These also come from profit-intended obstructions to patient care. Examples include purposeful hassle of clinicians (or patients) in their attempt to get needed care for patients, actually designed to wear them down by lengthy paperwork, frustrating phone procedures, often without a human at the end of the phone, hidden criteria for coverage, and other strategic procedures. Frank conflict of interest procedures in insurance companies in the guise of “cost control”, giving bonuses to health insurance staff for denial of care to patients, etc (“enemy fire”).

Excitation-Transfer Theory: Schachter claimed that emotional arousal is nonspecific, and the individual cognitively assess the emotion he is experiencing. Excitation-transfer theory is based on the assumption that excitation responses are, for the most part, ambiguous and are differentiated only by what emotions the brain assigns to them. Zillmann adopted and modified Schachter’s view on this: „residual excitation from essentially any excited emotional reaction is capable of intensifying any other excited emotional reaction”. Hence patient arousal from pain, frustration with obtaining care, etc may be a contribution to their aggression toward staff. Staff struggling with many aforementioned barriers to their care of patients, overloaded work assignments in staff cutbacks, etc, arouse staff which then can contribute to incivility or aggression toward patients or other staff.

Violence infliction: Four modes of violence infliction (World Health Organization): Sexual, Physical, Psychological, and Deprivation.

Law and ethics help define the bounds of sexual and physical violence. However the extent of psychological impact and deprivation can be individual in source, acute or delayed in manifestation, and sometimes diffused and harder to trace back to a singular source as they can be inflicted in forms of collective violence (Social, Political and Economic methods of violence).

Implications

Implications for practice, research, education & training, organization / management, policy and guidance: How might your work inform similar initiatives in broader health service and/or geographical contexts? A more systemically informed approach to regulation, law and policy is needed in health organizations and the external agencies that affect their ability to care for patients. Examples: State law that protects an individual patient’s rights requiring a judge to authorize medications over the patient’s objection, may greatly affect the safety of other patients and staff if swift legal resolution is not made available. Hospital and regulatory quality improvement procedures that are reactive to adverse events may collect over time, layering policies and regulations that may lose sight of the larger systems picture they intended to improve. The resultant chaotic impact on clinician work-flow are organizational contributions for violence to occur.

Conclusion

By translating concepts and language that had been unique to the many professionals that make up healthcare service systems or legal and law enforcement professions, professionals will be able to talk with each other with common conceptualization of the problem of WPV in healthcare, increasing the chance of sustainable solutions.

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Learning objectives

Participants will...

1. be able to explain how violence is a continuum from Micro Violence to Mega Violence.
2. learn that focus upon Micro Violence reduction is associated with High Organizational Health.
3. learn that major components of how the 3 Factor Interaction occurs in production of violence: (Person, Stimulus, Environment).
4. learn how visual Translational Models constructed from science of violence will improve the knowledge base of interprofessional decision makers.
5. be aware that the relationship that better knowledge base of decision makers may improve effectiveness of WPV interventions.

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The curse of battling it on your own. Managing workplace violence in primary health care

Paper

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Perspective: Research

Keywords: Workplace violence, focus groups, primary health care, emergency care, management

Introduction

Working in emergency primary care is associated with a high risk of experiencing violence from patients and visitors. In Norway, one in three emergency primary care workers has been physically abused during their work-time career (1). Norwegian emergency primary care centres are commissioned by law, and provide emergency primary care during evenings, nights, weekends and public holidays. They are also gatekeepers to secondary care. Depending on the size of the community served, number of staff on duty at any given time varies from one to several persons, including GPs (mandatory), nurses and other health personnel. The GPs primarily consult patients at the centre, but they also do home visits and participate at site in emergencies outside hospitals. When nurses or other health personnel are present, they often perform triage in the patient's initial contact with the centre, give advice when appropriate and assist the GP when needed.

A Norwegian study has described which preventive safety tools are available in emergency primary care (2), but there is little knowledge about how health personnel actually manage the violent incidents when they occur. There is also little knowledge about the impact of safety measures when implemented in the organization. Knowledge about the actual course of such incidents and how they are presently managed may give valuable information on how to improve safety. The aim of this study was therefore to explore emergency primary care personnel's own experiences of managing threats and acts of violence from visitors or patients, focusing on barriers and facilitating factors of the organization.

Methods

Due to the exploratory purpose of the study, a qualitative design was chosen. Focus-groups were performed to reduce the impact of the interviewer, as well as to help sharing and comparing experiences and views between informants.

Participants: Participants for the focus-group study were recruited by announcement at conferences, information in a school for higher education of nurses, emails forwarded via managers at emergency primary care centres in different parts of Norway and via a regional association for general practitioners (GP), and by snowball sampling (3). Participants were initially individually recruited, based on personal experience with threats or violence. However, due to difficulties in recruiting GPs, GP participants were later included if they were willing to discuss the issue. Potential participants were invited to contact the researchers by phone or by email.

Data gathering: Eight focus groups were performed in 2012 and 2013 with a total of 37 participants. These comprised 15 nurses and 22 GPs. A total of 23 participants were women. The mean age was 41 years (range 25–69 years). The mean years of work experience in emergency primary care was 9 years (range 1–33 years). The participants had work experience from an organizational and geographical diverse subset of Norwegian emergency primary care centres. The group discussions had two to six participants. Before the focus group discussion started, all participants received information about the study and gave written informed consent to the secretary (KA or TM) of the focus group. The consent form provided information about the goal of the study and the rights as participants in scientific research according to the Helsinki declaration. The participants were also asked to complete a brief form, including age, occupational title and years of work experience in emergency primary care. The moderator (IHJ or TM) initiated the interviews using an open-ended question inviting the participants to tell about experiences of threats or violence. When necessary, the discussions were prompted by asking for more details and views upon the management of the situation. All interviews were recorded by digital sound-recorder. The discussions lasted approximately 90 minutes, and each focus group was interviewed once.

Analysis: Each interview was transcribed verbatim by TM or IHJ. The transcripts were audited for reliability and managed by the use of Nvivo 10. In the analysis systematic text condensation (3) was used. First, the transcription was read by all authors to obtain an overall impression, focusing on available strategies and organizational conditions that influenced the management of the threatening situation. Based on the impressions, initial themes were established and meaning units were identified and coded according to the themes. The contents of each coded group were condensed, and finally the content of each code group was summarized to generate descriptions and concepts concerning the experience and management of threats and violence.

Results

One of the main themes in all the focus group discussions was the experience of being alone and how this had an impact on the possibility of managing an upcoming threatening incident. Several participants expressed a feeling of having to battle it on their own. The majority of stories told about working alone ranged from examples of being completely alone at work without any colleagues nearby, to working in a building with colleagues who were out of sight or earshot of another. There were also stories where the health professional was with other professionals, but were let down by them in critical situations. A rather typical experience for the nurses was incidents of workplace violence whilst they were the only professional in the emergency primary care due to the GP being out on a home visit or an emergency situation outside the emergency primary care centre, or even being at home, waiting for a call. In these situations, the nurse had to manage all contacts and attending patients by herself, and alert the GP when necessary. One nurse gave an example of a situation in which she was alone, waiting for the GP to arrive. She opened the door to attend to a young boy, who had arrived with a young girl and their little child. The mother was in pain, and the nurse tried to explain that she didn't have any GP present, but that she would try to help. The young man got angry, exploded and said: "Damn you, I have to come in. If you don't let me in, I will beat you down." The nurse was saved by the boy's parents who arrived immediately afterwards and calmed him down.

Some GPs told stories of being alone in the consultation room at emergency primary care centre with a threatening patient, though with colleagues being in another place of the building. Other GPs described experiences of going on home visits to unknown addresses, either being completely alone or sometimes together with a taxi driver. Consequently, the GP in both situations was the only professional and had to manage the situation alone.

The narratives further pointed to two factors which influenced how the challenge of being alone in a threatening situation was met: 1) The ability to summon someone, and 2) colleagues turning up "by chance".

The ability to summon someone

In many stories the ability to summon someone by an available alarm system at the emergency primary care increased the feeling of safety. By using an alarm many of the participants got help immediately either from colleagues or from the police staying nearby. However, for some participants the existing alarm system was not perceived a sufficient safety measure, and they gave several reasons for this. Some told that they could not rely on the alarm, as they had experienced at tests that it might not work. Others told that they actually had access to a safety alarm that worked, like the medical radio network, but the alarm was linked to an external alarm centre far away from the emergency primary care. The long distance between the alarm centre and the emergency primary care centre made them think that the help was likely to arrive too late to make any real difference. Thus it seemed that the ability of summoning someone only felt relevant and made a difference if this someone was nearby.

Colleagues turning up by chance

Many of the participants described that the experience of colleagues appearing by chance had been significant for their management of a violent situation. They told about being alone with a threatening person either in the consultation room or in the reception, though with colleagues present nearby who seemed to appear and intervene by chance. The concept of "by chance" was sometimes described as a work culture of increased awareness among colleagues, taking care of each other when they observed warning signs in the patient's behaviour. Sometimes this act was described like a pure coincidence.

One of the GPs told about an episode when she was pregnant and working at night. A man broke the window pane to get into the emergency primary care centre and was soiled with blood due to a hand injury. The patient was drugged, and the GP had some difficulties in assessing and treating the injury. She was alone with him in the consultation room. The patient started threatening her by saying he would kick the pregnant abdomen. Then her nurse colleagues suddenly appeared and came to her rescue. The GP explained that although it seemed incidental that they arrived just then, she thought they had kept an eye on her due to the general circumstances of the patient's arrival.

Other described situations where they actively increased the likelihood of "by chance" interventions by making agreements in advance. For example some GPs said that when they were visiting patients at home and were escorted by a taxi, the taxi driver was told to intervene "by chance" if a consultation took more time than expected. Stories were also told about the feeling of being completely left to your own device despite having colleagues at site who had observed the violent situation. A nurse told about an incident where a patient was about to beat her. The other nurse present just ran away into another room and shut the door behind her. The colleague apparently did the opposite of what was expected, and this increased the nurse's feeling of being left to herself.

Discussion/conclusion

The experience of having to battle workplace violence on your own seemed rather commonplace among the participating health workers. The stories imply that alarm systems, as well as the support from available colleagues or co-operators, influence the management of actual situations.

When lone working is unavoidable, organizational strategies should make the worker as safe as possible. A means of alerting others, like an alarm system, was described to be of high importance for the feeling of safety. However, the existence of technical measures is no guarantee for increased feeling of safety, especially if it is considered unreliable due to lack of maintenance or due to long distance to the persons who are alerted.

Observant colleagues who are available when needed may also be part of the routines in an organization. However, the experienced support from colleagues in this study was not presented as a planned organizational strategy, but rather something that happened “by chance”. It might therefore be understood as an expression of a culture of being aware of each other and taking care of each other. Some of the stories also suggested that lack of systematic preparedness and awareness in the organization in how to give support in a violent situation, could result in insecurity of how to act when a threatening situation occurred.

Combatting the experience of being left to oneself is an important factor in providing a safe environment for workers in emergency primary healthcare. Making sure everyone has a real opportunity to summon help when needed and increasing the chance of someone intervening by accident are two ways of increasing the safety.

Acknowledgement

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Learning objectives

Participants will...

1. realize that health workers experience being alone in managing workplace violence despite colleagues being present at the site.
2. appreciate that experienced safety is improved by organizational strategies.

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The (long) road toward safety and wellbeing for all. Are we there yet?

Paper

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Perspective: Education and Training

Keywords: workplace violence, prevention, safety, nurse training

Background

The University Hospitals of Geneva (HUG) are composed of five hospitals. With over 11,000 employees, it's the largest employer in the region of Geneva. Since June 2000 I've been working there as a psychiatric liaison nurse (PLN) and clinical nurse specialist. My practices regroup three spheres of expertise: direct care with patients and relatives, education and support of interdisciplinary staff, and clinical leadership. It's a transversal function depending directly on the Nursing Directorate (ND), with no hierarchical link to the medical departments. I work essentially in surgical, medical and neurological wards. I offer specialized mental health nursing care to patients with somatic and psychological needs and help ward nurses in the care of this specific group.

In 2002, in order to better identify difficulties and needs, I conducted a survey amongst 1686 nurses and orderlies with a response rate of 39% (n=657). Aggression, agitation and non-compliance clearly emerged as the three main sources of difficulties frequently encountered (sometimes 50%, often 40% or very often: 7%). Nearly 70% of respondents felt that some training was needed to offer proper care to these "difficult" patients.

Patient and visitor violence (PVV) is not a new phenomenon and has grown significantly in recent decades (Kingma, 2001; Kuehn, 2012). In 2011 (USA), the incidence of injuries and illnesses resulting in days away from work from a nonfatal assault was 14.6 per 10,000 workers in health care and social assistance compared with 3.8 per 10,000 workers in all private sector workplaces (Lipscomb, 2013).

The HUG don't have reliable statistics on workplace violence, but local surveys of nurses and physicians (in 2002, 2013 and 2014) suggest that violence is a serious and widespread problem in our hospitals. The data seems to be comparable to the national statistics (Hanh, Needham, 2008) available and to those of other international studies. Let's face it, here, as elsewhere, we must recognize that violence in health care facilities is not an epiphenomenon: it has now integrated them (Guerrieri, 2011).

HUG have numerous resources available to help staff prevent and manage violence at work, such as an internal security service, an employee health service, a team of personality protection, a medical unit for prevention of violence (UIMPV), a legal service, in-house training, PLN's and a consultation-liaison psychiatric service.

Despite this the survey (in 2002) showed that our staff felt unprepared and vulnerable. Where was I supposed to start to address those feelings? Those difficulties?

Methods

At first I organized small 2 hours workshops in the medical wards, as they were interested in developing violence management skills. These workshops were well received by the participants, but were too short to meet their needs. However they were an excellent start to work on a concept, to revisit the international initiatives and even to refine the training strategies. Over time these workshops evolved and spread to other wards. A network of people interested in this matter developed with clinical nurse's specialists, care managers, physicians and quality officers. This network created several educational interventions:

- half-day module called "managing conflict and violence" as part of the basic training course of the health care and community assistants
- one-day module called "managing violence and incivility" as part of a nurse post-graduate training course: care for patients with psychic suffering
- half-day module called "managing violence and incivility" as part of a nurse post-graduate training course: care of patients affected by musculoskeletal system pathologies.

More recently, at the request of the emergency and psychiatric departments, this network developed a full four day course. This course is now offered to all in the in-house training program and four sessions are held each year. Each session can accommodate 14 participants. Several topics are covered: personal relationship to violence, violence in care, physical and relational positioning, intervention strategies, institutional resources and legal aspects.

In 2012, an awareness module about violence prevention and management was introduced into the new employee's training program. In April 2014, our institution organized a one day conference on the topic of violence in health care settings. Being close to the employees' concerns, this day was a great success. It has enabled professionals and guests to share thoughts and experiences, as well as to highlight several projects already initiated in various medical departments.

Finally, for almost two years, in collaboration with the nursing department and medical managers of the Department of Rehabilitation and Palliative Medicine (DRPM), we created a one day workshop (RSVP: Coping together) entirely devoted to the prevention and management of PVV. It is mandatory and intended for all employees in direct contact with patients and their families. At the end of 2014, nearly 500 employees will have benefited from this course. This training distinguishes itself by a unique approach: it's based on interdisciplinarity. It allowed the development of a conceptual model and a common language (team approach). It clarifies the responsibilities of each staff member and provides emergency guidelines in case of a violent event. This program has been evaluated through a questionnaire addressed to all participants before the training and six months after.

Results

We found (evaluation of trainers and feedback from participants) that participation in such (all) training sessions allows employees to:

- feel less alone and less isolated
- take the necessary distance to promote reflective practice
- acquire a conceptual model (prevention, assessment and interventions)
- improve knowledge of available resources.

We are convinced that staff training can increase safety and reduce the risks for both health care providers and patients, but what evidence do we have? There is little research on the subject.

The first results of the RSVP project are encouraging. Participants stated that they acquired new knowledge (96%) and 89% used it in their practice. Participants feel more comfortable with the manifestations of aggression they encounter in their work (70%) and 95% would recommend this training to their colleagues. Finally, we can note a decrease in the anticipated anxiety level's at the evocation of a confrontation with a violent event, and an increase in the use of de-escalation techniques (comparative survey before and after).

This training, as well as the others, also highlighted the staff difficulties:

- Difficulty to be heard or to get adequate support
- Lack of assessment tools and/or clear guidelines
- Lack of knowledge of the available resources.

Discussion

After several years of working on those different training courses, we can now appreciate their benefits, but also their limits. Staff training is an essential element, but alone it cannot solve the problem. It could be a dangerous pitfall to think that once you've trained your staff, the violence problem is solved.

Violence is not just a relational problem, it's an institutional problem. Therefore it must be treated as such. The HUG are aware of this. This is why they also provide institutional responses in addition to the current in-house training and of all the others resources available. They published an information brochure for all employees: where to find help in case of violence at work (2007)? This brochure was also accompanied by two official guidelines: procedures in case of criminal offense against an employee or against a patient or visitor. The general management has recently taken new measures to further secure the workplace: restricted access requiring electronic badge and the presence of a security guard from 21:00 to 06:00 in the emergency wards, doubling the night staff in psychiatry and ending working alone in isolated care structures. The ND has made the prevention and management of violence a working priority: training, information, better diffusion of existing procedures, and is even considering an awareness campaign for the users.

Taken individually, each and every one of those "answers" has a relatively limited impact. It is by multiplying them that we can obtain a "safety net" that benefits to both employees and users alike.

Perspectives

Staff training is an essential element, but as we have seen, it's one element among many others. So what else can be done? New perspectives can be found both in literature and in elements brought by the training participants. Here are some other alternatives to consider:

- Precise institutional expectations

The creation of easily accessible emergency measures could help the employees to position themselves, to know what's within their competence's range, what's expected of them, and when it's time to "pull the

alarm”, so that other institutional actors can also fulfill their respective roles. This would also increase the employee’s knowledge of the available resources.

- Integration of assessment scales in the computerized medical record (CMR)
In addition to being a medico-legal requirement, clinical documentation is a powerful tool for ensuring care continuity and safety. Scales for rating violent behavior should be incorporated into the CMR. This would facilitate documentation and would also help “keeping alive” the conceptual models outside the training courses.
- Improving the management of incidents
The value of systematic hospital incidents reporting (falls, bedsores, etc.) is well established. These incidents are used to analyze the context, identify risks, contributing factors and to bring improvements. The same logic applies to the management of violent incidents. Yet it does not seem to be the case. The International Council of Nurses believes that only one case of violence in five is officially reported. Why? Because reporting is often seen as an additional and unnecessary workload, it could give a poor self-image or harm the department’s image, or because those who declare do not receive a response or satisfactory support. They sometimes have the feeling of not being taken seriously (ICN, 2007).

Since it is not easy to improve what’s not measured, it would be the next logical step for the HUG to adopt (for the whole institution) a classification scale (types and dangerousness levels) of encountered violent incidents. It would also be useful to create a rapid response system in case of a violent incident report. This kind of rapid response should be available to all workers, regardless of the medical department where the incident has occurred. Finally, the creation of a violent incident analysis grid for the incident management group members would help them to identify the relevant factors (human, organizational and environmental) to be considered in order to provide effective support and enable the formulation of recommendations to improve safety and security. Since violence incidents are underreported, we should welcome an increase in the numbers of reporting. Initially our goal should not be to reduce it.

Conclusion

Start by addressing issues you can have an impact on, and keep working on them. But there are only so many things that you can do alone: building a network in and outside of your institution is essential. PVV has important human and financial impacts (Kingma, 2001). It’s a complex problem that requires complex answers. This is why the HUG deployed, in addition to training, many measures and resources to improve the safety and security at work.

So far the results of our in-house trainings are promising: they increase knowledge, skills and staff confidence for dealing with PVV. Although training is a necessary element of a comprehensive approach to address workplace violence, it’s not by itself sufficient to prevent staff and patient workplace violence entirely. You can’t rely only on workers training as your sole strategy for violence prevention and management (Lipscomb, 2013). We still have work to do. Currently we are exploring additional means for optimizing the prevention and management of PVV: specifying institutional expectations, improving clinical documentation, developing the process of incident management and seeking better ways to support our teams.

Violence management isn’t an end in itself but an ongoing and never-ending process. And we all have a part to play. We’ve come a long way toward safety and wellbeing for all. Are we there yet? No, but we are getting closer.

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Learning objectives

Participants will...

1. realize that violence management is not an end in itself but an ongoing process and we all have a part to play.
2. Realize that with time, even small initiatives can have an impact on the organisation you are working for.

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Analysis of factors contributing to the reduction of control measures with a clientele with intellectual disability and challenging behavior

Paper

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Perspective: Research

Background and context

People with intellectual disability (ID) or ID with pervasive developmental disorders (PDD) are at risk of self-harm or other-injurious behaviors requiring the use of control measures (seclusion, restraints, private services). The cohort of patients transferred to a Canadian psychiatric hospital in June 2008 had a long history of institutionalization and could not be integrated into the community because of their dangerousness and application of important control measures. These patients were responsible for more than 50 % of the hospital's seclusion hours in 2008-2009. However, since their transfer to the ID program in psychiatry, one of them is now in the community while the control measures used for most of the others are reduced. Since this reduction has not been evaluated with a systematic way, we wanted to describe interventions that lead the reduction of seclusion and restraint. The presentation will answer the following questions: 1) What are the "administrative" and clinical interventions that have helped to reduce control measures? 2) How managers and care teams explain changes in the reduction of control measures for those patients?

Methodology

This is a retrospective examination of files / retrospective chart review / retrospective medical record review of 11 patients with ID-PDD and challenging behavior transferred in June 2008. Having established the seclusion and restraint curve for each patient, we examined periods of significant seclusion and restraint reduction. The analysis considered changes regarding medication, professional interventions, physical environment, family involvement and types of control measures. Four focus groups (managers, direct stakeholders, professionals and families) have documented the process of change.

Findings

Rigorous and systematic observation, finding accommodation, use of external resources and outstanding leadership are the ingredients that led to a better quality of life for patients without increasing assaults against staff.

Implications

Clinically, this study could inspire other teams to try different approaches with patients with challenging behaviours. Scientifically, we explored a reality that has been little studied in a psychiatric hospital setting.

Learning objectives

Participants will...

1. be knowledgeable of aggressive manifestations of patients with mental health problems coupled with intellectual disability.
2. know the essential components of a philosophy of seclusion and restraint reduction without risk to the safety of participants.

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Barriers to effective implementation of programs for workplace violence prevention in hospitals

Paper

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Perspective: Research

Background and context

The objective of this study was to determine the major barriers to implementation of effective workplace violence prevention programs in hospitals. Effective workplace violence prevention programs are challenging to implement in healthcare and the identification of factors that hinder success is a crucial gap in knowledge.

Methodology

Twenty-seven nurses and allied health professionals participated in structured focus group discussions that explored their perceptions of barriers to effective violence prevention programs, the effectiveness of legislative actions to reduce violence in healthcare, and their perception of what constitutes violence.

Findings

There were seven primary issues that the participants identified as the major barriers to effective implementation of workplace violence prevention programs. This list included a lack of action despite reporting, varying perceptions of violence, bullying, profit-driven management models, lack of accountability, the focus on customer service, and weak social service and law enforcement approaches to mentally ill patients.

Implications

Many of the challenges facing effective implementation are both within the program itself and related to broader industry and societal issues.

Learning objectives

Participants will...

1. understand major barriers to the implementation of effective prevention programs.
2. Be able to discuss potential solutions to resolve the implementation challenges of effective prevention programs.

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Using workplace behavioral incident data to assign employee training: Models for formulating risk

Paper

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Perspective: Research

Keywords: Violence Risk Assessment, Healthcare Violence Prevention, Employee Safety Training

Background

An important facet in the primary prevention of workplace violence is training employees to identify violence and its precursor behaviors, to intervene early, and to respond effectively. The Occupational Safety and Health Administration (OSHA) recommends workplace violence prevention policies in hospitals that analyze worksite risks and take “a step-by-step, commonsense look at the workplace” to determine appropriate preventive measures, including safety and health training for affected employees.¹ In busy health care institutions, the cost of training in lost work time can be difficult to justify. Management committed to employee safety wants to know how many employees truly need training, how much training they need, and how much time the training will take from primary health care duties. Veterans Health Administration (VHA) developed a tool and process for healthcare facilities to systematically collect and analyze data on disruptive behavior incidents for the purposes of informing violence prevention training assignment to employees. The tool formulates a risk level for each workplace in the facility and a minimum suggested level of training.

Methodology

VHA provided 141 healthcare facilities with the Workplace Behavioral Risk Assessment (WBRA) tool in the form of a Microsoft Excel workbook. Formulas were developed for the tool based on the Workplace Violence Risk Assessment Template used in Nova Scotia that identified high, moderate, and low risk areas based on frequency of events and severity of event outcomes.² To collect and analyze information for the WBRA, each VHA Facility was required to form a multidisciplinary team comprised of the Disruptive Behavior Committee (DBC) Chair (senior clinicians responsible for the review and management of patient-generated disruptive behavior events), VA Police Officer familiar with disruptive behavior incidence patterns, Patient Safety Manager, and Union Workplace Safety Representative. In addition to these required members of the team, suggested additional members of the team included Workers Compensation Specialist, Human Resources Representative, Employee Health Clinician, and Prevention and Management of Disruptive Behavior (PMDB) program coordinator to provide information regarding employee training patterns and needs.

WBRA teams were instructed to collect data from DBC reports, Veterans Administration (VA) Police reports, patient safety reports, employee injury reports, and any known system of records that would include disruptive or violent behavior occurring in the 22 unique workplace locations. The WBRA teams then entered specific information about behavioral incidents that happened in Fiscal Year 2012 including event location, behavior type, outcome severity, and other characteristics. The WBRA tool formulated a risk level based on event frequency and outcome severity.

Outcome severity was designated by the WBRA team as Catastrophic (fatality, coma, severe and/or persistent emotional trauma, cannot return to work), Critical (severe physical injury such as loss of limbs or use of limbs, hospitalization, significant emotional trauma, extended period of time lost from work), Marginal (minor physical injury such as bruises, cuts, sprains; mild to moderate emotional trauma; some lost work time), Negligible (no physical injury, minimal emotional trauma, minimal lost work time, i.e. less than 1 day), or None (no physical injury, no emotional trauma, no lost work time). In addition to these definitions, teams were instructed to also consider the severity of less tangible effects of violence on workplaces, such as changes in morale, employee burnout, absenteeism, and staff turnover. The tool used data entered by teams to formulate risk as follows:

Table 1 Frequency and Severity Used to Determine Risk based on Canadian Model²

		Severity				
		4 Catastrophic	3 Critical	2 Marginal	1 Negligible	0 None
Frequency	A Frequently/Regularly (12 or more events/year)	4A	3A	2A	1A	0A
	B Often (6-11)	4B	3B	2B	1B	0B
	C Occasionally (3-5)	4C	3C	2C	1C	0C
	D Infrequently/Rarely (1-2)	4D	3D	2D	1D	0D
	E Never (0)	4E	3E	2E	1E	0E

Determination	Interpretation	Risk Level
4A, 4B, 4C, 4D, 3A, 3B, 2A	Significant, immediate, and unacceptable risks.	HIGH
3C, 3D, 2B, 2C	Significant, predictable risks.	MODERATE
4E, 3E, 2D, 1A, 1B	Minimally significant risks	LOW
2E, 1C, 1D, 1E, 0A, 0B, 0C, 0D, 0E	Insignificant risks	MINIMAL
0E	Insufficient data to determine risk	UNDETERMINED

- Workplaces with catastrophic outcomes occurring at least once, critical outcomes occurring six or more times, or marginal outcomes occurring twelve or more times generated a suggested risk level of high;
- Workplaces with no catastrophic outcomes and critical outcomes occurring at least once or marginal outcomes occurring three or more times generated a suggested risk level of moderate;
- Workplaces with no catastrophic outcomes, no critical outcomes, and two or fewer marginal outcomes or six or more negligible outcomes generated a suggested risk level of low; and
- Workplaces with no catastrophic, critical, or marginal outcomes, and five or fewer negligible outcomes generated a suggested risk level of minimal.

An additional designation of “Undetermined” was generated by the tool when there were no documented events occurring in a workplace, indicating that more information was needed to determine actual risk in the workplace.

WBRA teams were instructed to use the formulated risk level as a suggestion, and then to determine, based on all information at hand, the most appropriate risk level assignment for the workplace. If teams assigned a risk level different than the risk level suggested by the tool, they were asked to document additional data and information taken into consideration when assigning risk. The VHA employee education program for workplace violence prevention has four levels of training (I, II, III, and IV). WBRA teams were advised that employees in high risk areas would need all four levels, while employees in moderate risk workplaces would need levels I, II, III; employees in low risk workplaces would need levels I and II; and employees in minimal risk workplaces would need only level I training.

For the 2013 administration, the tool was revised to formulate risk level based upon frequency and types of events rather than outcome severity. A field was added for WBRA teams to document whether or not hands-on physical containment or restraint was required during the event in order to continue the medical care of a patient safely. Similar to 2012, the tool used data entered by teams to calculate how many events happened in each workplace, how many of the events included verbal disruptive behavior and how many events included physical disruptive behavior. New in 2013, teams were also asked to identify how many events required hands-on physical restraint or containment. These calculations were then used to formulate suggested levels of risk as follows:

- Workplaces with three or more events requiring the use of hands-on physical restraint or containment were given a suggested risk level of high;
- Workplaces with less than three events requiring the use of hands-on physical restraint or containment and with three or more events that included physical disruptive behavior were given a suggested risk level of moderate;
- Workplaces with less than three events requiring the use of hands-on physical restraint or containment, with less than three events that included physical disruptive behavior, and with more than three events that included verbal disruptive behavior were given a suggested risk level of low; and
- Workplaces with less than three events requiring the use of hands-on physical restraint or containment, with less than three events that included physical disruptive behavior, and with less than three events that included verbal disruptive behavior were given a risk level of minimal.

WBRA teams were again instructed to use the formulated level of risk as a suggestion and then assign a level of risk to the workplace based on all information available to them. The teams could accept or upgrade the formulated risk determination, but could not downgrade the suggested risk. The 2013 tool automatically generated recommended employee training levels for each workplace once the team assigned and entered a risk level for the workplace.

Table 2. VHA Model for Frequency and Type of Behavior Used to Determine Risk

Frequency	Type of Behavior			
	3 Requiring Containment	2 Physical	1 Verbal	0 None
A Predictably Occurring (>3 times per year)	3A	2A	1A	0A
B Infrequently/Rarely (1-2/year)	3B	2B	1B	0B

Determination	Interpretation	Risk Level
3A	Predictable risk that employees will be exposed to patient-generated behaviors severe enough to require physical containment/restraint	HIGH
2A	Predictable risk that employees will be exposed to physical disruptive behavior	MODERATE
1A	Predictable risk that employees will be exposed to verbal disruptive behavior	LOW
0A, 3B, 2B, 1B, 0B	Minimal risk of exposure to violent or disruptive behavior in the workplace	MINIMAL

The analysis focused on workplace and facility-level findings. We examined descriptive statistics of reported incidents. One outcome of interest was whether or not the formulated risk level matched the risk level assigned by the WBRA team. We conducted a t-test to compare the matching rate in 2012 and 2013 across each workplace. If the updated formula was an improvement, we would expect to see a significant increase in the correspondence between the formulated and assigned risk level in the workplace.

Findings

A total of 29,708 behavioral incidents were reported (M=211, SD=169) by 141 facilities for 2012 (100% response), and 26,643 (M=186, SD=168) by 138 facilities for 2013 (98% response). Four of twenty two workplaces (Inpatient Psychiatry, Emergency Departments/Urgent Care Centers, Community Living Centers, and Inpatient Medical/Surgical Units) accounted for 50% of all reported incidents both years, but formulated risks for these workplaces were not significantly different from workplaces with fewer incidents in 2012. For example, out of all Acute Psychiatry units where 16% of all reported events occurred, only 9% had a formulated risk of high and 32% had a formulated risk of moderate. Similarly, Emergency Departments/Urgent Care Centers, where 14% of all events were occurring, had no sites with formulated risk of high and only 14% with a formulated risk of moderate. There was little appreciable difference between formulated risks when compared to locations such as Community Based Outpatient Clinics, Outpatient Psychiatry, and Outpatient Intervention Areas.

In 2012, outcome severity data showed that 83% of incidents were assigned a severity level of “none,” with 10% assigned negligible, 7% marginal, <1% critical or catastrophic. When higher risk incidents, such as sexual assault, physical assault, and patient abuse were isolated, similar patterns of low outcome severity assignment were revealed. Because the risk formulation in 2012 was based on both frequency of event and severity of outcome, the underestimation of outcome severity resulted in lower than expected risk formulations for workplaces with high frequency of behavioral events.

The revised risk level formula in 2013 outperformed the original model. The new formulation in the 2013 WBRA tool resulted in higher risk determinations in workplaces experiencing a greater frequency of physical disruptive behaviors and physical containment.

In addition to providing better differentiation between high, moderate, and low risk workplaces, the new formula generated risk levels for higher risk areas that were more consistent with levels of risk being assigned by WBRA teams familiar with the specific constellation of risk unique to each unit and each facility, as shown by a statistically significant improvement in match rates from 2012 to 2013 for three out of four areas with the highest frequency of events (Table 3).

Table 3: Comparison of change in formulated risk and match rates for workplaces with high and moderate frequency of events

	2012			2013			Match Rates		
	% of Events	Formulated as High	Formulated as Mod.	% of Events	Formulated as High	Formulated as Mod.	2012	2013	P<.05
Inpatient Psychiatry	16%	9%	32%	16%	70%	18%	0.53	0.86	*
Emergency/Urgent Care	14%	0%	14%	13%	47%	22%	0.37	0.7	*
Community Living Center	11%	8%	17%	10%	10%	51%	0.72	0.79	
Inpatient Medical/Surgical	9%	2%	19%	9%	31%	39%	0.75	0.88	*
Common Areas within Facility	4%	4%	11%	7%	24%	21%	0.82	0.9	
Community Based Outpatient Clinics	6%	7%	12%	6%	19%	13%	0.52	0.61	
Outpatient Primary Care	5%	3%	14%	5%	13%	56%	0.67	0.68	
Outpatient Mental Health	4%	3%	10%	4%	22%	42%	0.51	0.57	

Implications

Methods for formulating workplace risk must account for the types of information and processes available to assessment teams. The formulations based on the Canadian model required severity of outcome data not readily available to WBRA teams working in the United States Veterans Health Administration. With limited information regarding outcomes and limited ability to quantify outcome severity, WBRA teams defaulted to an outcome severity of “none” resulting in overall underestimation of workplace risk. The 2013 VHA Model overcame these limitations by using data readily available to risk assessment teams, specifically event frequency and behavior type. The resulting formulations more effectively determined high, moderate, low, and minimal risk areas and matched WBRA team assignments more consistently in higher risk areas. The updated formula resulted in greater minimum levels of training being assigned to workplaces which have some of the highest known risks.

While the model requires retrospective information, because it matches the type of training to type of risk documented in the workplace, it more effectively prepares employees to address and manage the types of disruptive and violent behavior they are most likely to face in their workplaces. Specifically matched training can be useful in preventing future incidents and lowering overall risk.

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Learning objectives

Participants will...

1. learn of an effective model for large healthcare organizations to assess workplace risk using behavioral incident data.
2. be able to outline a process for using workplace behavioral risk data to justify which employees need training and what types of training are needed.

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Managing Aggression: A holistic approach to challenging behaviours in an acute general healthcare setting

Paper

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Perspective: Research

Keywords: Prevention, aggression management, holistic care, challenging behaviours

Introduction

Workplace violence is internationally recognized as a major issue for many organizations and employees. The need to prevent and manage aggression in health services is important to provide a therapeutic environment for patients and their families and a safe workplace for staff. The emphasis needs to be on timely effectual clinical management and compassionate care of the patients, while at the same time protecting the safety of staff and others. Among healthcare professionals, nurses in particular are often exposed to occupational violence (Mayhew & Chappell, 2003). There has generally been a focus on mental health wards and emergency departments in relation to prevention and management of aggression and violence, with less focus on the general wards. Violence in general wards is an ongoing problem in Victoria Australia. Such violence can take the form of verbal abuse, threats and physical assault and in most cases is directed toward health workers who have immediate contact with patients and their families.

This pilot study is about the effectiveness of a staff educational package intervention which was undertaken in 5 acute general wards of a 600 bed Australian hospital where staff were regularly exposed to episodes of aggression and violence in the workplace arising from patients, visitors and other staff. However, senior staff had identified that mental health staff were more confident than their general health staff peers in managing and preventing episodes of aggression and violence in the general wards. Acute health staff felt poorly prepared to manage such episodes. A gap analysis was conducted with staff across the acute health wards and it was identified that there was a need for education related to the specific situations they face on the wards every day. These needs were not being met by the education provided by the standard package which had an Emergency Department (ED) /mental health focus. This included dissatisfaction with both content and mode of delivery. Staff were asked to provide examples of scenarios representing real life situations of workplace violence they faced in their wards. A literature review revealed there were minimal quality scenario based education packages appropriate for the general acute healthcare workforce. This led the researchers to develop a custom-made DVD style educational package to specifically meet the needs of staff in this particular environment that was effective, relevant and feasible to deliver.

Aim

To test the effectiveness of an educational package of a DVD and PowerPoint presentation entitled 'Managing Aggression: - A holistic approach to challenging behaviours and report the findings.

- Ensure safety of staff and patients through improving staff's ability to communicate with patients and relatives
- Engage the workforce to better assess patients behaviour and underlying reasons for this behaviour, thus ensuring individualised, appropriate and timely treatment is provided.
- Relate real life scenarios ensuring education, which staff can relate to.
- Develop an education package that is clear, concise and able to be delivered in 1 to 1 ½ hours ensuring accessibility for all staff.

Method

The pilot study was a pre-test post-test experimental design utilising the educational package (developed by the researchers) as the intervention: - Staff from 5 acute medical wards participated in an anonymous questionnaire, on three occasions over a 6 week period.

The intervention was an education package "Managing Clinical Aggression – A Holistic Approach" which was developed according to the general ward staff scenario descriptions. The package incorporates a DVD of 8 commonly requested clinical scenarios; the scenarios included managing a person with alcohol withdrawal, dementia, delirium, acute confusion state, families expressing high expressed emotions, fear, and pain. There is an accompanying PowerPoint presentation involving positive management approaches focusing on consideration of the patient as a whole person and factors such as Trauma, Drug and Alcohol, Environment,

Health and Well-Being and Communication. It also looks at the impact of staff's attitude in relation to the successful management of clinical aggression. The education package was presented by clinical co-ordinators of the Risk identification, Safety, Communication, Environment (RiSCE) program. Whilst there are eight scenarios in the package, the evaluation was conducted on a single scenario.

Evaluation was undertaken using a validated outcome measure, the Management of Aggression and Violence Attitude Scale (MAVAS). The MAVAS incorporates 30 statements about causes of violence and aggression on a visual analogue scale. Factor analysis identified four main concepts: Internal (patient experience), External (environmental), Situational/Interactional and Management factors (Duxbury, 2003). The MAVAS also explores staff beliefs or attitudes about the causes of aggression and violence, in general terms, specific to medication use and around the use of restraint and non-physical methods and staff interactions. Participants completed the questionnaire immediately prior to the intervention, immediately post the intervention and again approximately six weeks after the intervention (n = 31). The questionnaire also included short answer questions. Additional qualitative data was obtained with semi structured interviews with the unit manager's post the intervention period. (n = 5).

Results

The initial pilot included 71 staff, mostly female (85.9%), almost all registered nurses (97.2%) with a range of years of experience and more than half had had education in risk management. (53.5%) Of these, 44 completed the pre and post survey. Of the 30 items there was positive movement in agreement on all items of the MAVAS with a statistically significant shift on 7 of these (note $p < .0012$). These items were; Patients are aggressive because of the environment they are in ($p < .0001$); Patients commonly become aggressive because staff do not listen to them ($p < .0001$); Poor communication between staff and patients leads to patient aggression ($p = .0001$); Cultural misunderstandings between patients and staff can lead to aggression ($p = .0003$); Other people make patients aggressive or violent ($p = .0007$); Gender mix on the wards is important in the management of aggression ($p = .0003$); Patients who are violent are restrained for their own safety ($p = .0010$).

The six week post survey demonstrated maintenance of the attitudinal changes. Staff reflected on the impact of the education and how this has had an impact on their attitude when managing clinical aggression.

- "It identifies I need to listen to patients and clarify with them more, the importance of communication and the need to be reflective about the approach to use with each patient"
- "It has made me think about the individuality of each patient and how aggression can occur, when not managed well"
- "An opportunity to be reflective within my practice and the visual impact of the DVD was useful for reinforcing the need to be aware of my voice, body language and listening skills with patient interactions"
- "It provided real life events that can occur regularly in hospitals and provides the right and wrong way to deal with the situation".

The scenario based learning allows staff to reflect on current practices and what they can do differently to achieve a positive outcome for the patient, ultimately helping provide a better healthcare experience for all involved. Having staff recognise the importance of clear concise communication with patients and relatives assists with recognising early signs of aggression and allows staff to make accurate risk assessments improving safety for all. The education package provides great flexibility and can be adapted and developed to suit the individual needs of the setting in which it is being delivered ensuring relevance and supporting delivery by local staff at a time that is most relevant such as when a risk arises, when new staff are employed. Staff reported that the length of the education and reality of the scenarios allowed them to relate the education to real life situations in their own workplace. This mode of education also represents cost savings through the delivery of shorter more focused education that can be conducted locally during regular staff education sessions, rather than full day sessions.

Limitations

The absence of a control condition means that definitive statements about cause and effect cannot be made. Further, the limited number of participants, especially the number who responded at 6 weeks post intervention, means that the study had insufficient power to detect moderate effect sizes as statistically significant.

Discussion and conclusion

Managing Clinical Aggression – A Holistic Approach is being developed as an on-line program for timely access for staff throughout the organization over its various sites. The program expects to fill an urgent and peer identified gap as it takes the specific needs of the general medical wards and translates them into targeted education for that workforce. The real life scenarios while identified to Peninsula Health are readily transferrable to other organisations. The design of the package allows a greater number of staff to attend sessions and its flexibility of delivery makes it easily adapted to suit the needs of different clinical areas and for a range of professional groups.

It is innovative in that the mental health team have identified the needs of their peers, developed an educational package and made it accessible for them and therefore capacity building by transferring aggression management

skills from the skilled expert to the peer, Readers should be cautioned however that while these changes appear promising, the effect of this intervention on participant behaviours in practice settings is unknown and further research is recommended on a larger sample and will be undertaken by the researchers.

Through the regular use of this education package staff will be better equipped to manage situations and feel more confident when dealing with clinical aggression. This increased confidence supports positive outcomes for patients and staff and the benefits of a highly competent and engaged workforce are shared by all stakeholders.

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Learning objectives

Participants will...

1. develop an understanding of the strategies utilised in a management of aggression and violence education package.
2. have a greater understanding of the causes of violence and aggression in the acute health inpatient setting.

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Tell me how to support you: De-escalation preference tools as a means of creating safety

Paper

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Perspective: Practice

Background and context

De-escalation preference tools have been demonstrated to be effective methods of identifying key strategies for individualized de-escalation of potentially aggressive situations. Their use is required or highly recommended in mental health, substance abuse, general health and intellectual disability service settings in many countries. By using these tools, safety is enhanced for all stakeholders in human service settings.

Methodology

A representative sample of organizations using de-escalation preference tools and associated outcomes will be presented in this paper. Proposals to provide standard definitions so as to facilitate robust data collection will be identified and presented to participants.

Findings

Organizations using de-escalation preference tools have reported lower rates of use of restrictive practices such as seclusion and restraint. Organizations not using de-escalation preference tools did not report similar results.

Implications

For practice: Involving consumers in the process of identifying their own preferences to invite them to de-escalate not only empowers consumers, it facilitates the process of identifying methodologies to achieve de-escalation, and because the consumer at least participated, if not initiated the process, ownership of outcomes results in higher rates of positive response to cues to de-escalate.

For training: A primary focus is on teaching consumers (patients, residents, etc.) how to identify and then communicate their own preferences to achieve safety through de-escalation. Teaching consumers and staff together facilitates the partnership needed to do more than just ‘tick the box’ in the process of meeting regulatory requirements.

For policy: While required in mental health settings some countries, the efficacy of using de-escalation preference tools has been validated by the National Association of State Mental Health Program Directors. Expanding their use beyond mental health services and into the broader human service sector will increase the safety of all people.

Learning objectives

Participants will...

1. understand what de-escalation is and how de-escalation occurs and appreciate the potential physiological impact of escalation.
2. understand how a de-escalation preference tool can enhance impulse control.
3. receive and understand examples of de-escalation tools and techniques.

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Using actions plans to translate workplace violence data into prevention efforts in hospital units

Paper

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Perspective: Practice

Background and context

Many hospitals have routines for documenting incidents of workplace violence, but few have strategies for identifying preventive measures on individual units. This project introduced Action Plans as a method to aid unit supervisors in the development of data-driven violence prevention strategies. The aim was to introduce and implement Action Plans as a structured framework for violence reduction in hospital units at high risk for violence.

Methodology

In 2013, as part of an ongoing, randomized-controlled intervention, unit walkthrough visits were conducted with supervisors of 21 hospital units within a large, metropolitan hospital system. The research team provided unit supervisors with data of their unit's violent incidents over a 3-year period and a summary report of a recent, anonymous workplace violence questionnaire from unit staff.

Supervisors gave the researchers a description of the factors leading to violence on their units and were asked to fill out an Action Plan, a form used to develop and document strategies for workplace violence reduction. The Action Plan includes a checklist of environmental, administrative, and behavioral strategies for reducing workplace violence. In collaboration with unit staff, supervisors were to fill out their own unit-specific strategies for targeting violence, providing specific goals, a time plan for completion, and staff responsible for implementation.

Findings

Seventeen Action Plans (81%) were returned; of these, 14 gave specific strategies for violence reduction, 12 specified a time plan, and 14 named an individual responsible for implementing the strategies. Unit-specific strategies were based on the data provided by the researchers, and the factors for violence identified by supervisors. Units with high rates of patient-to-worker (Type II) violence outlined strategies such as higher security presence, de-escalation training, daily safety huddles, and environmental changes. Units with high rates of worker-on-worker (Type III) incidents included strategies such as mediation and conflict resolution training. However, each Action Plan was unique.

Implications

The Action Plan form with suggested prevention strategies provides a structured framework for developing efforts to target and reduce workplace violence. Inclusion of unit supervisors and staff who "own the problem" of workplace violence on their unit can lead to more effective prevention strategies targeted at unit-specific factors. Using Action Plans to standardize violence reduction efforts allows hospital system stakeholders to compare progress and specific strategies across units of different functions and sizes.

Acknowledgement

This work was supported by CDC/NIOSH, grant R01OH009948.

Learning objectives

Participants will...

1. understand how the Action Plan form is used as a framework for workplace violence prevention in individual hospital units.
2. understand that unit-specific data on violent incidents is the foundation for use of the Action Plan form for development of workplace violence prevention strategies.

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Worksite walkthroughs: A data-driven tool for reducing workplace violence in hospitals

Workshop

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Perspective: Practice

Background and context

Administrative reports summarizing the incidence and nature of violent events are the foundation of any workplace violence prevention program. However, individual worksites often lack routines for reviewing workplace violence data, making it difficult to develop preventive measures. This workshop will present the concept of a structured worksite walkthrough as a method for helping individual hospital worksites to reduce workplace violence.

Methodology

In 2013, walkthroughs were conducted at 21 hospital worksites as a standardized intervention as part of an ongoing participatory action research project aimed at reducing workplace violence. Walkthroughs were limited to 45 minutes and were conducted by a 3-person workplace violence task force that met with a manager and 1 or 2 staff members at each worksite. The task force, comprised of representatives from the research team and the hospital system's occupational health services, presented worksite-specific data on documented workplace violence in the previous 3-year period. Data were presented as graphs and included incidence rates of violence broken down by type of perpetrator (patient or employee). Data were discussed and a walkthrough of the worksite was conducted when it was deemed helpful, such as to describe specific risk situations to the task force. Based on the data, worksite managers were asked to devise an "Action Plan" describing specific measures that would be implemented in an effort to reduce violence. A checklist of possible preventive strategies was provided to assist in development of the action plan. Worksites were asked to submit their action plans to the task force within one month of the worksite visit. Brief questionnaires were used to gather perceptions of the utility and feasibility of the worksite visit from worksite managers and staff participants.

Findings

The walkthrough visits were well-received by worksite managers and staff, who stated appreciation for the overview of workplace violence and the breakdown by type, i.e., patient-to-worker and/or worker-to-worker. Worksite representatives also validated the data as reflecting what they perceived as their clinical reality with regard to violence, including possible underreporting. A key aspect of this worksite walkthrough is the involvement of hospital stakeholders – i.e., those who "own the problem," in the review and development of local solutions.

Implications

Worksite walkthroughs provide a forum for review and discussion of workplace violence based on a succinct graphic summary of documented violent events. They provide a structured platform for the development and implementation of data-driven workplace violence prevention strategies. This workshop will describe each aspect of the worksite walkthrough, including facilitating factors and challenges that were identified during the implementation process. The workshop will combine presentation with interactive participant involvement, encouraging the audience to pose questions and discuss their views and local experiences.

Acknowledgement

This work was supported by CDC/NIOSH, grant R01OH009948.

Learning objectives

Participants will...

1. understand that this local initiative represents a local effort to translate collected data into effective violence reduction and prevention efforts.
2. understand that worksite walkthroughs serve as a forum for review of documented violent events and have global applicability to all hospitals striving to reduce violence towards employees.

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Understanding underreporting: Comparison of self-report and actual documentation of workplace violence events in hospital settings

Paper

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Perspective: Research

Background and context

Underreporting is a serious hindrance to understanding the magnitude of workplace violence (WPV) and to the development of prevention strategies. However, few studies have examined the relationship between how health care workers report exposure to violence via survey and their actual documentation of WPV incidents. The aim of this study was to examine differences between self-report and actual documentation practice and explore patterns of healthcare workers who under-report.

Methodology

The study was conducted drawing from 42 hospital units at high risk for violence within a large metropolitan hospital system which maintained a system-wide electronic database for reporting workplace violence events. In 2013, all employees within these 42 units (n=2'010) were surveyed by mail about individual experience and reporting of WPV during the previous year. Survey responses were compared with actual events entered into the electronic reporting system. Underreporting was defined as the percentage of employees who had experienced a WPV event but didn't report any events into the electronic reporting system.

Findings

446 employees responded to the survey (response rate=22%). 275 respondents (62%) reported experiencing at least one WPV event in the previous year; of these, 243 did not document an incident in the database, representing an overall rate of underreporting of 88%. Surprisingly, 63 of the 275 respondents (23%) reported having recorded at least one incident into the hospital system database, but only 12 (4%) actually did so. Among the 212 employees who stated in the survey that they did not record a violent incident, 20 (9%) actually did. Thus, in actuality, only 32 of the 275 employees (12%) who experienced violence had reported an incident via the electronic reporting system. Underreporting was most likely on Surgery units (96%), least likely on Psychiatric (71%) and Security units (80%), and more likely among part-time (90%) and contingent employees (95%) compared to full-time workers (84%). Among the 32 employees who did report at least one incident into the hospital system database, 9 (28%) were injured as a result of that incident. However, the proportion injured was higher for those who indicated in the survey that they had reported the event (50%, n=6) compared to those who did not indicate so (15%, n=3).

Implications

The lack of agreement between employees' survey responses and actual report practices may be due to recall bias or may reflect a lack of motivation to utilize the central reporting system for violent events. Lack of injury may also be a risk factor for underreporting. Underreporting continues to be a serious issue in determining the actual extent of WPV. Understanding the magnitude of underreporting and the characteristics of employees who are more likely to underreport may provide hospital systems with a more accurate estimate of their levels of WPV and help to determine where to focus training and education.

Acknowledgement

This work was supported by CDC/NIOSH, grant R01OH009948.

Learning objectives

Participants will...

1. understand the relationship between self-report and actual practice of reporting workplace violence events.
2. identify characteristics of hospital workers more likely to underreport workplace violence.

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Reducing the risk of patient-generated violence in healthcare: A case study

Poster

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Perspective: Organisational

Keywords: Violence in healthcare, workplace violence, workplace assaults, emergency department safety, aggression management, de-escalation, violence prevention and mitigation, patient safety, healthcare worker safety, patient generated violence

Background and context

Historically, violence in healthcare education has taken a back seat to clinical training, often due to the time constraints of clinical staff and the allocation and prioritization of other resources. We have found that although most healthcare facilities invest capital resources into securing their environment, such as access control systems and video surveillance, they continue to miss in the more important investment of training and empowering staff to own their work environment in order to create a culture of safety.

In 2010, HSS worked with clinical and administrative leaders from a large southwestern healthcare systems to implement a comprehensive patient-centered aggression management training program. The program took a proactive, multi-tiered approach in managing the physical space as well as managing the aggressive and violent patient. The key topics identified by healthcare leaders included risk factors of potential violence, verbal de-escalation techniques, environmental controls, staff training, policies and practices, and staff response options. A complete risk assessment of high risk areas was conducted in order to incorporate environmental design changes into the work environment.

The program was designed to proactively create a safer care environment through the implementation of workplace violence prevention and mitigation strategies. The curriculum was uniquely designed for the healthcare environment and focused on empowering staff and creating a sustainable program that emphasizes a culture of safety. Specific goals of the program were to:

1. Improve medical staff perception of educational preparation for violence prevention, thus intent to remain in their current field
2. Improve the environmental safety of the emergency department
3. Improve the environmental safety of the emergency department through policy development and implementation
4. Increase the number of hands-off options for neutralizing the threat of escalating violent patient behavior.

Methodology

In 2012 a security services provider worked with clinical and administrative leaders from the health system to implement a comprehensive patient-centered aggression management training program for a large southwestern US healthcare system. The program took a proactive, multi-tiered approach in managing the physical space as well as managing the aggressive and violent patient. The key topics identified by healthcare leaders included risk factors of potential violence, verbal de-escalation techniques, environmental controls, staff training, policies and practices, and staff response options. A complete risk assessment of high risk areas was conducted in order to incorporate environmental design changes into the work environment.

The program was designed to proactively create a safer care environment through the implementation of workplace violence prevention and mitigation strategies. The curriculum was uniquely designed for the healthcare environment and focused on empowering staff and creating a sustainable program that emphasizes a culture of safety.

Goals of the program were: 1) to improve medical staff perception of educational preparation for violence prevention, thus intent to remain in their current field, 2) to improve the environmental safety of the emergency department 3) to improve the environmental safety of the emergency department through policy development and implementation, and 4) to increase the number of hands-off options for neutralizing the threat of escalating violent patient behavior.

Findings

Three hundred twenty clinical staff members completed a combination of questionnaires and staff surveys. Summary of staff training initiative outcomes: 98.9% content was relevant to their job and the program objectives were met. 97.7% indicated the methodology was sound and 98.9% indicated they believe they will immediately be able to apply what they learned and that the program was a good investment for their hospital. The survey measured the perception of staff safety culture with the question: intent to leave. Results showed

a marked improvement after the educational intervention. 14.3% of ED staffs were considering transferring to another unit or facility. Six months after the intervention, that number had dropped to 6%.

Implications

There have been numerous outcomes from the implementation of this program including increased violence mitigation education for staff, increased staff perception of a culture of safety, decreased injury in patient altercations, increased communication of potentially violent situations, and improvements in physical safety of the department.

Learning objectives

Participants will...

1. learn of strategies that empower staff to proactively manage their work environment in order to create a culture of safety and reduce the risk of violence.
2. understand best practices of creating safer work environments through environmental design planning.
3. learn how the effects of patient-generated violence can be mitigated through a comprehensive aggression management initiative.

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NIOSH Workplace violence prevention for nurses on-line course: Content and evaluation

Paper

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Perspective: Education and Training

Background and context

Recognizing the need for a workplace violence prevention course that will benefit nurses and many other occupations within healthcare, NIOSH researchers collaborated with Vida Health Communications, Inc. (Vida), to develop an on-line course accessible through any electronic device with an Internet connection. Designed to keep the interest of all healthcare workers, ranging from the novice to the most experienced, the interactive course employs text, case study videos, and personal interviews to convey the training materials using various engaging approaches. Healthcare workplace violence prevention experts from academia, labor, professional organizations, government agencies, and private consultants participated in developing the course.

Methodology

Subjects covered in the course include: definitions, typologies, and prevalence of workplace violence; risk factors and consequences; prevention strategies for individuals and organizations; and post incident response. To evaluate the content and its impact, a random sample of 203 registered nurses from across the United States were recruited. Nurses randomized to the intervention group (n=98) completed the online course, while those randomized to the control group (n=105) did not complete the course. Both groups completed pre- and post-intervention surveys via email which assessed knowledge of workplace violence, attitudes towards violence, perceptions of the magnitude of violence, and behavioral intentions of those committing violent acts. Participation rate was 98% and completion rate was 97%. Nurses in the control group were provided with information about the online course at the completion of the study.

Findings

Compared to nurses in the control group, nurses who completed the course (intervention group) reported significantly:

- Greater gains in knowledge about workplace violence including how to prevent, assess, and respond to violent incidents.
- More positive attitudes about reporting violence in the workplace and confidence that they could intervene to prevent violence.
- Increased likelihood for those who experienced or witnessed violent incidents in the past month to seek or recommend counseling for those involved.

All findings are significant at the $p < .001$ level.

Implications

The project demonstrated that a well-designed and relatively brief learning intervention can shift attitudes and behaviors of nurses so they become more engaged in a process of workplace violence prevention. The project team believes that this course can serve as a core building block to improve the outcomes for all workplace violence prevention programs through improved workforce engagement and empowerment.

Learning objectives

Participants will...

1. have a basic understanding of the magnitude of violence in the healthcare setting by typology and the associated prevention strategies.
2. identify factors that influence nurses decisions regarding reporting workplace violence incidents.

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Organizing the organization: A trauma centered approach to organizational management

Workshop

Tim Geels

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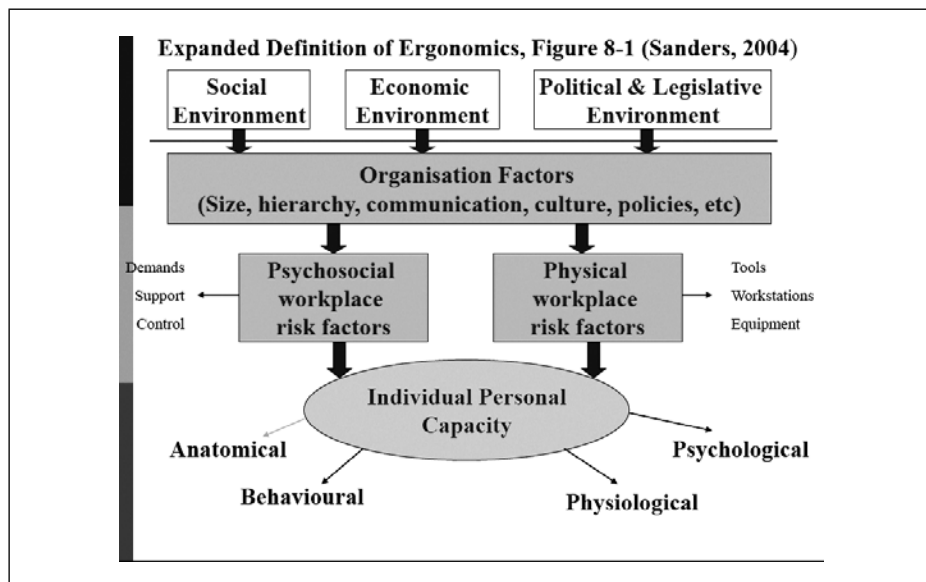
Perspective: Organisational

Keywords: Organizational culture, trauma informed services, toxic cultures

Background and context

Organizational Management theory provides the contextual framework which is used to structure relationships through the table of organization, policies and procedures, work flow, etc. Trauma Informed Services is an approach which seeks to inform the practices of an organization through knowledge of the prevalence, impact, and recovery from trauma in all aspects of service delivery. (Fallott, 2005) Given the prevalence of trauma within the population served by health care organizations, estimated to be above 80%, organizations will benefit not only from informing their practices, but also their basic organizational structures to reflect this sensitivity to their constituents.

Ergonomics is a term that is usually associated with physical aspects of a workplace, such as seating, wrist support when typing to prevent carpal tunnel syndrome, etc. The United States Occupational Safety and Health Administration (OSHA, 2014) definition of ergonomics focuses on musculoskeletal disorders and defines ergonomics as “fitting a job to a person.” This definition has been expanded upon to include all of the factors in fitting a job to a person, including their individual personal capacity, which involves behavioral, anatomical, physiological and psychological factors (Sanders, 2004).



Individual personal capacity is a broad term to help people understand that if the capacity for specific behaviors or actions are not present, then they must be built. Trauma histories change the neurosensory systems of all human beings (Perry, 2001). In researching this presentation, no peer reviewed resources could be found which addressed the trauma histories of staff. Their trauma histories, as well as that of individuals served, are part of the interactional framework of the organization, and must be integrated into the service structure of the organization.

Trauma histories of individuals served and of staff are part of the global understanding of how to structure an organization to maximize safety and minimize risk to all people. Our goal should be to manage and support safety, not just doing “risk management” as a way of decreasing risk for all people. (Bowen et al. 2012) By making an understanding of the prevalence, impact, and recovery from trauma central to the way organizations are organized enhances the interventions and supports offered by caregivers and leads to reductions in workplace violence as demonstrated by organizations that have taken this approach.

Methodology

A meta-analysis of Corporate Culture Change workshops conducted by the author and others in the sponsoring organization identified key areas of concern and opportunities for change organizations could make that increases safety for all people. The organizations reviewed included two forensic psychiatric treatment centers, one general, state operated psychiatric hospital, and four community based residential and vocational service providers located in the United States and Australia. The Corporate Culture Change workshops integrate information from many different sources into a holistic service approach that “supports people, not just their behavior.” (Bowen, 1999). McClelland’s Learned Needs Theory (McClelland, 1975), Invitational Education (Shaw, 2004), Transdisciplinary Teamwork (Direnfield, 2011) Positive Behavior Support (Horner et al. 1990) and The Mandt System® (Mandt & Bowen, 2014) are the central approaches that are used in this process.

Adding trauma informed services to the mixture of different models was the “linchpin” that empowered organizations to offer services and supports in ways that did not inadvertently re-traumatize individuals. The concept of including trauma informed services into the work we do in human services (Huckshorn, 2004) is a relatively new idea, and has spread rapidly at a clinical and programmatic level in human service settings throughout the world.

At a policy and procedure level, however, we continue to struggle with how to integrate what we know of behavior change theory at a consumer level and apply those same concepts to the behavior of staff. A tool to measure the presence of toxicity in human service settings from the model of Invitational Education was developed for the Corporate Culture Change workshop. The results from the organizations surveyed showed that over half of the staff in all organizations believed that the policies and procedures of the organization were contributors to the toxicity within the organization. These results were consistent across both American and Australian cultures.

Policies and procedures in any organization reflect the ways in which roles, relationships, and resources are organized to support the mission of the organization. Understanding the role of trauma history in this complicated dance of aggression (Bowen, 2009) helps to shed light on the processes necessary to change policies and procedures. The Adverse Childhood Effects study (Anda, 2007) demonstrated that only one third of respondents, who were middle class Americans, could say that they had no adverse childhood experiences as they were growing up.

Findings

The data on consumers in human service organizations demonstrates significantly higher levels of trauma, and while their histories have an impact on the organizations, it is the trauma histories of staff that are overlooked. Organizations that use the traditional models of multidisciplinary and interdisciplinary services had more difficulty in achieving meaningful increases in safety and security for all the stakeholders in the organization. Functional, Divisional, and Matrix structures are the three most common approaches used to provide guidance and structure within organizations to facilitate the work done. These structures all have advantages and disadvantages, and central to all the disadvantages is the level of trust within the relationships between staff. (Ketchen & Eisner, 2009) By understanding the effects of trauma on human beings, we can better understand each other and the needs of each has.

Organizations using approaches that “flatten” the organizational structure have been better able to provide supports to the staff in the organization who, in turn, support the individuals served. Given the level of trauma within general society as measured by the ACE study referenced earlier, and the levels of stress present in human service settings, anything which enhances our knowledge of each other, such as an awareness of trauma history, will improve our ability to support each other and the individuals served within the organization. In this model, “patients come second” (Spiegelman & Berrett, 2013) and staff come first. “You can only give what you have” is the phrase used to understand how staff who are sensitive to trauma can support those receiving healthcare services who have histories of trauma. It is only by putting staff first, by taking care of their needs, that they will be empowered to provide services and supports that are truly healing in nature as well as in word. It is the responsibility of leadership in the organization to integrate the model of trauma informed services into the day to day policies and procedures that either support or take away from services. While new theories of leadership can sometimes add to our skill sets, most of what we know about leaderships is derived from basic principles, and focusing on principle and not technique is what empowers cultural transformation and supports growth at an individual and corporate level. (Anthony & Huckshorn, 2008)

Implications for Practice: Restructuring the roles of an organization around the concepts of support, wellness, safety and security can result in the empowerment of staff to more fully support people in their care. Additional

outcomes of effective and efficient service delivery can be realized by fully supporting staff so they can support others. More research is needed on specific outcomes of interventions that are related to Trauma Informed Services.

Description of engaging participants: The presenter will use small group activities to provide structured participation in assessing their own organizational structures, and how these structures can be trauma informed and then transformed.

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Learning objectives

Participants will...

1. identify the differences between functional, divisional, and matrix structures in organizations.
2. be able to describe trauma informed services.
3. be knowledgeable on how to integrate trauma informed services and organizational structures.

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Violence prevention program implementation in VA medical centers: Perceptions of patient disruptive behavior committee chairs

Paper

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Perspective: Organisational

Keywords: Interdisciplinary teams; patient disruptive behavior; violence prevention; program implementation; organizational structure

Introduction

Comprised of over 140 major medical centers, over 1,000 community-based outpatient clinics, and employing over 304,000 individuals, the US Veterans Health Administration (VHA) currently is the largest single integrated healthcare system in the world. Organizationally located within VHA's Office of Public Health, the VHA's Workplace Violence Prevention Program is responsible for developing and implementing policies and programs that promote knowledge, skills, and appropriate use of evidence-based, data-driven processes for assessing, mitigating, and managing human behaviors that compromise the safety and effectiveness of the VHA healthcare workplace. The Workplace Violence Prevention Program identifies five areas that comprise a comprehensive approach to violence prevention in VHA: 1) Employee-Generated Disruptive Behavior, 2) Patient-Generated Disruptive Behavior, 3) Employee Education and Training, 4) Disruptive Behavior Reporting and Data Tracking, and 5) Environmental Design. Patient-generated disruptive behaviors represent an overwhelming majority of the reported disruptive behaviors in VHA healthcare settings, thus this area of workplace violence prevention programming is the most developed, having extensive policies, programs and initiatives already implemented across the system.

Unlike other healthcare organizations in the United States that are able to terminate provision of healthcare when patients engage in behaviors that might compromise the safety of the workplace, VHA specifically is prohibited by United States Code of Federal Regulation (38 CFR 17.107) from barring eligible Veterans from access to VHA healthcare due to their behavior. Therefore, VHA must have policies, procedures, and programs that are not found in other private sector healthcare institutions that are designed to promote a culture of safety in its medical facilities.

VHA requires each medical facility to have a patient Disruptive Behavior Committee (DBC). The DBC advises clinicians, clinic managers, and the Chief of Staff (or equivalent healthcare administrative executive who has oversight responsibility for clinical operations) on a coordinated approach for addressing patient disruptive behavior. DBCs operate under the authority of, and report to, the Chief of Staff.

The DBC is an interdisciplinary team chaired by a senior clinician who has training and experience in violence risk and threat mitigation. At present, DBC Chairs perform their work as ancillary duty to their formal healthcare provision responsibilities; they all have clinical productivity standards that are not adjusted for the time devoted to DBC duties. Other required members of the DBC include representatives from the Labor Unions, the employee violence prevention education program (in VHA it is the Prevention and Management of Disruptive Behavior (PMDB) curriculum), the Quality Management office, the Veterans Affairs Police department, the Patient Advocate's office, the Privacy office, the office of Regional Counsel (attorney), and other areas or services in the medical center known to be at high risk for workplace violence incidents (e.g., Emergency Department, Inpatient Psychiatry, Community Living Centers/Nursing Homes). This interdisciplinary team is charged with reviewing patient disruptive behavior reports, employing evidence-based approaches for assessing the safety risk posed by the reported behavior, and developing violence risk mitigation plans to support the overall culture of healthcare safety.

The VHA Workplace Violence Prevention Program hosts annual training conferences for the DBC Chairs to instruct and benchmark threat assessment and management best practices, and to improve understanding of national program policies, operations, and initiatives. During the January 2014 DBC Chairs Conference, a survey was administered to attendees that generated data regarding DBC case load, DBC Chair's evaluations of DBC functioning, sources sought for violence risk and threat assessment consultation, and perceptions of implementation priorities at the national level. Results from this survey are summarized and interpreted using the implementation science Replicating Effective Programs (REP) framework.

Methods

Forty-nine (49) DBC Chairs attended a three-day conference in January 2014. Participants completed a 10-item survey that included respondent characteristics, number of reports of patient-generated disruptive behavior reviewed over the last year, the source(s) used for expert consultation, satisfaction with the DBC in addressing patient behavior, and requests for national program implementation priorities for the next five years.

Results

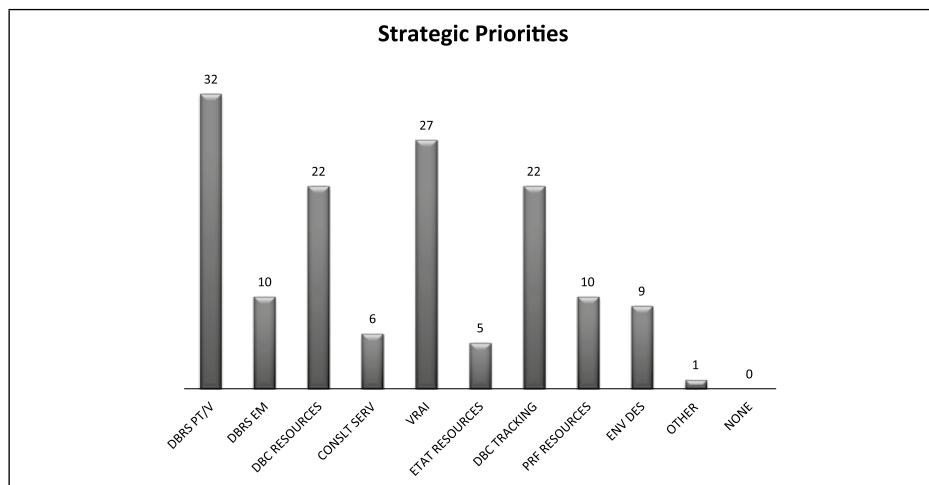
Participants (N = 49) were primarily doctoral level mental health professionals: Psychologists (PhD or PsyD = 61.2%) and Psychiatrists (MD = 16.3%). The remaining DBC Chairs reported being masters level Nurses (RN, APN = 8.2%) and Social Workers (MSE, LCSW = 14.3%). Approximately half (49%) of the conference participants reported attending a prior training session, a 4-day intensive Mini-Residency immersion experience, hosted by the VHA Workplace Violence Prevention Program. The average DBC chair tenure was 50.8 months (SD=42.2 months).

DBC Chairs assessed an average of 84.5 (SD=87.3) reports of patient disruptive behavior during the most recent year. Most DBC Chairs (73.5%) processed less than 100 individual cases per year; however, DBC Chairs from 7 medical facilities (14.0%) reported processing 101 – 250 reports of patient disruptive behavior, and DBC Chairs from 2 medical facilities (4.0%) reported processing more than 251 cases during the most recent year.

During the last year, 90% of respondents reported that they requested violence risk and threat mitigation case consultation from at least one source within the past year. More than a third (37%) of respondents indicated consultation with other members of the WVPP staff, 28% reported consultation with the Threat Management Call and email distribution list, 25% reported consultation with another DBC chair, while 10% of respondents indicated they did not consult with anyone. The majority of DBC Chairs (76.1%) reported being either satisfied or very satisfied with the operation and function of their local DBC (M=3.75, SD=.69). Consulting with the national program office was associated with higher DBC satisfaction at the facility level ($r=.26$).

DBC chairs identified a uniform national Disruptive Behavior Reporting System (65%), a structured clinical judgment guide normed in the healthcare patient population (55%), and DBC operational resources (45%) and DBC tracking (45%) as their top four implementation priorities for the national program office over the next five years (see Figure 1).

Figure 1: Strategic Priorities



Behaviors:

DBRS EM = Disruptive Behavior Reporting System for Employee Behaviors

DBC RESOURCES = Guidebooks and Toolkits to support the work of DBCs

CONSLT SERV = Formal Consultation Service (rather than email and phone call as needed)

VRAI = Violence Risk Assessment Instrument, a structured clinical judgment guide normed on the Veteran population

ETAT RESOURCES = Guidebooks and Toolkits to support Employee Threat Assessment Teams (those interdisciplinary teams that address employee, rather than patient, disruptive behavior)

DBC TRACKING: Tools for documenting and tracking the workload of DBC Chairs

PRF RESOURCES = Guidebooks and Toolkits to support DBC Chairs in their use of one risk mitigation tool available to them, the Patient Record Flag (Drummond et al, 1989)

ENV/DES = Resources to inform Environmental Design to reduce violence in healthcare

OTHER = Request for resources on sexual violence risk mitigation

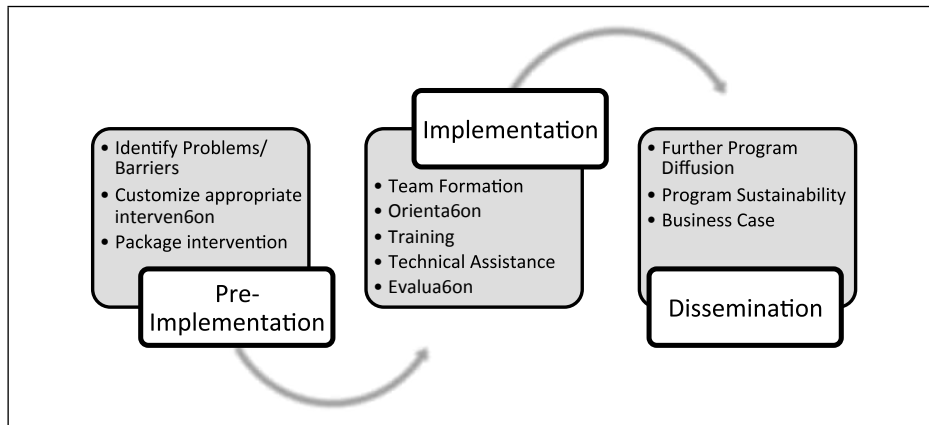
Finally, open-ended responses identified a pervasive perception that DBC function at the medical facility level would be enhanced through DBC Chair protected administrative support, role clarity, more training in evidence-based violence risk assessment, and more communication on policy expectations from the national program office. DBC Chairs reported that VHA's Workplace Violence Prevention Program would be more effectively implemented at the facility level if support resources at the local level were available, more time for attending training was protected, and more effective online computer-based learning systems were available.

Discussion

Successful implementation of national organizational programs addressing patient disruptive behavior requires feedback from local medical facility program users to inform the development of useful national strategies and initiatives. Stated slightly differently, people tend to support what they, themselves, help to create. For a program to be successful, it is essential that it maximizes the direct relevance of its national program elements through direct communication with those individuals who implement the program locally. The findings from this study summarize the outcome of the feedback process that informed the national program office of what is necessary to maximize DBC program relevance for continued success at the facility level.

The utility of findings from this survey, and how they inform continued development of the DBC program, are clarified by applying the Replicating Effective Programs (REP) model. The Centers for Disease Control and Prevention originally developed the REP model to translate Human Immunodeficiency Virus (HIV) prevention programs rapidly and effectively to community-based settings. The three-phase model (see Figure 2) readily translates into a useful infrastructure for informing workplace violence prevention program implementation.

Figure 2: Replicating Effective Programs (REP) Model



Based upon the REP model developed by the Centers for Disease Control and Prevention

VHA's process for assessing and developing risk mitigation strategies for patient disruptive behaviors has been evolving for many years. In 2003, the national policy requiring DBCs in all VHA medical facilities was published, thus benchmarking the completion of the Pre-Implementation phase of the REP model. Eleven years later, facilities across VHA are in varying stages of program maturation, with nearly all DBCs being solidly in the Implementation phase of the REP model. Evidence for the achievement of this phase of the REP model includes, but is not limited to, the fact that: 1) all medical facilities in VHA have formed a local DBC, 2) personnel serving on local DBCs have received basic orientation and training in DBC operations and functions, and 3) the VHA national Workplace Violence Prevention Program office provides technical assistance and currently is initiating more extensive program evaluation initiatives.

Findings from the present study provide valuable insight into propitious pathways for continuing forward movement of all DBCs to the Dissemination phase of the REP model. In particular, one way in which VHA might address the Program Sustainability aspect of the Dissemination phase would be to prioritize addressing the needs identified by DBC Chairs themselves in order for them to continue successful operation of their local DBC. In particular, DBC Chairs unambiguously indicated that the development and implementation

of standardized reporting systems, evidence-based and data-driven structured clinical judgment guides, and resource tools would increase the sustainability of the DBC process at the local medical facility level. Finally, the Business Case aspect of the Dissemination phase of the REP model likely would be supported, in part, by the development of standardized national workload tracking mechanisms requested by DBC Chairs.

In summary, findings from this study add valuable insight for VHA as well as other organizations that assess and develop programs and initiatives that address risk mitigation for patient-generated disruptive behaviors in the health sector. Most DBC Chairs indicated that the DBC process was effective, but identified areas where further support efforts would be beneficial. The clear relationship between consultative use of the national Workplace Violence Prevention Program office resources and satisfaction with the local DBC functioning supports the importance of national policy subject matter experts as a potential pathway for successful program implementation. Findings inform strategic roll-out of initiatives that move health sector Workplace Violence Prevention Programs forward in the three-stage REP framework.

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Learning objectives

Participants will...

1. realize that successful program implementation requires assessment of direct service utilizers to inform coherent national strategies and initiatives.
2. Appreciate that national workplace violence prevention program initiatives aimed at assessing and addressing patient generated disruptive behaviors that undermine the culture of safety need to consider prioritizing the development and implementation of standardized reporting systems, evidence-based and data-driven structured clinical judgment guides, resource tools and workload tracking guides.

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Assessment of the risk of violence in Portuguese psychiatric settings using the Broset Violence Checklist

Paper

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Perspective: Practice

Background and context

The risk of violence in psychiatric settings implies the assessment of dynamic predictors to adjust nursing interventions. So as to identify the pattern of aggressive behaviors, assess the dynamic predictors of violence in hospitalized patients and analyze the predictive qualities of the Broset Violence Checklist (BVC; by Almik and Woods, 2003), an exploratory/descriptive study was conducted in four psychiatric wards of two hospitals in Coimbra.

Methodology

The instruments used were: the Staff Observation Aggression Scale – Revised (SOAS-R) (Nijman, 1999; translated by Marques et al., 2004), a visual analogical scale, and the BVC. For the period of a month, 64 patients with a mean age of 29 years, unemployed and with psychotic disorders were observed.

Findings

In this group, thirteen people developed 15 aggressive behaviors of moderate severity, which had consequences for nurses; they were precipitated by the denial of something through verbal aggression and controlled by non-restrictive measures. The most common predictors of violence were irritability and anger.

Implications

It was also concluded that the BVC shows good predictive characteristics (sensitivity and specificity) of violence, which leads us to conclude that it is a useful and effective instrument for the assessment of the risk of violence and, consequently, to adjust nursing interventions to prevent this phenomenon.

Learning objectives

Participants will...

1. be able to identify the advantages of dynamic assessment of predictors of patient violence in acute psychiatric units;
2. be able to reflect on the characteristics of the BVC and its implications for nursing practice;
3. be able to make a proposal enabling the exploitation of specific nursing interventions for mental health given the risk profile of violence of psychiatric patients.

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Overlapping organizational contributions to workplace violence (WPV) and workforce burnout in healthcare: Is reduction of burnout an opportunity to reduce both?

Paper

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Perspective: Organisational

There has been increasing recent linkage in the literature and press of burnout in healthcare workers (HCW) and ultimate effect on patient care. Burnout of physicians, nurse and other workers is a factor that patients, staff and hospital administrators have to deal with on a daily basis.

WPV incidents are less frequent than daily, but have high impact when they occur. WPV prevention has gathered more interest but has a tendency to fall off administrations' focus because of the lower frequency factor.

Is reduction of burnout an opportunity to reduce both burnout and WPV and align incentives for patient advocacy and staff advocacy?

Institutional toll of burnout in HCW: Lower levels of clinical care quality, patient satisfaction, productivity, work effectiveness, job satisfaction, time on job. Higher levels of medical errors, malpractice risk, absence, physician and staff turnover, intention to leave, spending on training new employees, HCW visits to their PCP's with increase medical cost expenditures.

Personal toll of burnout in HCW: Lower levels of interest in engaging with others in normal activities, higher levels of divorce, alcohol and drug addiction, suicide, conflicts at home, difficulty sleeping, coronary heart disease increase 1.4 fold, up to 1.79 at high burnout levels, visits to primary care provider, double the medical cost expenditure.

Burnout is manifested by: Exhaustion despite rest, Depersonalization (with cynicism, sarcasm, keeping patients at a distance to not drain you more, compassion fatigue with nothing left to give. Lack of Efficacy from questioning the use of the work to work becomes subpar.

Causes of burnout are a combination of factors including being a HCW and the inherent stressors of the work, and personal life issues. However the modifiable ones at work are the stressful things at work that have nothing to do with diagnosis and treating patient, administrative load, extraneous cognitive load, and the psychology of healthcare work of self-sacrifice, self-effacement, superhuman expectations on themselves that is promoted in the culture of healthcare settings.

Organizational contributions to WPV involves organizations knowingly and unnecessarily placing their workers or clients in dangerous or violent situations or allowing a climate of abuse, bullying, or harassment to thrive in the workplace (Bowie 2011). Creation of an oppressive and violent climate may in turn trigger violence between staff, by patients and external intruders. Di Martino links excessive and chronic stress (from many of the factors listed that cause burnout) in the healthcare workplace as being associated with violence toward HCW (DiMartino 2003).

No central agency or administrative body defines what the total reasonable job description is for the healthcare worker (HCW). Incrementalism over years has increased expectations, regulations and mandates from state, national, and insurance companies. There is increasing loss of HCW control of their workflow made by near and distant sources in response to macro and exo level decisions about healthcare delivery. Self-effacement, self-sacrifice, super-hero expected culture feed into low acknowledgement of the cumulative excessiveness and chaos of the mandate, regulation, policy environment and management cause(s) of chronic severe stress and their effect on the daily duties of a physician, nurse, or other healthcare professionals.

Each mandate source blind to the others' mandates, Total physical and cognitive load is only seen by end-user HCWs, not by sources or even administrators enforcing them- exacerbating the sense of loss of control over the workflow of the HCW.

Logistical solutions to handle the tsunami of expectations can be offered at institutional level but administration may not be aware of this opportunity.

Cognitive Load Theory posits fixed amount of working memory and information processing capability. Intrinsic Load: immutable cognitive load needed to solve medical issues. Extraneous Load superfluous expectations to the training of the individual improperly assigned to the clinician reduces resources to process intrinsic load and germane load. Examples are excessive administrative paperwork, poorly designed workflows or training expectations, not allowing clinician to work at the top of their license. Germane load: those cognitive processes integrated into the work life of the clinician, like patient centered compassionate care, communicating with patients and families and the cognitive reserve to do so.

Split attention (juggling multiple demands, all with different schemas of operation, like different operating systems, on line mandate fulfillment from different sources and different inherent layouts use up cognitive load rapidly. See Yerkes-Dodson Law as a form of this type of extraneous load consuming needed working memory and information processing capability. Removing excess Extraneous Load on clinicians is an intervention helpful in reducing burnout may be helpful to reduce the part of workplace violence attributable to organizational issues.

By directly linking health and safety issues with managerial and developmental issues, this response (awareness of economic dimension to stress with administrative engagement to reduce it) offers the tools for immediate, self-sustained action at the workplace to reduce and eliminate stress and violence at work(Di Martino 2003).

Explanations of neuroendocrine, neurotransmitter, physiologic, behavior, biology and kindling from repeated sub threshold psychosocial stressors change the biology and processing of stimuli will be addressed. Experiences and efforts to reduce burnout at the University of Rochester Medical Center will be discussed.

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Learning objectives

Participants will...

1. learn that the reduction of Burnout by decreasing organizational contributions may reduce burnout and WPV.
2. appreciate that organizations can reduce extraneous load placed on healthcare workers to reduce the chronic stress that leads to burnout and WPV.
3. realize that administration and sources of mandates may be blind to cumulative incremental chronic and severe stress levels induced by lack of coordination of mandate and regulation sources.
4. realize that both patients and staff suffer as a result of this tsunami of stress that is increasing in healthcare.

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Iceberg model of violence as a continuum to improve efforts to reduce workplace violence and burnout of healthcare providers

Poster

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Perspective: Organisational

World Health Organization (WHO) classification of violence includes sexual, physical, psychological and deprivation as the four modes of infliction of violence. WHO defines violence as “The intentional use of physical force or power threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation (1). Galtung’s central premise as a peace researcher is that violence is due to an avoidable impairment of the fundamental human need groups of survival, wellbeing, identity/purpose, and freedom (2, 3) Some of the categories and examples are generally accepted by law or society as “violence” while others are less uniformly accepted as forms of “violence” by the general public. To be able to connect to more professional audiences the relationships between these forms, we devised a continuum illustrated by an iceberg whose water line divides Mega Violence from Micro Violence (4).

Mega violence will be defined as behaviors that meet or exceed law or society’s common perception of violence that represent severe transgressions against individuals. Examples include homicide, assault and threats of harm.

ICEBERG WATERLINE IS HERE

Micro violence will be defined as aggressive physical and verbal behaviors that do not meet threshold of Mega Violence but are significant enough to be the subject of policy, social justice or ethical considerations. Examples include incivility, disrespect, and deprivation of human needs, belittlement, bullying, micro assault, micro insult, micro invalidation, and micro situational antecedents. Common to the span of behaviors of micro violence is *the recipient’s perception of threat to physical or mental wellbeing* either acutely or by way of their repeated or chronic nature

On the lower range of this micro violence behavior span, though underappreciated on recipient impact would be sufficiently noxious behaviors and experiences to individuals that would often be the subject to avoid by ‘proper’ upbringing, normative social behaviors, and may be emotionally or physically toxic to individuals when persistent or chronic. Other micro violence experiences in this category may be the result of many cumulative small demands and aggravations on individuals that when incrementally additive reach the level of noxious or toxic. Examples include badgering behaviors, hassling others, persistent ‘humorous’ belittlement, persistent aggravations from family, relationships or work life, poorly designed work procedures, poorly designed policies, multiple uncoordinated mandates on staff and adverse management behaviors. Legal and neuropsychiatric literature help us to understand the importance of early intervention to stop the effects of chronicity or repeated low level events from progression from the perpetrator’s point of view (Broken Windows Theory or Kindling phenomenon respectively). A great deal of emerging literature in the neurocognitive realm show the depletion of coping skills, perceptual and behavioral change outcomes in normal individuals (recipients) from repeated or chronic low level stressors, especially when cumulative and incremental and often multifactorial in source.

Overlap of organizational contributions to Burnout and Workplace Violence-application of micro violence concept

Causes of burnout are a combination of factors including being a Healthcare Worker (HCW) and the inherent stressors of the work, and personal life issues. However the modifiable ones at work are the stressful things at work (organizational) that have nothing to do with diagnosis and treating patient, administrative load, extraneous cognitive load, and the psychology of healthcare work of self-sacrifice, self-effacement, and superhuman expectations on themselves that is promoted in the culture of healthcare settings (5, 6, 7).

Organizational contributions to WPV involves organizations knowingly and unnecessarily placing their workers or clients in dangerous or violent situations or allowing a climate of abuse, bullying, or harassment to thrive in the workplace (7, 8, 9). Creation of an oppressive and violent climate may in turn trigger violence between staff, by patients and external intruders. Di Martino links excessive and chronic stress (from many of the factors

listed that cause burnout) in the healthcare workplace as being associated with violence toward HCW (10). Organizational contributions to Healthcare Worker (HCW) Burnout and WPV toward HCW are overlapping. WPV is low frequency high impact. Burnout is high frequency with daily relevant impact on patients and HCWs.

Using the concept of micro violence, WPV and Burnout prevention initiatives may unite to reduce micro violence in workplace settings. There exists significant opportunity at an institutional level for interventions to reduce burnout and WPV caused by micro-violence. Awareness and opportunity may be increased by use of this unifying term of causality source.

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Learning objectives

Participants will...

1. realize that seeing violence as continuum may enhance efforts of prevention of both burnout of healthcare workers and violence toward healthcare workers.
2. appreciate that unifying many organizational factors that contribute to burnout and WPV with the term micro violence may enhance awareness of opportunity for prevention initiatives.

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Workplace violence: What gets reported by workers in this culture of caring?

Paper

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Perspective: Research

Background and context

The literature to date has failed to consider how the culture of caring in healthcare influences the reporting of patient/visitor-on worker violence (type II) by hospital staff. The International Labour Organization defines workplace violence as incidents where staff are abused or threatened, as well as assaulted. Similarly, workplace violence was found to be consistently operationalized by researchers into categories of physical assault, physical threat and verbal abuse in a systematic review of hospital-based studies that examined type II violence from 2000 to 2010. The circumstances under which these sub-types are consistently recognized by workers as violence, and the influence of such recognition on workers' post-event actions (e.g., reporting, fear/anxiety), has been largely unexplored. We aimed to examine these issues among hospital workers in the culture of caring with which they work.

Methodology

We examined the 12-month prevalence and reporting of type II violence in a large cohort of workers employed in 6 U.S. hospitals who participated in our study (n=5'385). Mixed methods were used including surveys, focus groups and in-depth interviews to examine contextual factors pertaining to the perpetrator, the worker's relationship with the perpetrator, and the work environment.

Findings

Thirty-nine percent (n=2'098) of hospital workers reported being physically assaulted (19.0%), threatened (18.7%) and/or verbally abused (62.0%) at least once in the prior 12-months, in which 75% (n=1.574) reported the event in some form (e.g., verbally to manager, written report). Workers were more likely to report an event that involved a physical assault or threat (82.4%) relative to verbal abuse (70.0%). Workers who felt worried about their safety from the event were more likely to report compared to those who did not feel worried (87.3% vs. 67.0%), as well as those who perceived the perpetrator intended to harm them relative to those who did not (88.6% vs. 66.6%). Workers indicated that they would not describe a patient as "violent" who displayed physical/verbal abuse due to medical reasons (e.g., Alzheimer's, post anesthesia) in contrast to those who displayed abusive behavior because they were drunk or seeking drugs. These types of differences in the patient care context influenced whether the worker reported the event. Reporting violence was perceived by some as inferring that an adversarial relationship with the patient/visitor perpetrator existed, which they deemed counter to their role as the caregiver.

Implications

In the context of delivering patient care in a culture that fosters patient safety and well-being, hospital staff were less likely to report unless they were physically harmed, afraid for their safety, or perceived that the perpetrator intended to harm. This operationalization is more in line with the broad World Health Organization's definition of violence that indicates "intentional use of physical force or power." To better capture workplace violent events for purposes of informing the development and evaluation of prevention efforts across the hospital spectrum of patients, administrators and researchers alike need to emphasize the non-punitive/non-judgmental nature of reporting violent events by workers. This is needed to adequately measure, and ultimately prevent, workplace violence in their institutions.

Learning objectives

Participants will...

1. be able to describe the context with which workers do and do not report workplace violent events and how this may result in incomplete measure of risk factors.
2. be able to describe the need for comprehensive workplace violence surveillance efforts for purposes of informing the development and evaluation of prevention strategies.

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Conflict Management Program: Fidelity Scale in psychiatric care

Workshop

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Perspective: Research

Background and context

The reduction of violence is a very important challenge in psychiatric care. In recent years the development of safety policies in psychiatry resulted in the implementation of protocols for aggression reduction, avoiding the use of force, physical restriction and isolation. The safety methods aim to prevent conflicts, manage aggressive behavior from clients and staff, and reduce the escalation of violence that can happen in these interactions. Staff is often trained to be non-violent, non-restrictive, non-authoritarian and non-provocative in their ways to approach clients. These modern approaches in psychiatric care focus mainly in prevention of aggressive behavior, enhancing of aggression control, training and education, client empowerment, and mostly in interactive techniques in which staff has a predominant guidance role in the management of conflicts. One approach that has been recently developed and applied in this field is the Response Crisis Intervention Method in Conflict Management. This method focuses primarily on securing personal safety of the staff, and assuring a safe scene and environment for the persons present in the situation where aggression is manifested. After the reassurance of these basic conditions the method focus in conflict prevention (Feel, Look and Listen), intervention (goal oriented) and resolution (appropriate communication and conflict guidance).

Methodology

This method, originally developed in the United States of America, has been applied in an in-patient psychiatry facility in Zeeland, the Netherlands. To investigate the effects of this method its application was researched in this psychiatric care organization. The research method included a fidelity scale especially developed to evaluate the Response Crisis Intervention Method in Conflict Management. The fidelity scale, which was based on structured interviews, has 3 models especially developed for clients, nurses, or coaches/managers. Besides the application of these sub-scales, also the files of the clients were assessed to include the analysis of data in relation to aggressive behavior or related events. In total 40 interviews were conducted, in 5 different wards of an in-clinic psychiatric service, being interviewed 3 staff members, 3 clients, one coach and one manager for each ward. The results were quantitatively and qualitatively analyzed and compared with the results of the COMPaZ (In Dutch: Cultuur Onderzoek onder Medewerkers over Patiëntveiligheid in Ziekenhuizen, which means Investigation of the Safety Culture of Staff and In-patients) another safety measure applied in the same organization.

Findings and implications

The research results as well as its implications will be presented and discussed in the conference.

Learning objectives

Participants will...

1. develop awareness of a model to improve safety culture in an in-patient mental health organization.
2. have knowledge about the application of the Response Crisis Intervention Model in Conflict Management.
3. be able to discuss a research on the use of fidelity scale to assess intervention models in conflict management.

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Evaluation of change in perceived safety at work after completing prevention training in the workplace

Paper

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Perspective: Education and training

Background and context

Even though mental health workers are among the groups of workers most at-risk of physical violence, there is very little evidence-based strategies designed to prevent workplace violence in psychiatric institutions. Omega is a training program designed in Canada that aims to develop among healthcare and social services workers skills and methods of intervention to ensure their safety and that of others in a situation of aggression. The program offers means to identify risk factors in the work environment, to classify aggressive behaviour with an evaluation grid according to level of dangerousness, and to select and apply, among different verbal, psychological, and physical techniques, the most appropriate according to the level of aggression expressed. The training also provides principles for protection and safe physical intervention and for teamwork, including effective communication in an objective of crisis resolution. Although Omega is used in several mental health institutions, its effects have only been partially empirically evaluated so far. However, changes in perceived safety at work have not been systematically studied.

The objective of the current study was to assess changes in perceived safety at work following participation to the Omega program. Participants received the 4 days Omega training which involves raising awareness of the values and learning techniques of the program. Participants were assessed before, at 3-months and 6 to 11 months after the training.

Methodology

Four questionnaires were developed to estimate the Perceived level of security in the work environment (6 items; $\alpha = .68$), the Perceived risk of exposure to violence (5 items; $\alpha = .89$), the Fear of being exposed to violence (5 items; $\alpha = 0.89$) and the Level of exposure to violence during the last 3 months (3 items for Tension, $\alpha = .85$; 3 items for Minor violence, $\alpha = .78$; 3 items for Major violence $\alpha = .77$).

Eighty nine workers (45% females) of the emergency, intensive care units and security (40% nurses, 28% beneficiary attendants, 24% safety officers, 8% professionals and managers) from a psychiatric hospital in Montreal (Canada) were recruited. The average age of the participants was 45 years old. The majority (56%) worked full time and the overall sample had a mean of 20 years of experience.

Findings

Results indicate positive significant changes in Perceived risk of exposure to violence in the work environment ($t = -2.04$, $p < .05$, $d = -.23$), Fear of being exposed to violence ($t = -2.09$, $p < .05$, $d = -.24$) Level of exposure to tension ($t = -3.48$, $p < .001$, $d = -.40$), minor violence ($t = -3.78$, $p < .0001$, $d = -.45$) and major violence ($t = -2.27$, $p < .05$, $d = -.27$) during the last 3 months. Changes observed between T0 and T1 persist in time (T2) to the exception for Fear of being exposed to violence.

Implications

Our findings suggest that staff perceive an increase in safety in managing potentially aggressive patients after completing the Omega training. These cognitive changes may lead to changes in practice in these workers' interventions responding to violence in the future.

Learning objectives

Participants will...

1. be able to share information on a training program designed in Canada for healthcare and social services workers.
2. appreciate the psychological benefits associated with a training program to reduce violence in the workplace.

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Intervention models for safety culture in psychiatric care in the Netherlands

Poster

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Perspective: Research

Background and context

In psychiatric organizations aggression by in-patients and staff is a permanent safety concern for all people involved. In the Netherlands a recent research has pointed that 67% of care providers in psychiatry has been a victim of incidents of physical violence in the last 5 years. Many theoretical and empirical studies on violence within psychiatric care have pointed at the importance of preventing incidents and establishing programs to manage conflicts between patients, as well as between patient/staff and management. Studies have shown that violence in psychiatry should be seen as the product of several variables that interact and influence human behavior. These include the type of clients' psychopathology, the organization's setting and environment, the characteristics of the specific ward in which the client lives, the type of interaction the client establishes with staff and other clients, the staff's level of education and their attitude towards clients' aggressive behavior. In recent years, research on in-patient conflicts has switched from focusing on patients' psychopathology and demographic characteristics (age, gender, race) giving more attention to the organizational environment and interactional factors that influence the occurrence of aggression.

In the Netherlands, the safety management system in psychiatric organizations focuses mainly on aggression, medication safety, suicide prevention, somatic co-morbidity, discipline, and fire safety. This system, in general, includes 6 basic elements: Safety policy and strategy; Safety culture; Prospective risk analysis; Safe incidents reports; Continuous improvement of client/staff safety; Client participation in the safety policy and strategy. To follow this system, mental health care providers need to choose methods, procedures and techniques that can be applied in conflict management not only to managers and staff, but also to clients in psychiatric care. Also in line with these procedures, staff members are often trained in managing verbal and physical aggression, in such way to avoid medicinal restraints and seclusion and to control dangerous situations, for themselves and for clients. Such training in violence management can also contribute making positive changes in the safety culture of the organizations concerned. Therefore the application of well-selected and planned procedures is necessary to improve and maintain a successful safety culture within the psychiatric care.

Methodology

Aiming to investigate intervention models applied to improve safety culture in psychiatric organizations, this research has examined 4 large psychiatric organizations in the Netherlands (in the provinces of Zeeland and Noord-Brabant). The method included semi-structured interviews with the involved organizations' managers and psychologists, to get an overview of all methods and procedures used (including management, staff, and clients) in aggression management and safety culture.

Findings and implications

The results were discussed and compared with the literature and state-of-art in the field. Suggestions to improve the investigated models and systems to reduce aggression in psychiatric organizations will be presented and discussed in the conference.

Learning objectives

Participants will...

1. develop an awareness of different models to improve safety culture in an in-patient mental health organizations.
2. be able to provide information about application of the Response Crisis Intervention Model in Conflict Management in a mental health organization in the Netherlands.
3. be able to discuss a qualitative research on the use of models in conflict management in mental health organizations in the Netherlands, including psychologists, managers and patient.

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A hospital's commitment to preventing workplace violence: Design, implementation and education strategies for a behaviour safety alert in the electronic patient record

Paper

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Perspective: Organisational

Abstract

In January 2014, a large urban multi site academic hospital implemented an Electronic Patient Record (EPR) Behaviour Safety Alert (BSA) to ensure that staff were aware of individuals entering the workplace posing a threat of violence. This requirement was mandated by a provincial Occupational Health and Safety Amendment Act and supported by Ministry of Labour recommendations, Accreditation Required Organization Practice (ROP) standards, growing union interest and an increasing awareness of the prevalence of incidents of workplace violence.

The BSA design, build, implementation and education was a collaborative effort between clinician experts and staff from security, administration, human resources, union representatives as members of the Workplace Violence Prevention Committee and an interprofessional Clinical Best Practice and Information Technology Committee that designs, builds and implements new functionality in the EPR.

The BSA is a tool for alerting all staff/physicians/students and volunteers to the potential increased risk of experiencing violence in the workplace, e.g. actual or threat of physical injury perpetrated by either a patient or associated visitor. Initiating the BSA in the EPR is the responsibility and a right of every clinician.

The BSA includes the description of the behavior, the contributing factors and includes a brief risk management plan which details suggestions unique to the patient/visitor. The BSA travels with the patient/associated visitor throughout their visit/admission, across programs, hospital sites and remains in place for all future visits/admissions unless removed by designated leadership roles.

Concerns related to stigma associated with labeling patients, privacy, addressing the needs of non clinicians, pre documenting BSA for well known at risk patients/associated visitors, accountability for transfers/discharges from the facility and the type and scope of training was addressed.

Unique outcomes include: BSA policy development and link with existing workplace violence policy, management/union collaboration, evidence of optimizing EPR and clinical/technical/project management partnership, addressing challenges of implementation across a very large and diverse organization, multimodal education strategies, link to unit electronic whiteboards used as a communication tool visible to all staff and implementation of an electronic BSA report available to all staff which highlights high risk units/programs, supports trend analysis and details completion rates.

Learning objectives

Participants will...

1. learn that the Electronic Patient Record is a useful tool to support a acute care hospital culture of safety by alerting staff/physicians/students and volunteers to patients/associated visitors at risk for violence.
2. realize that the development of a Behaviour Safety Alert in the EPR requires collaboration and partnership across professions, union/management, technical and project leadership.
3. learn that the implementation of a BSA in the EPR requires debate and decision making regarding stigma of labeling and privacy for patients integrated with a commitment to with staff safety.
4. realize that cross site/program implementation and education strategies are key to success.

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Developing a 'Psychiatric Core': Reducing patient aggression by shaping caregiver attitudes and teaching critical skills

Paper

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Perspective: Education and Training

Keywords: Continuing education, nursing, mental health nursing, psychiatric nursing, violence

Abstract

The global recession of 2008-2009 had a detrimental effect on mental healthcare delivery worldwide. Between 2005 and 2011, reduced mental health funding resulted in an overall decrease in numbers of psychiatric beds. The shortage of psychiatric beds often causes severely mentally ill patients to spend extended periods in medical-surgical units and emergency departments while awaiting treatment. The issue of involuntary psychiatric patients "boarding" in unsuitable treatment venues is particularly well documented in the United States. However, the issue of individuals with mental health needs receiving treatment in non-psychiatric settings is not specific to involuntary patients. People with psychiatric diagnoses routinely seek treatment in all clinical areas. Many nurses caring for psychiatric patients in non-psychiatric units have not had education in mental health for years. Stigma, misconceptions, and discrimination serve as barriers to effective treatment. In turn, inappropriate caregiver approaches can result in patient aggression and violence. Adequate staff training is essential to insure the safety of all.

A psychiatric core was designed for acute care and ICU nurses in a large public hospital in Seattle, Washington. Instruction incorporated basic precepts of recovery principles and trauma-informed care. Particular focus was placed on psychiatric diagnoses with a propensity for aggression. The full-day, continuing education program was conducted with approximately 85 nurses. Participants assessed the curriculum through a comprehensive course evaluation. Educational principles used to develop this course can be adapted to other healthcare facilities as well as medical and nursing education programs. Providing evidence-based care for psychiatric patients in all areas of the hospital can enhance caregiver safety, and improve outcomes.

Introduction

Economic, political and social factors are leading to decreased funding for mental health services. Billions of dollars have been cut from state mental health budgets since 2009 (Glover, Miller, & Sadowski, 2012). Washington State has reduced funding for mental healthcare by \$135 million during this period (Whiteaker, 2013, para. 2). As funding for mental health services decreased, the number of people needing mental health services increased by 10%. While more people seek mental health treatment, available inpatient psychiatric beds are disappearing. Nationally, 4500 mental health beds have been closed (Glover et al., 2012). In Washington State, the closure of long-term psychiatric beds at Western State Hospital has created a statewide crisis (Smith, 2011; Schrader, 2013). The most recent Report Card from the American College of Emergency Physicians ranks Washington State third from the bottom for the number of psychiatric beds per capita (American College of Emergency Physicians, 2014). This shortage of beds causes severely mentally ill patients to spend days or even weeks in medical-surgical units and emergency departments (Alakeson, Pande, & Ludwig, 2010; Nicks & Manthey, 2012; Rosenthal, 2013). Often, the RNs who treat these patients have not received instruction in psychiatric care since nursing school. This knowledge gap creates a healthcare environment where individuals with mental illness do not receive needed, and sometimes critical, care. Moreover, persons with mental illness experience greater rates of comorbid physical disease than the general population. Psychiatric patients routinely receive care from all medical disciplines. Because of this, nurses should be proficient in basic mental healthcare in every area of the hospital.

Background

Core curricula have been developed for many clinical specialties: neurology, spine, wound, pain and diabetes, among others. Typically, core courses provide condensed, comprehensive instruction in one- or two-day formats. A psychiatric core has widespread implications for enhancing patient care. Although persons with active mental illness would be best served in psychiatric units, the current healthcare environment necessitates improving treatment in other venues.

Workplace Violence

Violence in the health sector is an unfortunate reality. Hartley and Ridenour (2011) report that health sector workers are victims of assault twice as often as other occupations (para. 2). Untrained caregivers may utilize an

incorrect approach with certain psychiatric diagnoses that can increase the likelihood of aggression (Daffern, Day, & Cookson, 2012). For example, nurses who use an authoritarian approach with patients who have antisocial personality disorder face an increased risk of aggression. Moreover, psychiatric patients, particularly those with depression, are at increased risk of self-inflicted violence. In addition to the increased risk of violence, untrained nurses who care for psychiatric patients can miss unfamiliar, potentially life-threatening medical emergencies related to neuroleptic and antidepressant administration. Providing evidence-based psychiatric care for mental health patients on acute care units and in emergency departments may enhance patient quality of life, decrease violence against caregivers, and improve clinical outcomes.

Literature Search

A literature search was conducted using CINAHL Plus and PubMed. Search terms included: psychiatric nursing, education, continuing education, and mental health nursing. The search produced few recent articles related to post-graduate mental health education for nursing staff. No articles were found that described a wide-ranging, mental health continuing education program for medical-surgical nurses. A published review provided an overview of the state of the literature. Brunero, Jeon, and Foster (2012) reviewed research on mental health education programs for non-psychiatric, general health providers. Studies included in the review were peer-reviewed journal articles regarding mental healthcare education for general hospital providers. Articles related to training on dementia, delirium, and cognitive disorders were excluded. The authors identified 25 research studies between 1995 and 2010 that met inclusion criteria. Only three of the articles described educational programs in the United States (O'Boyle, Paniagua, Wasef, & Holzer, 1995; O'Hara, Gorman, & Wright, 1996; Smith, Johnson, Seydel, & Buckwalter, 2010). All of the US studies concentrated solely on depression and its effects. There was one article each from Brazil and China. All other studies were conducted in the UK, Canada, and Australia. Brunero et al. (2012) discovered that the usual scope of post-graduate mental health instruction is narrow: topics include psychosis or depression or strategies to treat patients with personality disorders, but seldom all. Several of the educational programs targeted triage nurses in emergency departments. Mental healthcare continuing education programs exist, but efforts are often narrow or concentrated at the hospital's point-of-entry for many patients, the emergency department.

Method

Setting

A psychiatric core was developed to educate nurses from Harborview Medical Center (HMC) and other area hospitals on best practices when caring for patients with mental illnesses. HMC is a large, public, 413-bed, level I trauma center in Seattle, Washington serving a diverse patient population. The goals of the core were to increase mental health nursing knowledge and shape caregiver attitudes towards persons with psychiatric illness.

Procedure

An instructor team was assembled to develop the psychiatric core curriculum. Experts in the fields of psychiatry and mental health nursing were identified to present course sessions. Prior to designing the course curriculum, the team assessed knowledge deficits and identified nursing needs. Staff nurses were surveyed and asked to rank their interest in various subjects related to psychiatric nursing. Using survey results, the instructors designed the core to focus on issues of most interest to RNs. The complete course curriculum included: de-escalation strategies, psychiatric diagnoses, suicide assessment and prevention, addictions, and legal issues for caregivers of involuntary patients. Diagnoses with a propensity for violence were emphasized to increase caregiver and patient safety. Patients with paranoia were the focus of the session on psychotic disorders. Swanson et al. (2006) reported that a positive correlation exists between suspiciousness and persecutory delusional and violence. Among mood disorders, bipolar mania was highlighted due to the potential for patient aggression. Self-directed violence was explored in the sessions on borderline personality disorder and suicide assessment.

Participants

Training was conducted in April 2014 with 85 registrants; participating nurses were representative of the general nursing population in the Pacific Northwest. Participants were recruited by advertising on the HMC continuing education website and by posting flyers in nursing break rooms. Most course attendees were HMC nurses; 13 nurses were employed at other Seattle-area hospitals. Nurses received 8.0 hours of continuing education credit after course completion.

Teaching Strategy

The psychiatric core curriculum employed a combination of pedagogical strategies: lecture, demonstration, problem-based learning, and discussion. Varied learning activities allowed instructors to use formal authority, demonstrator, and facilitator teaching styles. By using a range of instructional methods and teaching tactics, the instructors were able to reach students with diverse ways of learning.

Empathy and Attitude

Evidence is accumulating to support the use of empathy in medicine and nursing (Stepien & Baernstein, 2006). Instructors sought to elicit empathy through patient stories, discussion of environmental and genetic factors that influence psychiatric illness progression, and stories of recovery. Mercer and Reynolds (2002) report that caregiver empathy can increase patient and staff satisfaction while decreasing patient anxiety, depression, and hostility. Empathy influences how providers interpret and respond to patient violence (Gerdtz et al., 2013). Richmond et

al. (2012) propose that the potential for violence can be minimized when caregivers use an approach that includes empathy and a positive attitude when responding to an agitated patient. In addition, staff attitude regarding the potential for individuals to recover from mental illness impacts his or her ability to care effectively for patients (Meehan, King, Beavis, & Robinson, 2008). Aspects of self-care for staff were emphasized as a means to prevent caregiver burnout and sustain the capacity for therapeutic optimism and empathy.

Art as a Teaching Tool

Visual arts and music were liberally woven into sessions. The use of film, art, and literature to teach psychiatric nursing concepts is well documented in the literature. Wall and Rossen (2004) describe how media enhance mental health nursing instruction: "The use of media in the form of literature, film, and music in our psychiatric nursing course enhanced learning and knowledge transfer that students would not have obtained had faculty relied on traditional textbook methods alone" (pg. 39). For this training, each diagnostic group was introduced by a music video related to that topic. For instance, the session on psychotic disorders began with a YouTube video of Don McLean's "Vincent" (folkman123, 2007) and slides of Van Gogh's paintings to illustrate psychosis and the effects of mental illness. Other video selections, including TED talks, showed mental illness from the patient's perspective (TED: Ideas Worth Spreading website, n.d.). These personal stories served as reminders that individuals recover from mental illness and can thrive when given the tools.

Results

Text-Based Polling

Instructors evaluated the psychiatric core using two methods: a text-based polling website and written assessments. Text-based polling was conducted prior to instruction and at training completion. Participants texted their responses to three statements:

1. I am comfortable caring for psychiatric patients.
2. I am confident in my ability to de-escalate an agitated individual.
3. My knowledge of psychiatric diagnoses is sufficient for me to care for patients with mental health issues.

Poll results indicated improvements in all three areas (see Figures 2, 3, & 4). Before the program, 40% of nurses believed that they had sufficient knowledge to care for psychiatric patients. After the training, that percentage increased to 91%. Also striking were measurements of students' confidence when de-escalating an agitated patient. Prior to instruction, 28% of participants felt confident in their de-escalation skills. At course completion, that figure rose to 65%.

Figure 2: Bar graph illustrating results of survey for question 1.

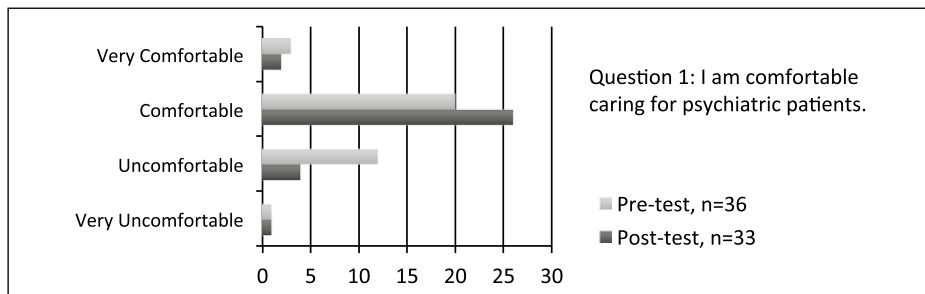


Figure 3: Bar graph illustrating results of survey for question 2.

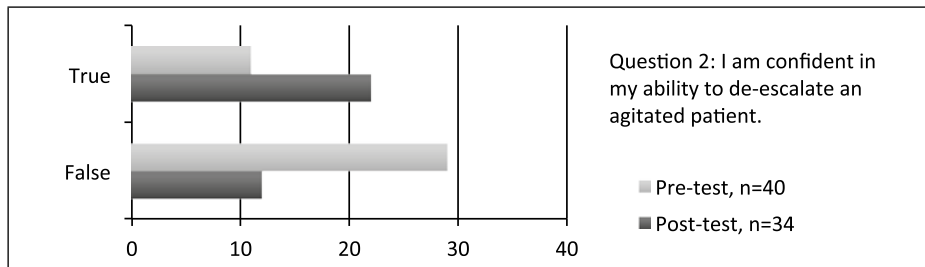
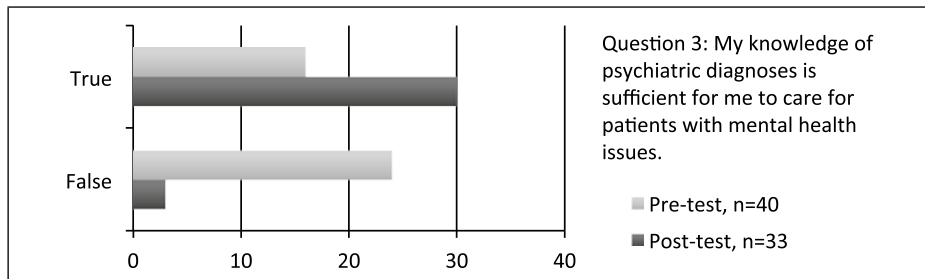


Figure 4: Bar graph illustrating results of survey for question 3.



Statistical significance ($p < 0.001$) was determined using a non-parametric McNemar's test. Questions 2 and 3 showed significant improvements in confidence of de-escalation skills and knowledge of mental healthcare with values of $p = 0.000$ and $p = 0.001$, respectively. Although participants rated improved levels of comfort when working with mental health patients on the post-test, the McNemar test determined that these results were not statistically significant ($p = 0.063$).

Course Evaluations

Students were asked to complete a written course evaluation at the end of training. Participants rated content and instructor performance using a scale from 1 (poor) to 4 (excellent). The average score for instructors was 3.67; individual session ratings averaged 3.63. Students were encouraged to provide written remarks, as well. Comments included: "Great, knowledgeable speakers, compassion-centered message," and "Practical applications, this is so needed." Participants appreciated hearing about mental illness from the consumer's point of view and TED talks were frequently mentioned as the most effective teaching tool.

Discussion and Future Implications

Many participants suggested extending the training. Students felt that the amount of information in the psychiatric core warranted a two-day program. Although this would allow more time for instructors to cover content, the time commitments for nurses and the cost to the hospital make this change prohibitive. Other evaluations indicated that additional written materials should be considered. Handouts of PowerPoint presentations and care plan templates, called "Keys to Success," were given to every participant. However, nurses asked for more convenient, at-hand job aids. Future course packets will feature the usual written materials plus "Keys to Success" badge cards. These laminated reminders attached to employee IDs will be helpful, ready tools.

Several participants suggested that other employee classifications participate in this training. Hospital assistants were specifically mentioned as a work group who could potentially benefit from mental health education. The current psychiatric core contains content specially designed for nursing staff; however, an abridged version of the course could be developed for support staff including social workers, spiritual care, hospital assistants, and other work groups. Comprehensive mental health education after nursing school is rare. The psychiatric core reacquaints nurses with the basic tenets of mental healthcare. After the success of the first psychiatric core, the HMC clinical education department determined that the program would be a regular, biannual offering. The HMC psychiatric core was, by all measures, a success. By learning basic mental health concepts, nurses who attended the training are better equipped to treat the increasing number of psychiatric patients in their care.

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Learning objectives

Participants will...

1. be able to explain the importance of regular staff training in mental healthcare.
2. be able to describe how staff attitude and approach can positively influence patient aggression.
3. be able to discuss how training in psychiatric illness can contribute to reduced rates of seclusion and restraints.

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The SOS project: Strategies to prevent violence and strengthen mental health among children at a psychiatric inpatient clinic in Stockholm, Sweden

Paper

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Perspective: Practice

Keywords: Nursing, child psychiatry, calming strategies, violence prevention

Background

In October 2012 the initiator of the “SOS project” went to Canada in order to attend The 3rd International Congress on Violence in the Health Sector. The main theme of the conference regarded local initiatives in a global context. It became clear that psychiatric wards, regardless from each other, tended to use calming strategies as a significant part of the daily care. The calming strategies were also a part of different research projects. Most of the strategies and methods used by caregivers were easy to comprehend and use, for the patients and for the nursing staff. However, not many of these lectures and research projects were described from a child psychiatric angle. Working with children, from age 0 to 18, in an inpatient psychiatric clinic in Sweden, we thought at first it was a lack in the presentation given us. Though we realized that we ourselves out to disclose the local initiatives at our clinic in a global context. The aim of the “SOS- project” was to describe the systematic nursing care at an inpatient psychiatric clinic for children in Stockholm, Sweden. The aim was also to describe the nursing work from a scientific perspective and the development of calming strategies in order to prevent threats and violent situations at the inpatient facility.

Methods

The nursing work at the inpatient child psychiatric clinic needed to be compiled and structured in order to present it in a comprehensive way. Local guidelines focused on caring, environmental therapeutic methods, calming strategies, methods being used to prevent violence and ongoing and completed research projects were gathered. The existing material was examined and summarized in writing for nursing staff and others to take part in.

Results

The nursing work at the inpatient child psychiatric clinic included a systematically and continuously correction of the ward’s environment.

Environment

The healthcare environment must create conditions so the care meetings will be as good as possible. The environment is important if caring should reach a good result. Good care environment is characterized in facilitates designed for meetings between staff, patients and relatives. Care should always be conducted in an environment as open and normalized as possible, and with access to different activities.

The wards should not be greater than anyone can establish a personal relationship. At the care of seriously mentally ill, especially psychotic patients, should the premises be small and transparent in order to provide a safe environment. Many wards have high standards of security and control that includes locked exterior doors. That in itself is no barrier from designing wards and the surroundings in a pleasant way. Experience shows that environmental changes could decrease the violence against staff and between patients. These changes could be replacing furnishing that’s broken with new, more colorful paintings on the walls and to create gathering places for staff and patients. Unit South is an inpatient ward within the Child Psychiatric Clinic in Stockholm. It is located in a beautiful setting beneath the South Hospital. The neighborhood consists of small allotment gardens and walking paths. All patient rooms have views of a bay called Årstaviken and the woods beyond. Outside the ward is a lawn with bushes and benches, a playground and basketball hoop. In connection with the ward there’s a partially secluded little garden called Lotten.

The environment of the department consists of a hall with a TV room, covered balcony and patient rooms on one side. Patient rooms have feature walls in various soft colors which distinguish them by their outer appearance. On the other side of the hallway is a small cloakroom and toilets for staff, two patient toilets with shower or bath, a treatment room, offices and a kitchen with dining room. A little further away is the laundry room, a room for clamping with belts, a major two-part patient rooms and two apartments. The hallway opens up into a large living room where there is opportunity for music, games and crafts. There is also a sensit-armchair

where one can find peace by closing themselves into heavy parts that contain balls that can be put on and off at your will. The staff members have been able to influence color selections, furnishings and wallpaper. In the hallway is a large mural with a cherry tree in full bloom. The wallpaper was chosen on the basis of patients' experience of abstract art can be experienced as frightening and often enjoys tranquil nature scenes with things that you recognize when you are in mental imbalance. The walls are white and the pillars in the hallway soft grayish blue. The living room is one wall painted in a warm purple color and one in gray-blue that frames the lake view from the large windows. On the purple wall hangs a large painting with round gray stones and a gray divisible sofa underneath. A similar purple wall comprises funds in the adjacent dining room. In the dining room is a large table that can be taken apart and customize how many to eat there. Even here there are large windows, a glass door to the kitchen and a glass door to the living room that can be set up in order to create a more open floor plan. In the middle of the corridor you find the comfort room as described in detail under the heading later. Even the room for clamping with belts is decorated based upon scientific evidence about patients' perceptions of the environment. The room has windows and is painted with a calm neutral blue. On one side the wall is covered with sound-absorbing thick curtains, and the other wall is covered with a mural with parts of Stockholm's archipelago, sea and horizon. The patient can choose whether he/she wants to see the photo or the neutral curtain wall.

Terma

Terma is a comprehensive approach to prevent and respond to threats and violence on psychiatric wards. The model aims to create an environment and care that works optimally for both patients and staff. The model is originally from Klinikk for sikkerhetspsykiatri at Haukeland Universitetssjukehus in Bergen, Norway. It has since 2005 developed further within the SLSO, Stockholm County medical center. Terma imbued with an ethical approach, which can be a difficult balancing act in connection with threats and violence. By setting limits on a patient's behavior or take physical control deprive the patient temporarily their right to self-determination, this may be necessary measure to either patient or staff will be injured. Staff must ensure that the patient is not exposed to significant physical risks, and that in restraint provides no or minimal pain and discomfort. To maintain a working order and prevent chaos from occurring, there should be a leader for the situation. A staff member will be responsible for listening and talking with the patient during the intervention and providing patient support in order to regain control over their behavior. A friendly service associated with coercion and restraint provides opportunities for continued good relations after the intervention. As far as possible, staff activities focus on the prevention of threats and violence from arising. Prevention work is divided into three levels.

1. Build and maintain good family relationships. Create clear and reasonable rules and procedures.
2. Set boundaries and calm down the agitation and aggressive feelings, use a behavior with low affections as to speak quietly with few words, use calm and slow body movements, staff withdraw so that the patient can calm himself down to possibly prevent a violent situation occurs.
3. Take physical control in a violent situation. To prevent damage and communicate with the patient during and after the event.

Studies have shown that if the first level doesn't work at the ward, the other levels will not. At all three levels, the staff focuses on three major factors that characterize each situation: positive attitude, emotional balance and functioning order.

Calming strategies

Calming strategies began to be used in a structured form in autumn 2011 and was then part of the now terminated Breakthrough Project. The results showed that the change process with soothing strategies were significant. The patients responded predominantly to the experience participation in planning and evaluation of the nursing care. Participation contributes to the sense of control, comprehensibility and meaningfulness. Nursing staff are asking questions about the patient's usual reactions and how they tend to handle them, in conjunction with the arrival status. This is documented with the keyword management strategies and is also part of the initial care planning.

- Can you tell me with your words, why you are here?
- What do you think about being here?
- How do you demonstrate that you are angry, worried, scared, and sad?
- What makes you feel good and secure?
- How do you want staff to behave when you're angry, worried, scared, and sad?
- How is it for you to ask for help and to accept help?
- Do you tend to speak up when there is something you do not want, and in what way?
- How are you affected by your environment? (For example: high noises, large groups, and the closest people around you, visits, dismissal, and change of staff).

The comfort room

There is a tradition in psychiatry which means that anxious and stressed patients often are thought to need a stimuli poor environment to make it easier to calm down. Although this strategy could help some individuals, there are now knowledge of brain functioning that assumes most patients would be better served by being able to reside in a distinct environment with active soothing components. The comfort room is a special room inside the hospital ward that is designed to offer patients actively soothing stimulation. The room is decorated to be

comfortable and pleasing to the senses and offers a haven from stress. It is a form of treatment with a focus on self-care and a tool for the patient to recognize early signs of increased anxiety, practicing relaxation and experience well being. Use of the room is taken entirely from a caring and health promotion perspective.

The room was built up with a fund wallpaper of forest and trees. Natural images and scents stimulate the brain to peace and harmony and enhance emotional memory. The second wall is painted and perfectly smooth. The room has access to various scents of lavender, pine, rose and lemon. One can choose which sensory input you want, how you want the light, which scent you want. An iPod with nature sounds is available, so even a heavy blanket and a ball blanket, heating pad in the shape of a dog and a rocking chair to sit in. The patient can also choose whether to have a relative, staff in the room or sitting alone.

The breakthrough project, better care – less coercion

The Breakthrough Project started at the clinic in September 2011 and lasted until April 2012. Purpose of participation in the Breakthrough Project was to improve the psychiatric inpatient care, focusing on compulsory treatment and coercion. The overall project objective was to reduce the need and therefore the use of coercive measures, to improve the patient experience of coercive measures, to understand and improve the quality of the use of coercive measures.

Calming strategies is an example of the methods introduced in the Breakthrough Project, which has become a central concept in nursing. The improvement work will hopefully help to prevent the occurrence of emergency situations which in some cases are liable to lead to enforcement action. At the end of measurements taken before the problem-and goal-setting, it became visible that many of the clinic's employees in one way or another work with nursing interventions to prevent violence and possible enforcement action. The Breakthrough Project systematized and quality assured care measures for the prevention of threats, violence and coercion.

Scientific foundation

Child and adolescent psychiatry in Stockholm compiled and created routines for the outpatient and inpatient care. Though there was a significant lack of nursing procedures. These routines are divided on the basis of child psychiatric diagnoses. Based on these routines established the Child Psychiatric Clinic in Stockholm, their own working groups consisting of both staff with nursing skills and other professionals at the clinic. The working groups proceeded as well from child psychiatric diagnoses, but developed guidelines by compiling and verify scientific evidence for nursing work in child and adolescent psychiatric inpatient care. The summary of procedures was completed in 2012.

Preventive health work among nursing staff

Staff working in psychiatric inpatient care is sometimes subject to threats, violence and other severe events. They are expected to handle these situations based on their profession, which involves putting patients' interests in mind. The balance between patient focus, to protect family members and fellow patients, to protect colleagues and not to self-expose themselves to the discomfort and danger, is often difficult. Becoming threatened or hit can affect mental health negatively. The treatment for severe events is also important from a trauma perspective and to counteract any re-traumatisation at similar events in the future. It's not just intimidation and violence that can be perceived as difficult and which could ultimately detrimental to their mental health. In working with children and families who have various serious symptoms and dysfunctional behaviors, it is inevitable to be touched and dragged into processes and parallel processes. Strategies that can facilitate staff working in psychiatric nursing are a field that has begun to be explored internationally. However there are no such concrete policies based on individual needs at the clinic yet. After a difficult event has taken place, the staff has been offered the opportunity to come together and discuss what happened. Each person may give his view of what happened and to be able to express thoughts and feelings. If possible it may be helpful if a person who had not been in the situation takes responsibility and leads the mirroring based on the needs of the staff. The mirroring is used to describe their own feelings and to ask questions of others. It is important that this is not expressed in a blaming or insulting manner. Debriefing of nursing staff is continuous and based on needs during difficult events and situations. Mandatory tutoring is done every two weeks. On these occasions, an external tutor is engaged with a temporary assignment from the clinic. Tutoring of staff should be supportive and develop the work in direct patient care. Although physical activity is critical to cope with the sometimes physically demanding nursing work, it's also important regarding the staff's mental wellbeing. It is therefore possible to dedicate one hour per week of the regular working hours of physical activity. There is also the opportunity for staff to get compensation from the employer for training costs up to 3000 SEK a year.

Conclusions

Caring included psychological, social and environmental adaptations depending on the individual's and the group's situation and need. The nursing demanded flexibility, creativity and continuous updates regarding different strategies to master negative feelings within patients. These strategies could be different depending on symptoms and diagnoses. The core of using calming strategies is the exploration together with the patient and the parents. In order to do that caregivers need to be able to create an alliance and to have the curiosity to stay open minded.

What became clearer during the project are the capability and the willingness among the caregivers to help the patients and their relatives. The importance of the nursing staff developing their own strategies in order to handle strong feelings and difficult situations also became clearer. Methods and strategies were provided to the nursing staff in order to manage their own feelings and behaviours in stressful situations, but there is a lack of more individual coaching.

Strategies to prevent mental illness and distress among the patients, and to prevent violent situations, are being commonly used by the caregivers. These strategies are also grounded in science and/or proven experience. Despite the extensive work carried on at the ward there is still a lack of research based nursing, especially when patients are younger than eighteen years old. There's also a need for clarification regarding the roll of parents and relatives in nursing care. Parents often need support from staff to be able to support their child. But they are also a significant co-worker in order to prevent violence and avoid coercion in all forms.

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Learning objectives

Participants will...

1. have a clearer understanding of caring methods and strategies being used in child psychiatric inpatient care.
2. appreciate that strategies to prevent mental illness and distress among the patients, and to prevent violent situations should be preferably grounded in science and/or proven experience.

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How does the collation of data of current practice impact on future training and practice? Redaction team

Workshop

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Perspective: Practice

Background and context

Kibble Education and Care Centre started its life back in 1859 providing direction and guidance to young people from disadvantaged backgrounds. It remains on the original grounds in Paisley, however has significantly changed since those days. What hasn't changed is the organisational commitment to disadvantaged young people, its charitable status and desire to be at the forefront of developing best practice in residential childcare services. It has achieved this in recent years by presenting at and attending national and international conferences exchanging and sharing information on new developments; on theoretical and practice issues.

In 2001, I was fortunate enough to attend a conference in Los Angeles organised by the Child Welfare League of America, the theme of the conference; The Reduction of the use of Restraint and Seclusion. I had previously carried out some research within Kibble Education and Care Centre and discovered that on average a physical restraint lasted forty five minutes, and in many cases exceeded this. It was also the case that debriefing figures did not reflect the number of actual incidents - this information had been shared with our Directors. It was obvious at this time that there was a need for an organisational shift in culture. It was our conclusion that this could only be achieved through training and as a direct result of this we looked into alternative crisis intervention training. One of the tasks of attending the conference was to look into and consider alternative interventions. We reviewed a number of intervention systems before having a more in depth discussion with J.K. Mullen, who in collaboration with others had developed an intervention course known as "Safe Crisis Management" (SCM). Joe's background had been in Laysville Youth Development Centre and he went on to be the Director of training for the Pennsylvania Juvenile Courts Judges Commission.

Safe Crisis Management was developed through the nineties using the theories and findings of a number of well thought of authors in the child care field - Howard Polsky, Nicolas Long, Albert Treischman, Mary Beth Hewett and Redl, to name but a few. The emphasis on theoretical concepts and developing the individuals understanding of the reality of service users, the in depth teaching of primary and secondary strategies and understanding one's own triggers also led us to believe that this type of training would assist staff to manage crisis more effectively. The proactive use of de-escalation techniques as a way of reducing the need for physical intervention was just what Kibble Education and Care Centre required at this time.

"If the only tool you have is a hammer you treat everything as a nail" (Abraham Maslow)

Late in 2002 and the beginning of 2003, Kibble Education and Care Centre began to have all Directors, Senior managers and managers trained as safe Crisis Management Instructors. By 2004 all staff (500) throughout the organisation had been trained. During this time the organisation complied with a rigorous accreditation process under the direction and guidance of the British Institute of Learning disabilities (B.I.L.D.). B.I.L.D. is the only organisation within the United Kingdom that can accredit any Physical Intervention courses. Part of the accreditation process requires that organisations have robust measures of recording and evidencing incidents detailing holds used, time taken, and those involved. Failure to evidence this would result in Kibble's accreditation being withdrawn. Kibble Education and Care Centre developed a data base that processed all incident forms and began to develop a bank of information that complied with the accreditation and that allowed us to review the progress, with regards to the reduction in duration of intervention and holds most commonly used. By 2010 annual training and recertification of all staff had made a clear impact on these two most important factors. Duration was now under seven minutes and the use of prone intervention had reduced dramatically. It was around this time that the organisation began to develop a more analytical and complex data base. This coincided with the need to provide service purchasers with clear evidence of outcomes. There was also a need to begin to learn from practice what worked and made an impact and what didn't work and why. This information is crucial in relation to managing and developing staff and best practice. How was practice making an impact on ethos, culture, supervision and training? The need to develop a more robust measurement of current practice began to emerge through the on-going development of the data base in relation to the recording and evidencing of Safe Crisis Management.

Methodology

Safe Crisis management sits at the centre of all Kibble Education and Care Centre services. The core principals are used throughout the organisation; education, secure care, fostering services, residential services and community based services and employment services. It is essential for our staff and young people that a consistent approach is adopted throughout the organisation, in order to effectively manage transitions and change. The assimilation of data across all services is crucial to the development of young people and the supervision, training and if necessary disciplining of staff. All Data was gathered on specific areas from January to August 2013 and compared to the same time over 2012. The analysis of this data allows the organisation consider a number of aspects when it comes to staff recertification annually. The data from 2013 has informed the organisation that there are a number of issues that have to be reviewed and addressed in 2014 training programme.

Findings

The findings comprise the following:

- 1) The need to accurately and timeously complete documentation will be reinforced throughout the 2014 training programme.
- 2) In terms of escalating factors staff should be reminded of the difference between touch prompt and escort.
- 3) An emphasis to be placed on the use of primary and secondary strategies in order to provide more opportunity for de-escalation of crisis situations.
- 4) Accurately record and reflect life space interviews.
- 5) All managers to receive retraining of supervision of crisis intervention performance.
- 6) Improve percentage of post incident debrief.
- 7) To remind staff of the importance of space when in physical intervention reducing the likelihood of injury through biting.
- 8) To teach staff to become more confident in the use of standing holds reducing the duration and need for floor holds.

As well as informing the organisation of the staff training requirements, the data provides us with the opportunity to identify individual training or supervision in relation to individuals and teams. In some instances the data may have made it look that an individual is counter aggressive in their approach leading to that individual being involved in a high number of interventions. However closer examination of the factors leading to the intervention may suggest inconsistencies within the team. Sharing this information with managers affords opportunities for team development and learning outcomes. In relation to individual young people involved in a high number of incidents the review and collection of data allows multidisciplinary teams to identify patterns and alternative strategies. In a number of incidents this information has assisted to develop a functional behaviour assessment. This results in a more detailed and tailor made plan for the individual. Creating and improving the opportunities for better outcomes and the reduction and duration of intervention.

There is still a higher number of male staff involved in physical intervention than female staff. The gender issue is a complex one and cannot be attributed to any singular factor. Within Kibble Education and Care Centre there is proportionally a higher number of male residents than females, there is also a higher number of male staff than female staff therefore one could assume that the percentages are proportionate in relation to this matter. However in a recent matter a female workers name regularly appeared in the documentation as one of the main escalating factors. Further examination of these incidents indicated that she had never completed any documentation as she had never been involved in a physical assist. When raising this as a concern with her line manager he was surprised that this was the case. What became apparent through supervision was that the individual was counter aggressive in her response to crisis and clearly escalated situations that led to her male colleagues feeling obliged to intervene on the grounds of safety. Data only provides us with a sketch analysis and interpretation helps to paint a picture. It can be used to provide us with training and supervision opportunities or in extreme cases lead to disciplinary matters.

Kibble Education and Care Centre provides Local Authorities with an outcomes framework. This is used to measure and evaluate progress made and identify key areas for on-going intervention. A high number of our young people have had a significant history of violence and aggression in previous placements. Recording and evidencing the individuals involvement in this type of behaviour allows us to demonstrate what impact our interventions have in relation to this behaviour. The data base allows us to plot on a monthly basis the number and duration of these behavioural issues. We can readily identify over a period of time whether or not the interventions are having an impact on behaviour. Transparency and sharing this information with the Authority gives credibility to the organisation and can result in an increased uptake of the organisations services. In strategic terms it is good for business. One of the drawbacks of the data base is that it has not evidenced or recorded early intervention and when a crisis has not led to physical intervention. This will be reviewed and changed this year. It is difficult to encourage staff to complete yet another paper trail, however the absence of this data does not allow us to reflect how often primary, secondary strategies and de-escalation techniques have avoided physical intervention.

The collation of practice based evidence has had crucial impact on the development Kibble Education and Care Centre policies on crisis management, staff training, policy and legal and liability issues. By recording and evidencing our practice in relation to the management and reduction of violence we have been able to evaluate

and review training, supervision and staff development. Not only does the data base inform practice it should also safe guard and protect the integrity of the organisation in relation to any investigatory matter. Evidencing practice has provided credibility to training and policy development within the organisation. Sharing this strategy with the external organisations that we provide training to gives further evidence that the importance of collating data is a crucial factor in providing consistency in the development of good practice.

For SCM the integrity of the programme, implementation of the strategies and the practice of its trainers have been crucial factors in the reduction and management of critical events across the sector in Scotland.

Structured workshop activity

The presentation would last approximately thirty five minutes allowing ten minutes for questions.(45 minutes used).

The group would then be split into smaller groups to discuss five key issues for approximately twenty five minutes. These key areas would be along these lines.

1. Within the health sector what would you consider to be the key aspects of practice based evidence?
2. Why would the collation of data be important within your work environments?
3. Does your organisation collect and analyse data? If not why not?
4. Data will often identify training and strategic needs for an organisation. What would be the benefits/dilemmas for your organisation?
5. In terms of balance how much emphasis should be placed on practice based training vs theoretical based training? What is the balance?

Feedback from the groups should be approximately ten minutes. This would leave five minutes to summarise and review. Of course dependant on size of groups these timings could be modified.

Learning objectives

Participants will...

1. realize that recording and evidencing practice matters.
2. learn that evidence based practice makes training and education relevant for staff, young people and organisations.
3. appreciate that analysing data helps us to reduce the duration and level of intervention required improving outcomes for all.

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Horizontal violence among nurses: A chronic condition

Paper

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Perspective: Research

Keywords: Horizontal Violence, Nurses, Code of Conduct, Research, Qualitative methods

Background

Horizontal Violence (HV) is an expression used in nursing literature to describe a wide variety of hurtful, unhelpful, hostile, and intimidating behaviors that occur among nurses (Farrell, Bobrowski, & Bobrowski, 2006). Terminology commonly used examining this topic includes verbal and physical abuse, bullying, disruptive behavior, interpersonal workplace violence, and incivility, among many others. The consequences of horizontal violence are significant for both nurses and health care organizations.

The Joint Commission (2008) identified communication as one of the top three root causes of sentinel events. Effective communication is essential for nurses to perform patient care. Violent acts such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities threatens communication between nurses putting patient and employee safety at risk. The Joint Commission (2008) considered these types of inappropriate behaviors such a widespread problem that it called for the creation of a Code of Conduct aimed at stopping disruptive and intimidating behaviors among health care professionals, effective 2009.

Methodology

A qualitative study was conducted using a grounded theory approach. Data collection methods included participant observation, semi-structured interviews, and textual materials. One hundred and forty four hours of participant observation was done over a six month period on one nursing unit. Interviews were conducted with 16 nurses from the observational unit and four other interviews were conducted with pertinent healthcare workers (unit manager, unit secretary, New Graduate Orientation Coordinator, and Human Resource Representative). Textual materials (e.g. policies) were collected for contextual background purposes. Interviews were recorded and transcribed verbatim and observation data were recorded through field notes. All data were coded and analyzed using data analysis strategies from grounded theory and ethnography (Bernard & Ryan, 2010).

Findings

Two categories of nurses initiated HV regularly on the nursing unit: disruptive nurses (individuals who had a pattern of continual HV) and stress-reactive nurses (individuals who initiated HV only under stressful circumstances). Although stress-reactive nurses' behavior troubled the nurses, the disruptive nurses caused much more anguish and suffering. The focus of this paper is on the struggle of the nurses and manager to deal with HV instigated by the disruptive nurses. Names have been changed to protect anonymity.

Solving HV on the unit was difficult for the nurses and unit manager. HV, especially by the most disruptive nurse on the nursing unit, had been occurring for many years. In their effort to address HV nurses either reported, confronted, or surrendered to the situation. Meanwhile, due to the difficulties associated with each of these strategies, the nurses became despondent and the manager struggled to follow the process laid out in the Code of Conduct policy leading to a seemingly never-ending rise and fall of HV. The most common problems related to a lack of knowledge about the reporting process.

Not knowing that they could report HV: Nurses knew that patient-related incidents could be reported, but a few were unaware that behavioral issues of nurses could be reported. Darlene: "I don't know how to report it." However, during hospital orientation for new employees there was a short informational session on the hospital's Code of Conduct policy, but nurses who recently completed orientation said that they did not remember much about it due to the sheer volume of information that they receive during that time. New graduate nurses, during their year-long orientation, met monthly in groups with the hospital's orientation coordinator to review various socialization issues concerning them. At the fourth meeting, Just Culture was discussed and during the sixth meeting Horizontal Violence. Furthermore, nurses employed for a long time stated that they were vaguely aware of a policy or "some form that we have to sign every year" regarding HV. It was mandatory for all the health care workers in the hospital to receive education on the Code of Conduct policy annually.

Not knowing how and to whom to report: The Code of Conduct stated that HV events could be reported orally, in writing or via the hotline. Most nurses reported events verbally or by e-mail, but were not sure if this was

correct. None of the nurses used the hotline. Likewise, nurses did not always know to whom to report HV. The unit manager and charge nurse were the recipients of complaints most of the time. During the day, the nurses reported events to the manager orally if the unit manager was on the unit and available. During the night shift or on weekends a HV event may be reported to the charge nurse, who made a note on a shift report sheet and the sheet was relayed to the unit manager. The department director and the Human Resource Department also received reports of HV directly from the nurses.

Reluctance resolving HV by themselves and reporting: The Code of Conduct described the steps to be taken in HV event: first try to resolve on your own, if unsuccessful, report to immediate supervisor (e.g. charge nurse or unit manager), then department director, vice president or compliance/abusive behavior hotline. Nurses did not follow the first step of resolving it on their own. They did not speak about “resolving,” but rather used the term “confronting.” New nurses especially, who were afraid of the disruptive nurses, let the situation dissipate by itself, while only a few reported it to the charge nurse or unit manager. Ella, a new graduate nurse, said: “We are afraid - I usually won’t say anything.” Other nurses also avoided the first step; some because they did not like confrontation and others (due to long term exposure and many HV events) learned that the disruptive nurses were always able to justify their actions and behaviors. In addition, there was a fear of retaliation. The disruptive nurse, in reaction to being confronted, retaliated with further acts of HV, in particular against the nurses she suspected reported her. Renee, echoing the words of seven other nurses, said: “don’t expect there will not be repercussions.”

The Chronicity of HV

When the nurse manager heard about HV, following the policy, she encouraged the nurses to talk to the disruptive nurse about the event in an effort to resolve it. As described earlier, nurses omitted this step, or after trying, gave in to the disruptive nurse. Renee, feeling angry and overwhelmed after multiple HV events over many years, believed that the situation with the most disruptive nurse had evolved beyond the nurses’ ability to take action. She said: “we took the steps for many years... we can’t talk to her anymore; they [the management] need to handle that now.”

On the other hand, five nurses said that they confronted the disruptive nurse. How and when the confrontation occurred depended on the nurse and the situation. Some nurses confronted the disruptive nurse immediately, others waited until it had occurred a few times or until they reached a point when they felt they absolutely had to confront the disruptive nurse. Rhonda told me that she waited to see if the behavior continued before confronting: “I was really counting – like the third time now, the fourth time I need to do something...” Confrontation with the disruptive nurses was only partially effective. The disruptive nurse either found a way to retaliate or reduced her attacks for a short time, continued the behavior, or changed to a different type of HV (e.g. spreading gossip).

The unit manager investigated HV when she received oral or written complaints. Many complaints were vague; for example “she was rude to me.” If the nurse was unwilling to be more specific (date, time, exactly what happened, witnesses) the unit manager had more difficulty investigating the complaint. She checked who was on shift and asked those nurses if there were any HV events that day. The nurses were not forthcoming and for the manager it felt like she was “pulling teeth sometimes to get information.” Charles said: “...the nurses don’t want to write anything about that that person.” The manager, aware of the fear of the nurses, often offered to document the event in writing and substantiated it with the nurse’s signature. As complaints about the disruptive nurses mounted, the manager followed the policy step by step. Each stage of the process had requirements and time limits, and when complaints lessened, time limits lapsed and the documentation process had to start over.

Meanwhile, the nurses felt powerless and became more and more despondent, since they felt that no action was being taken. Nurses wanted to know that the disruptive nurse was being addressed, and they wanted an apology, mediation, or conflict resolution, but this did not happen. Not resolving the problem, or knowing that it was being addressed left the nurses feeling dissatisfied. Rhonda and Steve exemplified the sentiments of several nurses when they said: “I don’t know if the person has been spoken to or not...” and “I wanted an apology – I never got an apology – it was just swept under the rug – I did not feel good about it.” Nurses felt that the manager could have worked harder to resolve HV, and that the disruptive nurses were being let off the hook.

Nurses blamed the manager or felt that she was unable to deal with the situation. Nurses made a typical comment of: “...she has done nothing...” Simultaneously, some nurses felt that the manager was also powerless, that she did not have the ability to discipline the disruptive nurses, or that she (the manager) did not have administrative support. The unit manager said that she met frequently with the department director and a representative from the Human Resource Department for guidance and counseling on how to best manage the situation.

Nurses spoke about a pattern of behavior that occurred. When a major HV incident occurred involving the most disruptive nurse, more nurses reported the incident. The disruptive nurse’s behavior would be addressed; she would behave better or “be quiet” for one to two weeks and then resume her HV. Rowena exemplifies this behavior in her statement:

“the behavior was quiet for one weekend and then back to normal - a slap on the wrist and then it will be quiet for a while and then you can see it build back up – so you see things aren’t taken care of – there is never any explanation given.”

Surrendering to the situation

After experiencing HV from the disruptive nurses and reporting their behavior multiple times, but not seeing an improvement in the situation, the nurses felt powerless and many stopped reporting the behavior. The nurses often told me: “nothing changes...finally I just gave up.” Rowena said: “why try - because obviously they do tolerate bullying, they do tolerate it - every year we have to sign a thing that it’s no tolerance – I sign it knowing that it’s a lie - they do tolerate it ...”

In conclusion, Charles said: “so the disease continues, I call it a disease because it is a human interaction, there is no harmony – no therapeutic communication, what is there: interactions that cause stress, frustrations, it has not been a good experience.”

Implications

HV will continue to compromise the work environment, staff morale and satisfaction, and safety of patients and healthcare professionals unless recognized and appropriately managed. Recommendations based on this study include:

- **Practice:** Awareness of HV needs to be raised by schools of nursing, healthcare facilities, and at local, state and national nursing organizations. Nurses (and other healthcare workers) must be able to recognize HV, and it must be given higher priority and visibility at all levels of nursing.
- **Education and Guidance:** Education of Workplace Violence and Code of Conduct policies must be improved at administrative levels and reinforced at unit level. Reporting procedures must be simplified, standardized, clearly explained step by step, and displayed in common areas on nursing units.
- **Management:** The unit manager must respond to each complaint immediately and earnestly. If the victim nurse is not able to talk to the disruptive nurse by him/herself, the manager must facilitate a meeting. The manager needs to validate victim and witness nurses’ emotions and provide psychological support. Lastly, managers must provide feedback to the victim nurses regarding steps taken to resolve the issue.
- **Organization:** Workplace policies regarding HV need to be easily accessible, simplified and enforced. Nursing managers must receive additional education on the steps involved enforcing Workplace Violence and Code of Conduct policies, communication skills, conflict resolution, and mediation. Counseling and support must be provided for the unit manager, victim nurses, and all the nurses witnessing and enduring HV.

If HV is not resolved adequately it can become a chronic problem that affects all the members of the healthcare team. With education and administrative support HV can be recognized, managed and resolved.

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Learning objectives

Participants will...

1. have an increased awareness of how horizontal violence continues to occur.
2. receive ideas on how to implement overt strategies and procedures for reporting and follow-up of horizontal violence incidents.

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Workplace mapping a strategy for enhancing quality safety and risk reduction in the health sector

Paper

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Perspective: Practice

Abstract

Workplace mapping is a strategy developed by trade unions and has been used over years to eliminate workplace hazards and on different occasions organize workers into unions. Workplace violence is an occupational hazard that is highly prevalent in the health and social care sectors and it can be significantly reduced if workers engaged in a workplace mapping exercise. The mapping exercise is a participatory process that involves as many workers as possible making them work collectively, respect each other and share power.

This paper will focus on the process of developing a workplace map in an accident and emergency department which is a visual representation of the workplace, identify service points where risks of violence are highest and using fact sheets label service areas then describe specific hazards in the service areas. Using color coded circles on the map different forms of violence are recorded and based on the map the violence that concerns workers most are recorded and strategies developed on addressing them.

Learning objectives

Participants will...

1. be able to identify common forms of workplace violence in an accident and emergency department.
2. be able to identify service points with the greatest risk of violence.
3. learn of strategies of addressing the different forms of violence.

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HealthWISE: a participatory approach to tackle violence and discrimination in health services

Workshop

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Perspective: Guidance

Introduction

Health services are complex work environments, which can at times be hazardous. Unsafe working conditions may lead to attrition of the health workforce. Decent work in the health sector must include workers' safety, health and well-being, since the quality of the work environment can influence the quality of care.

Violence against health personnel is a widespread problem, affecting all professional groups and work settings in the health sector, and both women and men workers. The negative consequences affect not only the victim but the work environment as a whole. No matter where or how it occurs, workplace violence is costly and unproductive. It reduces motivation and efficiency, has negative effects on working relationships and collaboration and creates a hostile work environment. On the other hand, a productive workplace is where staff feel supported and protected, with working relations underpinned by trust. Creating a work environment where staff and managers treat each other fairly, equally and with respect is the way forward in tackling violence and discrimination at the health services workplace.

Work Improvement in Health Services: HealthWISE

Often, health workers and health service managers have good ideas on how to improve the work environment and practices in their health facility or unit, but are not sure how to approach the implementation of their ideas.

HealthWISE -- a joint ILO/WHO publication -- is a practical, participatory quality improvement tool for health facilities. It encourages managers and staff to work together to improve workplaces and practices. HealthWISE (Work Improvement in Health Services) promotes the application of smart, simple and low-cost solutions leading to tangible benefits for workers and health services, and ultimately for patients. The topics are organized in eight modules addressing occupational safety and health, personnel management and environmental health issues. HealthWISE combines action and learning. The Action Manual helps initiate and sustain changes for improvement, using a checklist as a workplace assessment tool, designed for identifying and prioritizing areas of action. Each of the eight modules illustrates key checkpoints to help guide action. The accompanying Trainers' Guide contains guidance and tools for a training course.

Workshop objectives

The workshop introduces HealthWISE, a new workplace tool and training approach that enables health workers and health service managers to take action in improving the work environment. HealthWISE integrates various topics on occupational safety and health, personnel management and environmental health.

The workshop will focus on the topic "Tackling violence, harassment and discrimination". This is one of the eight modules, thus integrating action on violence into a broader workplace improvement approach. The workshop consists of a mix of presentation, exercise and discussion. Participants will experience the HealthWISE principles which promote learning-by-doing, building on local practice; focusing on achievements; linking working conditions with organizational goals; and exchange of experience.

Conclusions

HealthWISE is designed for use by all who are concerned with improving workplaces in the health sector, including health workers and health-care managers, workers' and employers' representatives, labour inspectors, occupational health specialists, trainers and educators. It is particularly useful for health facilities in resource constrained situations, while applicable in every health service. HealthWISE encourages managers and staff of healthcare organizations to use proactive and collaborative problem-solving techniques to promote safe and healthy workplaces. Pilot tests have demonstrated that health facilities can use HealthWISE to empower employees to develop low-cost solutions based on local needs; enhance health management capacity; and encourage health worker retention.

References

HealthWISE Work Improvement in Health Services – Action Manual. Geneva: International Labour Office, 2014

Learning objectives

Participants will...

1. learn that taking action – “you can do it” – may help initiate and sustain a respectful workplace.
2. realize that joint action and collaborative efforts of staff and management work best.

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Learning from critical incidents: Effective interviewing of people with special needs

Workshop

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Perspective: Practice

Background and context

By definition, clients of the health sector present with special needs. In care facilities for the elderly, residents may present with a variety of age-related special needs, including neurocognitive disorders (e.g., dementia, Alzheimer's disease) and/or physical limitations. In general-care facilities, residents suffer from longstanding and often complex conditions (e.g., neurodevelopmental disorders). In hospital and other primary health care facilities, patients may present with physical and/or mental health complaints. Across settings, clients may have comorbid conditions, such as a mental illness, substance abuse and/or personality problems. Given the high prevalence rate of clients with special needs in the health sector, professionals working in these settings are receiving specialized training in how to identify and manage individuals with special needs. The premise is that by attuning healthcare professionals to the special needs of their patients and better equipping them to tailor their approach in response to the presentation of symptoms, the better the standard of care and the less likely that interactions will result in critical incidents (e.g., disruptive outbursts, aggression, violence, complaints of maltreatment or malpractice). However, despite these efforts, critical incidents continue to occur. Therefore, to further mitigate the risk of critical incidents, it is imperative that healthcare professionals learn from each incident. This can only be accomplished through the effective interviewing of clients and staff.

Methodology

The proposed presentation will provide an overview of the StepWise Approach™ to effective interviewing, a research driven, evidence-based methodology which is being used internationally for a variety of fact-finding and investigative purposes. It is a semi-structured interviewing model that minimizes the negative impact of the interview upon interviewees while concurrently maximizing the quantity and quality of the information obtained. In this presentation, participants will learn how to triage witnesses to maximize the efficiency of the fact-finding and interview processes while protecting each individual's memory from possible contamination. Given that the investigation of a critical incident is dependent on the memories of those involved, participants will learn about memory formation and recall in order to understand how to develop questions that cue memory without contaminating it. The interview steps will be explained. Participants will learn about the importance of preparing for the interview, a step that is often overlooked. Participants will also learn about developing rapport and assessing baseline, how to evaluate the information to develop and test multiple hypotheses and how to adapt the various interview steps to meet the special needs of their clients. This presentation will conclude with an overview of the importance of conducting effective interviews in the pursuit of truth. Only through effective interviewing can we hope to learn from critical incidents and, therefore, improve the standard of care and increase safety for clients and staff in the health sector.

Learning objectives

Participants will...

1. learn an approach to interviewing that minimizes the impact of the interview on the interviewee while concurrently maximizing the quality and quantity of the information gathered.
2. have a basic understanding of the steps to follow to conduct effective interviews when investigating critical incidents.
3. learn to formulate and test multiple hypotheses when conducting critical incident investigations.

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Trauma informed Self Care: Building resilient staff and teams

Workshop

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Perspective: Education and Training

Background and context

Many health organizations are incorporating trauma informed care (TIC) principles into their workplaces as one aspect of preventing and managing workplace violence. These principles are based on the five core values of safety, trustworthiness, choice, collaboration and empowerment (Fallot & Harris 2009) Such a trauma informed approach is supposed to be applied at the service user, staff and organisational levels. However many current training workshops and initiatives around stress management, burnout and vicarious trauma for health staff faced with violence focus mainly on changing staff attitude and skills, resources or situation. In practice often such trainings do not incorporate up to date information and practice on trauma informed care as it relates to staff and so often make little difference in reducing staff stress and related vicarious trauma and compassion fatigue levels.

Methodology

This workshop is based on the presenters more than thirty years of experience and knowledge in running violence management and self-care workshops. It incorporates current research in the areas of trauma informed care and services, trauma transformation, resilience and aspects of The Sanctuary Model to ensure long lasting, effective self and team care training and resources. The workshop will use case studies, scenarios, interactive exercises and participant's self-reflection.

Findings

This workshop will give trainers, supervisors and managers skills and knowledge to incorporate trauma informed approaches into staff wellness programs. It will also equip attendees to start developing their own tailored, effective trauma informed self-care plan based on current best practice as they face violence in their workplaces.

Implications

The effectiveness and impact of current stress, burnout and vicarious trauma prevention and management programs can be greatly improved by incorporating trauma informed care principles into the training. Such an approach can also be applicable in a wide range of related Human Services contexts internationally.

Reference

Fallot, R. & Harris, M. (July 2009) 'Creating Cultures of Trauma Informed Care (CCTIC) A Self-Assessment and Planning Protocol.'

Learning objectives

Participants will...

1. understand the key concepts of Adverse Childhood Experiences (ACEs) and the neurobiology of trauma as it effects workers.
2. be able to examine how their own childhood experiences, or those of their staff, may effect the way they deal with stress, trauma and violence.
3. understand the principles of trauma informed care (TIC) and services (TIS) and how that applies to worker and organisational well being.
4. be able to apply the concepts of trauma transformation, resilience and aspects of The Sanctuary Model to their own well being and that of their organisations.
5. be able to develop a specific trauma informed self care plan for themselves in their workplace.

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The influence of violence risk screening at emergency department triage on code grey responses and access to clinical care

Poster

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Perspective: Research

Background and context

Research and best practice guidelines indicate that violence prevention in hospitals requires a systematic process for identifying high risk individuals on arrival to the Emergency Department (ED), however there is no validated method.

Methodology

A mixed methods approach explored how violence risk screening was used in practice and this informed the development and implementation of a revised violence risk screening decision support system (intervention). The use of code grey responses and access to clinical care for patients who required a code grey response was compared before and after violence risk screening was introduced.

Findings

This study found triage nurses identified more than half of the patients who required an emergency response for actual or potential violence (Code Grey) on arrival and the revised system alerts staff to the risk of violence prior to over 60% of code grey responses. The intervention resulted in fewer Code Greys on arrival and the proportion of unplanned emergency responses reduced. However, the number of coercive interventions such as mechanical and physical restraint increased. A review of patients not identified at triage but who required a code grey found there are some patients that do not have warning signs for violence at triage.

Implications

A structured process to identify patients and communicate the risk of violence has been integrated into triage nurse practice. Identifying the risk of violence at triage captures dynamic risk factors and using iPM (flagging files) captures the static risk for violence. Identifying the risk of violence on arrival provides an opportunity for intervention to reduce the risk of violence and is one component of an overall approach to prevent and manage clinical aggression.

Learning objectives

Participants will...

1. learn of the added value of a structured process to identify patients and communicate the risk of violence for triage nurse practice.
2. learn that the identification of the risk of violence on arrival provides at the emergency department is an opportunity for intervention to reduce the risk of violence.

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A model of continuous professional development for instructors in management of aggression and violence

Paper

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Perspective: Education and Training

Keywords: Instructor recertification, Aggression, Violence, Instructor, Continuous professional development

Background and context

Work related violence is a serious problem within healthcare which diminishes the quality of working life for staff, compromises organizational effectiveness and ultimately impacts negatively on the provision of care services. While there has been increasing recognition that manifestations of aggression and violence vary greatly between and within services, what is clear is that staff may be affected irrespective of their work location, occupation, or department (McKenna 2004). There is compelling evidence that the extent of the problem within HSE DNE mirrors that replaced in national and international regulatory and research reports. (Mc Kenna 2004)

Recognition of the indisputable risks to service users and staff associated with the management of work related aggression and violence imposes professional, statutory, and moral imperatives upon organisations to provide staff with safe, effective and appropriate training. The provision of such training has been reported to reduce associated risks, improve staff effectiveness and result in cost savings from reduced injuries and related expenses. The provision of training should not however be considered solely in the context of risk alone. From a service perspective, the provision of compassionate and skilful care requires that staff are competent to recognise, assess, and intervene with individuals experiencing difficulty controlling their behaviour McKenna K. (2006).

In 2004 the Health Service Executive, Dublin North East HSE/DNE, (then the North Eastern Health Board), conducted a thorough review of staff training in the management of aggression and violence from national and international perspectives which concluded that the provision of training lacked regulation and standards, and was a cause of concern from clinical and safety perspectives which mirrored reports by both professional and regulatory bodies internationally.

The HSE/DNE in response engaged extensively with clinical, professional, academic, and regulatory bodies, and developed the Professional Management of Aggression and Violence (PMAV), programme. This programme prepares healthcare staff from multiple disciplines as instructors who are competent to design and provide training which is needs assessed, service specific, fit for purpose, and responsive to the various manifestations of aggression and violence encountered within diverse clinical settings. An internationally peer reviewed study which paralleled the implementation of the programme has demonstrated the safety and effectiveness of this response. In addition to being unparalleled nationally and, at the very least equalling best practice internationally, the programme meets or exceeds all prevailing regulatory and professional standards in the management of aggression and violence.

While the programme adequately prepares instructors, one aspect which remained unaddressed was the absence of a satisfactory structure and process by which instructors could demonstrate the ongoing professional competence and organizational effectiveness necessary for the continued performance of their role. Far from being a uniquely Irish or HSE/DNE problem, this issue reflected a broader absence of agreed standards and regulations governing this area of practice which has been highlighted internationally.

The customary practice had involved a proprietary organisation providing an annual programme of five days which reviewed exclusively the physical intervention component of the PMAV instructors practice. While of some benefit, the exclusive attention to the physical interventions, did little to develop the other professional, regulatory, organisational, and educational dimensions of the instructor's role. This historical practice, lacked formalized standards and evidence base within the Irish context, was of unproven effectiveness, and without investigation of the quantum of value added for either the instructor or the organization.

Considering the significant financial and human resource invested in recertification, there was an understandable realization of the need to undertake a cost-benefit review of the practice from the perspectives of both the instructors and the organization. This resulted in an organisational mandate to develop an evidence based best practice structure and process of instructor recertification which is fit for purpose, adds value for all concerned,

and is defensible from organizational, professional and regulatory perspectives. The output of this work will provide recommendations which are robust enough to inform the formulation of an organizational policy in this regard, and achieve considerable and sustainable cost savings both in the short and longer terms.

Study aims and objectives

The aim of the study was to develop an evidence based, best practice structure and process of instructor recertification which is fit for purpose, returns value of investment for all concerned, and is defensible from organizational, professional and regulatory perspectives. Specifically the study:

- Appraised prevailing practice with reference to national and international evidence based best practice.
- Drew upon this appraisal to develop a revised model for recertification.
- Prepared evidence based recommendations which are robust enough to inform the development of organizational wide policy and guidance in this area.

Study phases

The Study involved three distinct but related phases of work, which are outlined below.

Phase One: evaluated current practice with regard to the recertification of PMAV instructors with reference to national and international evidence based best practice. This involved a systematic review of subject related professional and regulatory literature. In addition to this literature review a series of focus groups was conducted with key stakeholders including instructors, service managers, corporate quality and risk, and performance development departments and representatives from professional and regulatory agencies. The output of phase one was an agreed “preferred future state” which adequately and equitably addressed the needs of all concerned.

Phase Two drew upon this “preferred future state” to develop a draft structure and process of recertification in line with the project goal which was distributed to stakeholders for review.

Phase Three involved the implementation and evaluation of the reformed structure and process of recertification.

Methodology

An action research methodology involving three cycles underpinned the study. Cycle one evaluated current practice through a collaborative engagement with stakeholders and developed an agreed “preferred future state” which adequately and equitably addressed the needs of all concerned.

Cycle two involved the development of a reformed structure and process of instructor recertification which reflected the stakeholder “preferred future state”.

Cycle three involved the implementation and evaluation of the reformed structure and process of recertification.

Presentation of Findings:

The conference presentation will:

- Discuss the challenges and potential involved in the ongoing continuous professional development and recertification of instructors.
- Present a proposed framework which structures the ongoing learning needs of instructors within a continuous professional development frame.
- Present the experience of implementing a revised instructor recertification programme.
- Provide an opportunity for delegate engagement/discussion

Conclusion

The education and training of those who teach and support staff in the safe and effective management of aggression and/or violence plays a pivotal role in a properly integrated total organizational response. It is imperative that the trainers, staff, service users, and the organization have confidence in a process that delivers safe, effective training which reflects relevant and up to date evidence based best practice.

There is considerable financial and human resources invested in preparing instructors in the management of aggression and/or violence, and there is evidence to support the proposition that this can be done effectively. There is a considerable difference however in the challenge to establish the competence of an instructor in the first instance and the process by which their ongoing competence and practice is validated.

There is a need therefore for the perception of the instructor training as an ‘end point’ producer of ‘instructors’ to be replaced by an understanding of instructors as professionals whose practice should be held to standards of review, and demonstration of ongoing competence similar to other professionals. It is equally important that this shift in understanding is paralleled by the necessary evidence, standards and resources.

Implications

The implications for instructors, the organization, professional bodies and regulatory agencies will be discussed.

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Acknowledgements

This work was supported by a grant from the Linking Service and Safety Joint Governance Group of the Health Services Executive Ireland.

Learning objectives

Participants will...

1. have an understanding of the importance, purpose and function of on-going continuous professional development for instructors in the management of aggression.
2. have an understanding of the key components of a best practice model of continuous professional development of instructors in the management of aggression.

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Building the alliance between security and clinical teams

Paper

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Perspective: Education and Training

Keywords: Hospital, security, training, clinical assault, restraint reduction

Introduction

This paper features a project at the Brighton and Sussex University Hospitals (BSUH) NHS Trust, a large general hospital in England that has successfully reduced risks to staff and patients linked to aggressive behaviours. A key feature of this work has been the building of a successful alliance between the dedicated hospital security team and clinical staff on wards. The Trust has two large acute hospitals with diverse services including emergency departments, extensive inpatient services and specialisms including trauma and neurosciences. It employs 6500 staff and treats over 750,000 patients per year of all age groups. Over 24 months this project has delivered positive outcomes for patients and staff including a substantial reduction in assaults, restraints and safeguarding incidents.

The drivers for the project were:

- High levels of reported ‘assaults’ on staff related to the clinical condition of a patient.
- Concerns for patient safety.
- Dissatisfaction with existing regulatory training provision.

The clinical risk factors ranged from physical conditions causing acute confusion to mental health issues such as dementia, and sometimes a combination of these. This situation was not unique as Government national data for England and Wales indicated that in the region of 70% of reported assaults were clinically related.

Existing Training Limitations

Government already had in place a requirement for frontline staff working within the National Health Service (NHS) in England and Wales to be trained in a generic NHS Conflict Resolution syllabus. The content of this NHS syllabus did not however address clinically related challenging behaviours and instead focused on the deliberate aggression and abuse that had been a feature in emergency departments (often alcohol related) and widely portrayed by the media. BSUH recognised that the problem was not confined to the emergency department, identifying higher levels of assault on certain inpatient wards typically linked to a patients’ physical and/or mental condition.

Many NHS Trusts including BSUH had provided additional ‘physical skills’ training to staff in units experiencing higher assault levels including ‘breakaway’ skills, but these again focused on deliberate aggression and lacked relevance to the actual activities and risks that staff faced when providing treatment and care to confused patients.

A Security Team Initiative

A unique feature of this project is that it resulted from the initiative of the BSUH security team and its manager Simon Whitehorn. Responsibility for staff safety, patient safety and training often sits with different departmental managers and Simon set out to win support across the organisation and build further confidence and regard for the security team.

This project shows how ‘in house’ and contracted security providers can contribute to positive safety and care outcomes, and thereby enhance their perceived credibility and value across the wider organisation. Hospital security teams and clinical staff are often drawn together in response to escalating situations when effective communication and teamwork is critical. Clear expectations of roles are vital to the safety of patients and staff in such reactive scenarios. This project shows the value to be gained from proactive security engagement and building of positive relationships.

Project Goals

The Security function set out to address the gap in training with Trust wide support and full backing of the Chief Nurse. The initiative set out dual and complimentary goals:

- To design and deliver a bespoke training programme to help security and clinical staff teams work together to reduce clinically related challenging behaviours and assaults
- To reduce the use of restraint and ensure patient safety and dignity is maintained when intervention is necessary

BSUH NHS Trust engaged Conflict Specialists Maybo to help research and design a bespoke programme that met NHS Conflict Resolution Training syllabus requirements and then built an understanding of how to recognise, prevent and respond to clinically related challenging behaviour.

Method

The first step was to analyse incident data to better understand the nature and causes of challenging behaviours and identify the priority areas. As such incidents are often underreported a staff survey was developed with Maybo which helped provide a fuller picture of the challenges and identified key scenarios that would form part of the training. Staff completed eLearning and attended a one day course which covered NHS Conflict Resolution Training outcomes and included additional knowledge and skills to:

- Recognise, prevent and defuse conflict and challenging behaviours.
- Avoid clinically related assaults through safer positioning and working practices.
- Safely guide and re-direct confused patients.

For staff in services experiencing higher levels of challenging behaviour practical skills were included to help reduce risk of assault when going about tasks in close proximity to patients. This included positioning awareness and simple skills to re-direct and guide individuals, together with guidance on how to reduce risks of harm to confused and vulnerable patients.

Security staff had two further days Maybo training including safer holding and clinical holding skills, ejection methods and incident response teamwork. The training was mapped to NHS and National Occupational Standards for Work Related Violence and was accredited by the educational awarding body City & Guilds. The initial challenge was twofold; covering costs of training delivery and securing release of operational staff. To win support from local clinical managers to release and cover for staff, the team presented their research on risks and needs at a stakeholder workshop with a taste of the proposed training.

A blended learning approach was taken to delivery involving bespoke eLearning and direct training. A key success factor has been the Ward based 'coaching' and support role the internal trainers and security team have provided to clinical staff. This has helped ensure transfer of training into working practices and safer behaviours i.e. Level 3 Kirkpatrick evaluation, which many training initiatives fail to achieve. "Everyone is now talking a common language about communication strategies, personalised care, de-escalation strategies and where it becomes necessary, safer physical intervention". Sherree Fagg, Chief Nurse.

The programme was rolled out to 32 Security officers and circa 1000 clinical staff thus far on a priority basis i.e. to those wards experiencing the highest levels of clinical assaults and challenging behaviour. Members of the Security Team also attended the clinical courses to promote communications and teamwork between functions. The supporting bespoke e-learning programme provides underpinning knowledge of Conflict Management which is assessed and recorded in a sophisticated learning management system.

The face to face training is delivered on a training ward with wheelchairs, patient trolleys and beds to provide extra realism and the manual handling and dementia trainers have been closely involved to ensure full integration. Pilot courses successfully secured the buy in of key staff and managers. "The training design was based on a comprehensive Training Needs Analysis informed by a bespoke staff survey and review of incidents. It has been an incredibly thorough and risk/evidence based approach". Simon Whitehorn, Security Operational Manager.

Results

There is strong anecdotal evidence and data to show this training has delivered results locally and has also informed the development of good practice guidance in this area. Targeting of highest risk areas has produced dividends, for example the fully trained Neuro Unit saw a reduction from 15 to 6 assaults in the first 12 months of the project, which the Unit attributed to the training. Over the two year period the Specialised Division as a whole reported a 71% reduction in restraints for clinical reasons.

Prior to the training the Trust had experienced organisation wide in the region of 200 physical assaults on staff per year and whilst many areas are yet to receive the enhanced training, levels of assault have more than halved. Similar reductions are reported in restraints of patients for clinical reasons.

Since the start of the project in 2012 data shows year on year reduction in assaults and restraints. Current levels show:

- 52% reduction in non-physical assaults on staff Trust wide.
- 42% reduction in physical assaults on staff Trust wide.
- 58% reduction in restraints for clinical reasons Trust wide.

- 71% reduction in restraints for clinical reasons within the Specialised Division.
- 31% reduction in calls to Security for assistance with patients exhibiting “challenging behaviour”.

“Qualitative evaluation of this training by security and clinical staff has been very positive and we have seen a dramatic reduction in the number of reported physical assaults and clinically related restraints”. Simon Whitehorn, Security Operational Manager

Staff training evaluations pre and post training consistently rate the training as ‘excellent’ and comment on its practicality and relevance to their work. “All staff trained felt very positive and more confident in dealing with confused and aggressive patients and I see them putting this into practise. Through training together working relationships have improved and nurses are quicker to call security. The first course I have seen of its kind after 30 years of working with “challenging patients”. Thank you. Matron Neurosciences.

When physical intervention and restraint is a necessity, the security team are now using less forceful, low arousal methods instead of traditional ‘pain compliant’ techniques. These methods have been developed by Maybo to address the specific scenarios faced by staff dealing with deliberate and non deliberate (clinically related) aggression in a hospital setting. “Since the training the Adult Safeguarding Team has seen a reduction in the number of safeguarding alerts raised in relation to allegations of physical abuse due to intervention by staff to manage violent or aggressive behaviour”. Allison Cannon, Associate Director Quality/Safeguarding Adults.

The success of this initiative has helped secure further investment and in-house trainers are now in place to further ensure its sustainability and reduce direct delivery costs. The Trust runs 6 monthly refreshers for its security team which further demonstrates its commitment. “We have delivered a greatly enhanced training package within the same training time and at similar cost to the Trust”. Simon Whitehorn, Security Operational Manager.

The thorough review of risks and training needs was key to getting senior buy in to the training and the stakeholder workshop and pilot courses helped win the support of local Matrons and Managers who had to release staff. A Matron for Older People who came on one such course, said “Why didn’t someone show me this 20 years ago?” and immediately instructed her Ward Managers to come on the training and get their staff trained.

The feedback from the initial courses was excellent which spread good news and led to staff asking to get onto the training and not being ‘prisoners’. The cross functional commitment of Health & Safety, HR, Clinical Divisions, Safeguarding and Security was excellent and perhaps the biggest turning point was securing the active backing of the Chief Nurse. “In the NHS Security has a complex relationship with Health and Safety and Fire Safety with often competing agendas. This initiative also shows how the BSUH Security Team are always willing to work through challenging safety issues with the Trust Risk Management team to improve the safety of patients, visitors and staff”. Lyn Allinson, Head of Risk Management.

There is a positive feedback cycle backed by a drop in assaults and restraints which provides a strong case for continued investment.

Conclusions

This programme is successfully addressing one of the most complex areas of behavioural safety and one that was proving costly with staff injuries and presenting safeguarding concerns. It is an excellent example of partnership in developing and implementing training. Key Success Factors have included:

- Thorough research of risks, causes and training needs
- High relevance to staff by using real world scenarios taught using beds, trolleys, wheelchairs etc.
- Buy in of the Chief Nurse and Matrons at a stakeholder workshop aided staff release from wards
- Security team follow up and support to wards post training further improved communications and relationships and encouraged transfer of learning into working practises.

Learning has successfully transferred to working practices by securing full management buy-in and on-going support to Wards from the Trainers and Security Team. Relationships and respect between clinical and support staff have been further improved.

It has delivered a win-win by improving staff safety and contributing positively to patient centred care and safety. This contrasts with some work related violence ‘zero tolerance’ strategies which can be adversarial, encouraging a ‘them and us’ mindset that simply sets up more conflict. Such approaches often fail to recognise that a high proportion of ‘assaults’ on staff involve clinical factors with individuals who lack capacity and have limited control over their behaviours. “The programme we have piloted and implemented has strengthened relationships and had a positive effect on staff confidence and patient’s perception of safety”. Sherree Fagg, Chief Nurse.

Moving forward there are plans for the project to move under senior clinical leadership to ensure it continues to be supported and firmly embedded in clinical practice.

This initiative by the BSUH NHS Trust in partnership with Maybo has contributed to good practice on a wider level as a featured case study in the 2014 NHS Guidance 'Meeting needs and reducing distress'. William (Bill) Fox and Simon Whitehorn were invited to join the NHS expert group responsible for developing this guidance.

The initiative also won the coveted 2013 Security Excellence Awards at Park Lane, London.



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Learning objectives

Participants will...

1. appreciate the potential benefits of collaborative interdisciplinary engagement in developing positive and safe care environments.
2. understand some of the opportunities and challenges involved in building alliances between security and clinical teams.

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Training Implementation and Evaluation (TIE) Study: An investigation of a “process” approach in providing training in the safe effective management of work related aggression and violence within health and social care

Paper

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Perspective: Education and Training

Background and context

The phenomena of aggression and violence encountered within the clinical setting is a complex issue which presents a unique challenge both to staff and to healthcare providers. The uniqueness of the challenge is embedded in the realization that such behaviours must be understood and managed within diverse health and social care contexts in which duties of care exist both to those receiving and providing services. Effectively managing the problem is however essential as the impact of such occurrences can diminish the quality of working life for staff, compromise organizational effectiveness and ultimately impact negatively on the provision of care services (McKenna 2008).

Notwithstanding the now well acknowledged recognition for effective responses to include multi-faceted organizational approaches, one critical component of any response is the provision of safe effective training to staff in the management of aggression and violence. In 2001 a Committee on Workplace Violence, was established in the former North Eastern Health Board (now Health Service Executive Dublin North East) to develop a comprehensive organizational response to this problem. The paucity of Irish research evidence prompted the committee to undertake the first large-scale multi-disciplinary study investigating the problem within Irish healthcare (McKenna 2004).

The findings of the study validated the normative nature of encountering aggression and violence for staff in diverse service settings. The need for training was identified as a priority concern with 66% rating their need for such training as ‘essential’ while only 27% had received training (McKenna 2004). The study also reported concerns regarding the structure, content and effectiveness of the training which had been provided. These concerns prompted a thorough review of training from national and international perspectives. While the extent and findings of this review are beyond the scope of this paper, it served as the impetus for the most critical re-appraisal and radical reorganization of training provision undertaken within the Irish health service.

The response: Practice perspective

In their commitment to address this issue, the committee consulted extensively with clinical, professional, academic, and regulatory bodies, and developed a programme of education entitled the Professional Management of Aggression and Violence (PMAV) at BSc level in partnership with the Dundalk Institute of Technology. This development involved two national stakeholder Delphi exercises. The first of these determined consensus regarding the didactic components of the programme, and the second established consensus as to the ‘safety’, ‘effectiveness’, ‘acceptability’, and ‘teachability’ of the physical interventions component of the programme.

The overall objective of the BSc PMAV programme is to prepare students from multiple disciplines as instructors who are competent to design and provide training that is needs assessed, fit for purpose, and responsive to the various manifestations of aggression and violence encountered within diverse clinical settings.

The Response: Organisational perspective

While the provision of training is a vital component of any comprehensive strategic response, the erroneous assumption that training alone can address this issue is now increasingly acknowledged (McKenna & Paterson 2006). For training to meaningfully contribute to the effective management of aggression and violence it must be embedded within an integrated organisational matrix involving clinical practice, health and safety, risk management and corporate policy. For this reason PMAV instructors provide training within an organisational approach which was developed concurrently to the BSc in PMAV programme. This organisational model effectively embeds training within a governance framework which adequately and equitably addresses the concerns of all stakeholders. The MOAT framework (McKenna 2005) provides a structure through which instructors systematically evaluate training needs by collaboratively exploring the practice concerns of staff

and service managers related to aggression and violence, reviewing service specific health and safety audits and risk management data and considering the prevailing legislative and policy frameworks specific to each service.

From this consultation process, instructors design, develop and deliver training that:

- Responds to safety and practice concerns of services
- Addresses legislative health and safety obligations
- Addresses corporate risk management concerns
- Includes only professionally, legally and organizationally permissible interventions
- Is congruent with the organizational philosophy of care.

The objective is to provide training which is needs assessed, service specific, fit for purpose and which ultimately will enhance the quality of the service experience for both recipient and provider. In combination the BSc in PMAV supported by the MOAT framework represents a radical revision of training provision which strives toward a standard of excellence which at the very least, equals best practice internationally.

Training Implementation and Evaluation (TIE) Study

The implementation of training by the first graduates of the BSc PMAV programme was structured within the Training Implementation and Evaluation (TIE) study, an initiative which was resourced through an innovative multi-agency collaborative funding bid involving the Health Service Executive, the National Partnership Forum, and the Health Research Board.

Aim: The overall aim of this study was to parallel the implementation of a multidisciplinary programme of training in the management of aggression and violence with a systematic investigation of the impact and effectiveness of the training provided.

Question: The ultimate question investigated the effectiveness of this ‘process’ approach in providing training which is needs assessed, service specific, and fit for purpose.

Study population: The study involved 300 staff from seven diverse services including: Ambulance, Accident & Emergency, Childcare, General Hospital, Intellectual Disability, Older Persons, and Psychiatry

Measurements: The study employed a quasi-experimental design of pre, post, and re-test measures utilizing two stands. [Figure 1]

The first strand utilised a questionnaire series which evaluated the:

- frequency of occurrences encountered by participants
- extent to which participants formally reported occurrences
- the emotional impact and physical impact of occurrences
- the relevance of training to their practice setting
- the effectiveness of training to their practice setting
- confidence to manage aggression and violence.

The second strand involved the assessment of the ‘safety in practice’ and the ‘clinical effectiveness’ of participants demonstrated performance of interventions from recorded vignettes which were recorded pre and post training, and again at 90 days following the completion of training.

Figure 1 Quasi Experimental Interrupted time series design

	Pre-Test	Inter-vention	Post-Test	Re-Test 1 (Q)	Re-Test 1 (S)	Re-Test 2 (Q)
	Day 1		Day 3-5	Day 30	Day 90	Day 180
Questionnaire N= 300	Qo1		Qo2	Qo3	-----	Qo4
Occurrences within previous 30 days	X		-----	X	-----	X
Reporting of Occurrences	X		X	X	-----	X
Impact of Occurrences: Physical Injury	X		-----	X	-----	X
Impact of Occurrences: Distress	X	MOAT	-----	X	-----	X
Impact of Occurrences: Work Absence	X	Assessment	-----	X	-----	X
Confidence managing aggression/violence	X	& Training	X	X	-----	X
Relevance of Training Content	X		N/A	X	-----	X
Effectiveness of Training in practice	X		N/A	X	-----	X
Impact of Occurrences	X		N/A	X	-----	X
Skills Observations N= 30	So1		So2	---	So2	---

Qo = Questionnaire Completion So = Skills Observations

Survey Measurements

Occurrences: were measured using the ‘occurrence’ subscales from the SOVES study relating to ‘verbal abuse’, ‘threats’ and ‘physically assaults’. These scales involve respondents recording the frequency with which they had encountered each of these categories, directed toward them in relation to their work, within the previous thirty days. Occurrences were measured on three occasions, prior to training, 30 days following training, and at 180 days following training.

Reporting was measured using the reporting subscale from the SOVES study which involved the respondent completing a scale rating the frequency with which they formally report occurrences of verbal abuse; threats, and physical assaults. Participants completed the scale on four occasions, prior to training, after training, and on two subsequent occasions at 30 days and 180 days following training. The response following training rated ‘intention to report’.

Impact Emotional: was measured using the reporting subscale from the SOVES study which involved respondents completing a scale rating the emotional impact of the most recent occurrence of ‘verbal abuse’, ‘threats’, and ‘physical assaults’. Participants completed the scale on three occasions, prior to training, and on two subsequent occasions at 30 days and 180 days following training.

Impact Physical: was measured using two measures from the SOVES study. The first measure involved respondents rating any injury sustained subsequent to the most recent occurrence of physical assault. The second measure compared the absenteeism rate due to all manifestations of aggression and violence in the six month period prior to training and the six month period following training.

Confidence: was measured using the confidence scale designed by Thackrey (1987) which involves respondents completing ten scales rating their confidence in managing both non physical and physical aggression and violence. Participants completed the scale on four occasions, prior to training, after training, and on two subsequent occasions at 30 days and 180 days following training.

Effectiveness: was measured by asking respondents to rate the degree to which the ‘verbal interventions’, ‘disengagement interventions’ and ‘containment interventions’ delivered during their training were effective in dealing with actual situations in practice. Participants completed this measure on three occasions, immediately following training, and on two subsequent occasions at 30 days and 180 days following training.

Relevance: was measured by asking respondents to rate the degree to which the ‘verbal interventions’, ‘disengagement interventions’ and ‘containment interventions’ delivered during their training were relevant to their practice setting. Participants completed this measure on three occasions, immediately following training, and on two subsequent occasions at 30 days and 180 days following training.

Recorded Vignette Measurements

The second strand of the investigated the ‘practice safety’ and ‘clinical effectiveness’ of participants demonstrated performance of ‘non verbal interventions’ from recorded vignettes which were recorded prior to training, following training, and again at 90 days afterwards. These vignettes measured participants performance of three categories of non verbal interventions namely, ‘approach’, ‘disengagement’, and ‘containment’. Recorded vignettes were randomized and rated by an international panel of experts who were blind to the training status of participants. A specifically constructed rating instrument was utilized to measure experts ratings and the results investigating differences in performance were then statistically analysed.

Study findings demonstrated that:

- Occurrence of verbal abuse was largely unaltered
- Occurrence of threats diminished significantly
- Occurrence of physical assaults diminished significantly
- Physical injuries diminished significantly
- Absenteeism diminished significantly
- Confidence of staff improved significantly
- Effectiveness of training was highly rated.
- Relevance of the training was highly rated.
- Safety of physical interventions performance improved significantly
- Effectiveness of physical interventions performance improved significantly.

However

- Emotional impact of occurrences remained unchanged
- Reporting of occurrences remained largely unchanged

The presentation will present the findings from both strands of the study and provide the opportunity for discussion of the implications, from professional and organizational perspectives.

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Learning objectives

Participants will...

1. have an understanding of the potential of utilizing a ‘process’ rather than a ‘product’ approach to providing training in the management of aggression.
2. have an appreciation of the potential contribution of effective staff training to enhancing the care experience of both the provider and recipient.
3. have an appreciation of limitations of staff training, and highlight aspects of the staff experience which require alternative management.

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Treatment and violent behavior in persons with first episode psychosis during a ten-year prospective follow-up study

Poster

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Perspective: Research

Background

First episode psychosis (FEP) patients have an increased risk for violence and criminal activity prior to initial treatment. However, little is known about the prevalence of criminality and acts of violence many years after implementation of a treatment algorithm for a first episode psychosis.

Aim

To assess the prevalence of criminal and violent behavior during a ten-year follow-up period after the debut of a first psychosis episode, and to identify early predictors and concomitant risk factors of violent behavior.

Method

A prospective design was used with comprehensive assessments of criminal behavior, drug abuse, clinical, social and treatment variables at baseline, five, and ten-year follow-up. Additionally, threatening and violent behavior was assessed at 10-year follow-up. A clinical epidemiological sample of first-episode psychosis patients (n=178) was studied.

Results

During the 10-year follow-up period, 20% of subjects had been apprehended or incarcerated. At ten-year follow-up, 15% of subjects had exposed others to threats or violence during the year before assessment. Illegal drug use at baseline and five-year follow-up, and a longer duration of psychotic symptoms were found to be predictive of violent behavior during the year preceding the 10-year follow-up.

Conclusion

After treatment initiation, the overall prevalence of criminality in psychotic patients drops gradually over time to rates close to those of the general population. However, persistent illicit drug abuse is a serious risk factor for violent behavior, even long after the start of treatment. Achieving remission early and reducing substance abuse may contribute to a lower long-term risk for violent behavior in FEP patients.

Learning objectives

Participants will...

1. learn that psychosis patients are stigmatized as being more violent than the general population. Realize that stigmatization counts only for untreated patients and for a minor subgroup of patients in treatment and those with high levels of persisting positive symptoms and with illegal drug use.
2. understand that early and easy access to treatment and assertive treatment strategies are pivotal in reducing the risk for violent behavior in first episode psychosis patients.

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Cognitive Rehearsal Training (CRT) as an anti-bullying intervention for nursing students

Poster

Michelle Seibel, Florriann Fehr
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Perspective : Education and Training

Abstract

Nursing students are more vulnerable to being victims of bullying behaviours due to lack of knowledge and experience, as well as lack of status and power. However, they represent the future of the profession, and as such, should be taught effective strategies to cope with workplace stresses such as bullying.

The poster describes the preliminary findings of an exploratory pilot study that measures the efficacy of an anti-bullying intervention (Cognitive Rehearsal Training workshop and tools) to increase third year Baccalaureate nursing students' knowledge, perceptions of and confidence to address bullying behaviour. The study was conducted in a workshop format with two group interviews before and after an interactive role play with theater students and the participants regarding various scenarios of bullying. Feedback from the participants enabled the researchers to refine the intervention to ensure its utility and benefit for future student nurses and practicing healthcare professionals.

Bullying and other forms of violence are prevalent in nursing practice, and while interventions to impact this reality exist on a theoretical level, few have been tested within a pre-licensure nursing program and within practice. There have been few studies that have addressed bullying prevention using a specific intervention for nursing students.

Learning objectives

Participants will...

1. gain ideas on how to implement an anti-bullying intervention for nursing students to take into practice.
2. gain ideas on how to integrate the "Stop! Reflect and Respond" to bullying into curriculum development for nursing students.

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Experiencing violence in a psychiatric setting: Generalized hypervigilance and the role of caregiver attitudes in the modulation of fear

Poster

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Focus: Practice

Background

Exposure to violence in the healthcare sector affects workers and impacts on the quality of care offered (Arnetz & Arnetz, 2001). These acts of aggression can generate various behaviors in healthcare workers, such as fear and avoidance of patients (Gates, Gillespie, & Succop, 2011).

Context

The current phenomenological study attempts to understand and describe the experience of psychiatric hospital workers who were victims of a severe act of violence from a patient, as well as the impact of this event on the care offered. A phenomenological approach allows for a novel outlook on this issue by diving into each worker's universe and understanding his or her interpretation of the act of violence experienced. The use of this approach provides access to more content and allows for precisions to be made in regards to the ways in which their daily lives were altered by this phenomenon.

Methodology

Thirty semi-structured interviews were conducted, or two with each of the 15 participants (11 women) employed in a psychiatric hospital. Our analyses were based on Karlsson's "Empirical Phenomenological Psychological" technique (1993). Particular attention was paid to the possibility of differing experiences based on the gender of the worker.

Results

Four main themes, which are present independently of gender, were identified by our analyses: hypervigilance, caregiver attitudes, specific fear and generalized fear. A state of hypervigilance is observed in all workers that were victims of an act of aggression from a patient. Comparatively to workers who had witnessed an escalation of aggressiveness from a patient, those who had been taken by surprise report that the repercussions of this vigilance extend into their personal lives. Caregiver attitudes are present in the majority of participants. These attitudes involve benevolence and authenticity towards patient care. By placing the patient at the heart of the intervention, these healthcare workers are able to develop a trusting relationship with their patient and act as agents of change. A feeling of fear is also expressed by participants. This emotion is modulated by the presence or absence of caregiver attitudes. Workers who demonstrate caregiver attitudes developed a specific fear towards their aggressor, whereas those who manifest few or no caregiver attitudes developed a generalized fear of the clientele. Following a violent event, healthcare workers possessing caregiver attitudes are able to conserve them, whereas those who have few or none of these attitudes are more likely to disinvest and disengage from their relationships with their patients.

Implications

Generated by violence suffered in a psychiatric hospital setting, hypervigilance and fear (specific or generalized) both impact the quality of care offered. Considerable attention should be paid to caregiver attitudes, which seem to modulate this fear and its resulting effects. Future studies should clarify the origin of these attitudes – are they learnt or do they result from a vocation? These studies could establish methods of reinforcing or developing these caregiver attitudes.

Learning objectives

Participants will...

1. understand the difference between the state of hypervigilance and the feeling of fear that the workers who were victims of a severe act of violence from a patient experience.
2. understand what the caregiver attitudes are and to appreciate how the feeling of fear is modulated by them.

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Workplace violence in the health sector in Kirikkale Province in Turkey

Poster

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Focus: Research

Background

Like elsewhere, workplace violence has become an issue of increasing concern for public health, in Turkey. Healthcare workers are at high risk for assault. In order to develop monitor, and manage prevention policies, baseline data should be available. This study was designed to determine the extent of current workplace violence in Kirikkale province.

Methodology

A cross-sectional study was conducted in 2013. Using a questionnaire adapted from survey questionnaires developed by International Labor Office, International Council of Nurses, World Health Organization and Public Services International. We also used "Leymann Inventory of Psychological Terrorization" questionnaire for mobbing. The survey population consisted of all (5359) healthcare workers in Kirikkale province in Turkey. Stratified random sampling was used to achieve reliable prevalence estimates for Kirikkale province as a whole and sample size was computed to be 828. The first stratum was health care institution level and the second stratum was professional staff level.

Findings

A total of 659 workers were interviewed with a response rate of 79.6%. Mean age of subjects was 39.14 (20-65 years) and 40.4% 55.7% of subjects were male and 59.6% 44.3% were female. Frequency of exposure of healthcare workers to violence in the last 12 months was estimated to be 42.2% (95% CI: 38.5-46.1). Frequency of violence types were physical 8.0%, verbal 40.8%, mobbing 4.3% and sexual harassment 0.9%. The rate of any type of violence among the female was 47.5%, and among the males was 38.3% ($p < 0.001$). Violence incidence experienced by participants was 32.2% in the primary healthcare system and 43.6% in the secondary and tertiary healthcare systems ($p = 0.016$). In the previous 12 months, 62.3% of the physicians and dentists, 42.2% of the nursing and midwifery professionals, 44.1% of the ambulance/emergency medical services workers, 38.8% of the health officers, 33.3% of the security staff, 47.0% of the laboratory, radiology, and sterilization technicians, and 55.6% of the therapist, psychologist, pharmacist, dietitian, audiologist, speech therapist, social workers, 29.3% of the support service staff and 28.3% of the administrative staff experienced at least any type of workplace violence ($p < 0.001$). Frequency of any type of violence experienced by 20-29 age-group was 61.5%, which was 42.7% for 30-39 age-group, 37.1% for 40-49 age-group, and 33.8% for 50-and-over age group ($p = 0.001$). Experience of any type of violence by the length of work experience was observed 51.6% among participants with 1-9 years' work experience group, which was 41.3% for 10-19 years' work experience group, 37.3% for 20-29 years' work experience group, 31.2% for 30 and more years' work experience group ($p = 0.035$).

Discussion and conclusions

Our study indicates that the workplace violence among healthcare workers is a significant problem in Kirikkale province. All healthcare workers within the health sector are at high risk for workplace violence. Comprehensive and analytical preventive programs may decrease the number of violent incidents as well as their severity. To our knowledge, our study is the first study on workplace violence that draws a representative stratified sample from an entire population of health professionals from a specific province in Turkey. Therefore, the results of this study can serve as the basis for future analytical studies about workplace violence. Furthermore, the findings may provide insight for the development of appropriate prevention efforts in the health sector, especially in regions with similar cultural and social structure.

Learning objectives

Participants will...

1. have knowledge of the incidence of workplace violence in the Kirikkale province in Turkey.
2. be aware of the high risk that workplace violence poses to healthcare workers.

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The lived experience of incivility in nursing classrooms

Poster

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Focus: Research

Background

In recent years the prevalence of incivility in educational settings has received heightened attention in academic and popular press. Recent studies affirm that incivility is experienced or witnessed in a large percentage of nursing classrooms and clinical placements, affecting performance and stress levels of both students and faculty. In light of nursing's position as a profession of humanistic interaction, measures to reduce incivility are of dire need in the academic setting. The presence of incivil behaviors not only diminishes the modeling of professional nursing and fails to set a standard of acceptable behavior, but restricts learning and destroys the educational environment. Intervention and prevention measures have been suggested in the literature, but few have been the focus of research for effectiveness. Also missing from current research is the study of whether faculty, using a conscious, caring approach are able to defuse escalating incivil encounters. The purpose of this phenomenological investigation was to describe the lived experiences of nursing faculty who have experienced or witnessed incivility in the classroom and to elicit reflection on how these situations might have been defused.

Method

A phenomenological approach was used to guide data collection and analysis. Purposive sampling will be used to recruit 10 nurse educators who self-identify as having experienced incivility in the classroom as a nurse educator. Participants meeting the inclusion criteria participated in single session, 60 minute interviews with one of the co-researchers. Inclusion criteria consisted of possessing a Master's degree in nursing and have been employed in a school-based, classroom setting as nurse educator for longer than 12 months.

Findings

Themes from this study are consistent with prior research describing the causation, sequelae, and suggested measures for prevention/intervention. New to the discussion on incivility in academic settings and proposed for consideration in the health care sector, are reflections from participants on strategies to defuse escalating incivil encounters.

Learning objectives

Participants will...

1. be able to evaluate strategies to defuse escalating incivil encounters in the health care sector.
2. be able to appraise the impact of incivility on job performance in health care settings.

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Identifying unit risk: Reducing staff injuries with patients with co-occurring developmental disabilities and psychiatric illness

Poster

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Focus: Practice

Background

When a specialty unit for patients with co-occurring developmental disabilities and psychiatric illnesses had an increase in acuity, injuries occurred. This environment created a concern to clinical staff and leaders. There was a need to inform staff of the increased acuity to prepare for their shift in terms of safety of the unit.

Method

IHI Methodology; PDSA testing; Weekly run charts with raw data measures of all staff injuries with annotations with testing across the timeline.

Findings

The quality improvement initiative was executed within an inpatient psychiatric unit for patients with co-occurring developmental disabilities and psychiatric illness. Clinical leaders, internal and external, to the psychiatric division engaged frontline nursing clinicians in education, testing and sustainment of system principles, reliability design concepts, risk identification, mitigation planning and a preoccupation with failures. All interventions were determined by a team approach and carried over time.

Implications for Practice

Have a data supported risk identification system that will guide unit program changes for staff and result in zero injuries. Continue to gather base-line data, continue testing, and establish interventions to address when the system is at an increased risk for staff injury.

Learning objectives

Participants will...

1. appreciate the challenges of caring for patients with co-occurring developmental disabilities and psychiatric illnesses with regard to aggressive behaviour.
2. learn of the merits of a data supported risk identification system in reducing violence.

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Behavioral safety: Reducing staff injuries due to aggressive patient interaction

Poster

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Focus: Practice

Background

Children admitted to medical surgical inpatient units may present with aggressive behavior that place staff at increased risks of injury. The frequency and severity of injuries to staff due to aggressive patient-related interactions were a concern to clinical staff and leaders. Inpatient medical staff are often not well equipped to deal with behavioral challenges in the medical setting.

Methodology

Quality improvement principles and interventions, led by clinical leaders from psychiatry who engaged multidisciplinary medical staff, were used within the inpatient medical surgical center for patients with identified behavioral risk. Weekly run charts with raw data measures of all staff injuries and "days between" OSHA recordable injuries were utilized to guide initiatives and measure outcomes. OSHA recordable injuries are injuries that require more than first aid. The run charts were annotated to reflect interventions tested and adopted across the chronological timeline of the initiative. The formal quality improvement initiative began June 2011.

Findings

Four months into formal quality improvement work, a drop in OSHA recordable injuries was first observed. Current data indicate a change from an average of 33 days between to an average of 168.5 days between OSHA recordable injuries. This reflects a significant reduction in severity of injury. Frequency of injury also noted an initial drop; however, the overall trend since the initiation of this work has been highly variable. This variability is impacted by increased injury reporting as part of an overall hospital safety initiative, and program growth that has dramatically increased the number of inpatient beds and record inpatient census. This data continues to inform ongoing work in this area.

Implications

The application of improvement science methodology to employee safety is in its infancy. This project reflects the utility of this methodology for systematically addressing employee safety that has a positive impact on both the organization and the patient. Employee safety initiatives are applicable across all healthcare agencies, regardless of the populations served. Benefits to the family include improving the patient and family experience, improving access to healthcare to reduce healthcare disparity for vulnerable populations, and reduction in length of stay for children with complex behavioral challenges. The reduction in OSHA recordable injury has resulted in improvements in employee satisfaction, a decreased need for medical intervention for employees, and reductions in lost time from work.

Learning objectives

Participants will...

1. be able to discuss how Quality Improvement Science can be applied to address employee safety in healthcare.
2. identify three interventions used to improve staff safety when working with individuals with behavioral challenges.

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Quality and Safety Education in Nursing: Core competencies to improve safety awareness in a BSN pre-licensure nursing curriculum with a global perspective

Poster

Lorraine Bormann
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Focus: Education and Training

Background

Pre-licensure BSN students were entering the nursing program unprepared for what to expect if they chose nursing as a profession and attrition levels in the beginning semester were unacceptable. Nursing faculty felt that students could use more understanding of the nursing profession and the workplace environment. Lack of understanding of the health care system and of a global perspective was also identified. A NURS 102 course was originally developed as a 3 hour lecture with critical thinking activities in the traditional classroom.

Project goals

The following goals were defined:

- 1) To develop a pre-nursing course to better prepare students for what to expect when choosing nursing as a professional career and the inherent workplace environmental hazards.
- 2) To implement a logically stepped approach to introducing concept-based Quality and Safety Education in Nursing (QSEN) into the NURS 102 Introduction to Professional Nursing course.
- 3) To include resources for teaching QSEN in the didactic and active learning classroom settings.
- 4) To increase student retention of information, gain deeper level of understanding, and to increase student motivation for learning.

Implementation

An Introduction to Professional Nursing course (NURS 102) for students not yet admitted to the BS nursing program was developed in 2010 to help students understand what to expect if they chose nursing as a profession and to improve factors thought to be related to success in the nursing program. NURS 102 became a required pre-requisite course in fall 2011 for all students applying for the BS nursing program. Nursing faculty felt that students could use more experiences with the realities of the nursing profession and the workplace environment. Lack of understanding of the health care system was also identified. All of these items were to be addressed in the NURS 102 course. The concept-based QSEN was adopted in fall 2012 with the expectation that students would have a better foundation to start the actual nursing program and the realities of the workplace environment.

Methodology

A literature review was conducted in spring 2012 that specifically evaluated the call for nursing education reform (Carnegie Foundation Report, 2010) and the NLN position statement on nursing education reform (NLN, 2003). The Quality and Safety Education in Nursing (QSEN) competencies align with the Essentials of Baccalaureate Education for Professional Nursing Practice (American Association of Colleges of Nursing, 1998). This laid the foundation to adopt the Finkelman/Kenner text: Professional Nursing Concepts: Concepts for Quality Leadership now in a second edition (2013). The QSEN competencies include 1) patient centered care, 2) teamwork and collaboration, 3) apply evidence based practice, 4) quality improvement, 5) safety, and 6) employ informatics.

Findings

As expected, the pre-nursing students report overwhelming satisfaction with the blended format of the NURS 102 course and reflect more positive scores in teaching effectiveness and course evaluations since implementation of the concept-based approach to teaching and learning. Students and faculty feedback are being used to further enhance the experience. To date, over 900 students have completed NURS 102. Evaluations have measured a trend of improving student learning outcomes. In addition, the QSEN competencies have been directly linked across the course curriculum in the BSN nursing program in both didactic and clinical settings. Students report greater understanding of professional nursing and the workplace environment and report greater awareness and confidence with safety awareness in the workplace.

Learning objectives

Participants will...

- 1) be able to describe the core competencies of Quality and Safety Education in Nursing (QSEN).
- 2) be able to evaluate the effectiveness of implementing QSEN core competencies in a BSN pre-licensure nursing curriculum.
- 3) be able to explain the signs of escalation in the workplace and strategies for de-escalation.

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Proposed measures to combat violence in Swedish occupational injury reports 1987, 1997 and 2007

Poster

Sofia Wikman

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Focus: Research

Background

One of the advantages associated with studying occupational injury reports is that they provide an opportunity to examine the views regarding preventive measures held by the victims themselves. In addition, they have also been collected for a long period, which allows us to examine whether there have been changes over time. The current study focuses on 1.400 reports from three specific years: 1987, 1997 and 2007.

Study objectives

The article's objective is to analyse the measures proposed by victims of violence themselves and to discuss changes over time. The following research questions are addressed:

1. How has the violence reported changed over time? Does the violence occur in new situations, and has the nature of the violence changed?
2. Has the view of the perpetrator changed?
3. What measures do the victims of violence propose in their occupational injury reports? Have the proposed measures changed over time?

Results and discussion

The results are presented in two stages: first in the form of quotes drawn from the occupational injury reports and second in the form a quantitative overview of the frequency with which different types of measures is proposed, and trends over time. The results suggest that measures relating to psychosocial factors and structural factors such as adequate staffing are much more important than surveillance, staff training, and penal sanctions.

The measures have been broken down into three distinct frames: the normalisation frame, the control frame and the deviance frame. The results shows that the staffs exposed to violence most often propose countermeasures from within the normalization frame with a focus on improving the psychosocial work environment. Irrespective of the type of risk situation that preceded the violent incident, the staff would prefer to see the problems resolved internally at the workplace, for example, by sitting down and talking through what happened with other staff members in the form of coaching sessions or debriefing. Time and again the staffs ask for resources in the form of the time and staff required to do the work.

Looking to the control frame, the violence problem is sometimes "resolved" by transferring responsibility to someone else, either by defining the patient as being too ill to be given care or as being responsible for his or her actions, despite the fact that the violence of these patients and clients is often only a case of them acting in accordance with their diagnosis or illness. Proposals involving countermeasures from the deviance frame in the form of repressive interventions on the part of the police and the justice system are uncommon.

This happens because people's firsthand knowledge of crime often contradicts the pictures painted by politicians and the media. The individual who is exposed to violence analyses the situation on the basis of a knowledge base that differs from that of those located further away from the sequence of events leading up to the incident and who have to develop their understanding of such incidents retrospectively.

Implications

This study may serve as providing an empirical example of a paradox. Although the objective of violence prevention today has considerable legitimacy and is also furnished with relatively substantial resources, we are at risk of completely failing to prevent violence as a result of having an overly simplistic understanding of the problem. To the extent that we lack both an analysis of the negative effects of social change on the prevalence of violence at work and any interest in using measures other than legal strategies focused on individuals, we risk finding ourselves in a situation where measures to combat threats and violence at work are restricted to a focus on personal interactions between staff and clients. What we are failing to address are the underlying factors that serve to structure the framework in which these interactions take place.

Learning objectives

Participants will...

1. be aware that an overly simplistic understanding of violence may produce paradoxical results.
2. realise that social change should be taken into consideration when investigating the phenomenon of violence in healthcare.

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Building frontline leader capacity in responding to violent incidents

Poster

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Focus: Guidance

Background

The British Columbia Nurses' Union (BCNU) represents more than 42,000 nurses and allied healthcare workers in the province. Violence is a significant workplace hazard for our members. Of the BCNU 2009 Cultural Survey participants, 86% have experienced verbal abuse and 61% have experienced physical violence. Eleven percent of accepted compensation claims in healthcare is attributable to violence.

Despite employer policy and procedures, a provincial violence prevention curriculum, guidance documents, and requirements of the Occupational Health and Safety (OH&S) Regulation for reporting, investigation, and implementation of corrective actions; under-reporting and appropriate follow up remains a challenge.

BCNU stewards are elected worksite leaders who assist members in addressing worksite issues. Stewards provide support to members who seek assistance about "what to do" following a violent incident. They also participate in investigations as worker representatives. To assist with their role in these activities, stewards requested a resource to guide them through the steps for supporting members immediately after an incident, and confirming appropriate actions are taken to ensure staff safety on the unit where the incident occurred.

Methodology

BCNU developed two post-incident checklists and an awareness poster, standardizing the stewards' approach to ensuring that investigations are completed, regulatory requirements are met, and that members receive the support they need, following a violent incident. The "member support" checklist prompts the steward to suggest options for facilitating completion of the following: referral to first aid, reporting requirements, and seeking counseling.

The "unit response" checklist assists stewards with verifying that appropriate follow up has taken place, including that care plan updates are communicated to staff, unit critical incident stress debriefing is provided, and an investigation is initiated. A poster was created describing appropriate steps for members to take after an incident of violence.

The poster correlates with the direction provided in the member support checklist. Five stewards are currently testing the resources at four urban acute care facilities in BC. Feedback has been collected through interviews and a focus group is planned for September 2014.

Findings

Stewards indicated the resources bridge OH&S workshop learning with practical worksite application. They reported increased confidence in their ability to handle situations. Stewards also noted that checklist helped them:

- stay focused during an emotional moment,
- work systematically,
- ensure items are not forgotten,
- focus on worker and patient safety,
- increase team communication and documentation,
- improve efficiency, and
- facilitate timely follow-up.

Discussion and conclusion

The project demonstrated successful implementation of resources that provide practical guidance to the individuals tasked with ensuring post incident follow-up and support. They will be distributed to stewards and incorporated into OH&S education. Building on this initiative, similar checklists will be developed on other OH&S topics.

Learning objectives

Participants will...

1. learn of practical resources that guide and standardize an approach to violent incident response
2. realize the importance of ensuring that investigations are completed, regulatory requirements are met, and that workers receive the support they need.

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The future is now: Changing the culture for a safe learning environment

Poster

Pamela Hutchinson

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Focus: Education and Training

Abstract

Creating a culture where students and faculty have a safe learning environment is imperative to the educational process for the next generation of professional nurses. Students must feel they have an environment where they are free to ask questions, learn from mistakes, and participate in a team based care environment. Clinical faculty must be full partners in healthcare environment, receiving both respect and resources from the healthcare team. Much has been done in the arena of education and training at this organization to create a culture for a safe learning environment for both students and nursing faculty. Examples of education and training include a comprehensive faculty orientation for new and returning nursing faculty, opportunities to network through the academic year, and inclusion in clinical education skills. Both Faculty and students are given full access to the organization's intranet as well as the EMR, with on-line modules to support the EMR specifics within the organization. Students are included in safe handoffs, bedside rounds, and family-centered care principles in the organization.

The QSEN (Quality & Safety in Education) principles have been presented to faculty and staff. A nursing grand rounds was presented on how staff can improve and partner with nursing students to achieve successful clinical experiences. An evidence-based handout was created on the "The Power of One" was distributed on the impact of mentoring nursing students. Student clinical cohort groups were reduced from 10 students per group to 8 in 2008 and now further reduced from 8 students per group to 6 per group in 2015. This reduction will further enhance a safe learning environment by allowing the clinical faculty to focus on fewer students at one time. With the implementation of the above mentioned strategies, student issues concerning medication safety, negative nursing perceptions of working with students and bullying, have decreased in the organization. Positive feedback is received from all faculty orientations as well as from the nursing grand rounds presentation. The feedback from the faculty orientation includes statements about making faculty more prepared to teach at the organization while empowering them to address relational aggression and bullying when as soon as it's perceived by the students.

Creating a culture for a safe learning environment has strong implications for nursing practice in the future because evidence demonstrates the positive impact of a safe patient care environment. Providing a culture where learning and education is valued and been made a high priority has supported the overriding goal of safe patient care at our organization. All of the above mentioned interventions could be easily successfully instituted at other organizations.

Learning objectives

Participants will...

1. appreciate that education and training helps create a safe learning environment.
2. appreciate that a safe learning environment positively impacts the safety of patient care.

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Workplace violence among nurse practitioners in the primary care setting

Poster

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Focus: Organisational

Background

Countries outside of the United States suggest that primary care settings may be vulnerable to workplace violence (WPV). In the United States, workplace violence is understudied among nurse practitioners (NPs), as well as among other primary care practitioners, but there is a complete absence of literature regarding NP experience with WPV in primary care in the United States. Data from the 2008 National Survey of Registered Nurses reveals that 32% of nurses in the United States report increased violence in their work settings, and that the problem is growing. Equally concerning is that WPV is often not reported, and nurses feel ill-prepared to deal with WPV. Consequences of WPV may include physical injury, in addition to psychological disturbances, burnout, and job turnover. With the growing number of NPs in primary care settings throughout the United States, understanding the extent to which workplace violence may exist is necessary to ensure that this vital group of practitioners is provided with the most useful and comprehensive education and other institutional supports to minimize the incidence and consequences of WPV. Using the Haddon Matrix as the theoretical framework, the study provides important information regarding incidence and frequency of WPV among NPs in primary care settings; host, agent, physical, and social environment factors associated with workplace violence in primary care settings; and the institutional supports reported by NPs to deal with WPV if it occurs.

Methodology

The study utilized an on-line survey using the Survey Monkey program. The survey was derived from the Workplace Violence in the Health Sector, Country Case Studies Research Instruments: Survey Questionnaire (Geneva, 2003). Full sections of this questionnaire included: personal and workplace data, physical workplace violence, psychological workplace violence, verbal abuse, healthcare sector employer, and opinions on workplace data. Subjects included all NPs who were members of the professional advanced practice nursing society of one state in the northeastern United States who self-reported working in primary care settings. Data were analyzed using frequencies, with chi-square contingency tables used to determine patterns regarding host, agent, physical, and social environment more frequently associated with either physical violence or verbal abuse in the workplace. Qualitative data provided by subjects provided additional supportive information regarding subjects' perspectives and experiences with WPV in primary care.

Findings

Forty out of 81 potential subjects returned completed surveys (49.38%). 22 (55%) reported experiencing or observing physical violence or experiencing verbal abuse in primary care settings. Although no clear patterns related to host or agent factors was evident, possibly due to sample size, the study revealed general deficiencies in the existence of and knowledge about workplace policies and their implementation.

Discussion and implications

The study provides evidence of WPV in primary care among NPs, and reveals an important deficit in the preparation of primary care NPs with regard to WPV training and policy development. Workplace violence does appear to exist in primary care settings among nurse practitioners. There is a lack of knowledge and deficiencies in institutional supports to prevent and deal with workplace violence in many primary care settings. As more care is provided by nurse practitioners in these settings, this area is important to include in nurse practitioner education and training programs, as well as workplace orientation and continuing education programs.

Learning objectives

Participants will...

1. learn of the prevalence of violence in primary care settings.
2. learn of deficiencies regarding the management of violence in primary care settings and possible measures to be taken.

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Disruptive behavior in the workplace with a focus on healthcare: A review of the literature

Practice

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Focus: Practice

Background

Workplace violence is one of the most complex and dangerous occupational safety issues for nurses in today's healthcare environment. Much of the literature on healthcare workplace violence focuses on nurse-patient violence. However, this literature review focuses on nurse on nurse violence also called: disruptive behavior, bullying, incivility, lateral violence, or horizontal violence. This review uses the term disruptive behavior (DB) for workplace violence because it is the term adopted for use by The Joint Commission (TJC, 2009). Rosenstein (2011) defined DB as any inappropriate behavior, confrontation, or conflict—ranging from verbal abuse to physical or sexual harassment—that harms or intimidates others to the extent that quality of care or patient safety could be compromised. TJC estimates that DB is related to around 70% of the sentinel events that occur in hospitals (2012). Workplace violence makes healthcare today an unsafe place to be for both the staff and patient.

Methodology

The nursing and medical research about workplace violence was reviewed for its appropriateness for inclusion in this review. The initial literature review identified 150 articles published between 2000 and 2012. The author reviewed these articles for their true relevance for this review.

Inclusion criteria

1. Nurse on nurse violence, 2. workplace violence, 3. impact of DB on healthcare workers, 3. DB prevention. 4. causes of DB. The final review yielded 35 journal articles which discussed at least one of the inclusion criteria.

Findings/Implications

1. U.S. employment law provides little protection for workers experiencing DB.
2. The causes of nursing DB are not well studied. What has been reported as probable causes of DB are communication problems, oppression theory, a history of organizational tolerance for DB, nurse workload and an overall difficulty in addressing behavioral rather than clinical problems.
3. The impact of DB amongst nurses ranges from feelings of stress and frustration with coworkers, to impacting patient safety and mortality, to increasing healthcare costs. The serious consequences of DB create urgency for finding ways to decrease DB.
4. Innovative educational strategies to address DB are lacking. Most nurses report no training on DB. Nursing students also need education about ways to decrease DB prior to their entry into practice. Providing education to increase awareness of DB and training on how to improve communication skills from nursing school throughout a nurse's career may decrease DB.
5. To date, effective interventions to decrease DB have not been identified. Appropriate DB management techniques need to be taught to healthcare organizations to begin addressing this healthcare issue.
6. It is time to stop describing the problem. Nurse researchers need to turn to developing and providing effective interventions to prevent DB.

Learning objectives

Participants will...

1. Be able to identify 3 causes of violence in the nursing healthcare workplace.
2. Be able to compare and contrast interventions used to decrease violence in the nursing healthcare workplace.

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Chapter 4 - Evidence of threats to security

In harm's way: The impact of workplace aggression in Australian clinical medical practice

Paper

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Perspective: Research

Keywords: Aggression, medicine, well-being, workforce participation intentions

Introduction and background

Workplace aggression has been shown to be a major concern in health care work (1-3), but only a limited body of significant research on the prevalence, predictors or impact of workplace aggression in medical practice, internationally, has been published in the peer-reviewed literature. While many health service organisations in Australia have well established workplace incident reporting and data management systems, workplace aggression has been considered to be grossly underreported by health workers (4-5). As a consequence, the most reliable data on the prevalence, predictors and outcomes of aggression in health care are likely found in the research literature.

A small number of studies have found that workplace aggression is prevalent in Australian clinical medical practice (6-10). While most Australian studies have focussed only on patient aggression or aggression in general practice settings, the first national study of workplace aggression in Australian clinical medical practice investigated aggression from all sources and in all clinical medical practitioner sub-populations. Overall, 70.6% of clinicians experienced verbal or written aggression and 32.3% experienced physical aggression in the previous 12 months, with the younger and primarily hospital-based clinicians being at greatest risk of exposure (6). Patients were identified as the most common source of aggression, followed by aggression from patients' relatives or carers and then co-workers (6).

A range of risk and protective factors for workplace aggression exposure in Australian clinical medical practice were identified. In logistic regression modelling, workplace aggression exposure was found to be being positively associated with clinicians who have a greater external control orientation, and experiencing more challenging work conditions and patient concerns (11). Importantly, key aggression prevention and minimisation factors were identified as being protective for workplace aggression exposure. For example, the presence of optimised lighting, noise levels, comfort and waiting times in patient and public waiting areas was negatively associated with aggression from patients and their relatives or carers, and verbal or written aggression from co-workers, while the presence of incident reporting and follow-up systems was negatively associated with physical aggression from patients and their relatives or carers (11). In addition, the presence of five or more prevention strategies was negatively associated with verbal or written aggression and physical aggression from patients, and the presence of seven or more prevention strategies was negatively associated with physical aggression from patients' relatives or carers and verbal or written aggression from co-workers (11).

Few studies have investigated the consequences of workplace aggression for medical clinicians, and most have focussed on the impact of exposure to patient aggression only (12). Workplace aggression has been reported as leaving clinicians feeling vulnerable or inadequate (13), losing confidence or enthusiasm for treating patients (14-15), and experiencing diminished job satisfaction and greater psychological stress compared to those not exposed (16). General Practitioners have reported restricting patient access to services, including by raising consultation fees or refusing to take new patients, and in the partial or complete withdrawal of after-hours services, as a result of aggression-related apprehension (17-18). There has been little research conducted on the differential impact of workplace aggression from internal sources (co-workers) as compared to external sources (patients, patients' relatives or carers and others).

Methods

This cross-sectional study was a component of the third wave of the Medicine in Australia: Balancing Employment and Life (MABEL) longitudinal survey, conducted from March 2010 to June 2011. Self-report data were provided by a representative sample of 9449 Australian General Practitioners, Specialists, Hospital Non Specialists and Specialists in Training on the frequency of verbal or written and physical aggression experienced in the previous 12 months from patients, patient relatives of carers, co-workers and others external to the workplace (6), and a range of personal profile and work-related variables (11). Survey participants also provided data on job satisfaction, satisfaction with life in general and self-rated health, as well as their intentions to reduce their clinical workload in the next five years, leave patient care within five years or leave medicine entirely within five years. Associations between internal and external workplace aggression exposure, and each of intrinsic job satisfaction, satisfaction with life in general, self-rated health and the three workforce participation intention variables, were determined in logistic regression modelling.

Results

In fully adjusted models (controlling for personal and professional profile, work-related and patient-related variables), exposure to workplace aggression from both internal and external sources was associated with greater intrinsic job satisfaction, satisfaction with life in general and self-rated health, and positively associated with a greater likelihood of intending to leave patient care in the next 5 years. Only external aggression was associated with a greater likelihood of intending to reduce clinical workload and only internal aggression was associated with a greater likelihood of intending to leave medicine altogether in the next 5 years.

Conclusions

This study of Australian medical practitioners provides important evidence that workplace aggression from internal and external sources is a highly negative experience for medical clinicians. Exposure to aggression from external sources, across the multivariate models, was consistently negatively associated with well-being, and clinicians feeling more likely than those not exposed to reduce their clinical workload in the next five years or leave patient care within five years. The outcomes highlight the potential risk of aggression from patients, their relatives or carers and other persons external to the workplace, both to clinician well-being and to community access to medical care, through subsequent clinician decisions to reduce or eliminate their clinical workload. This study also highlights the potential risk both to clinician well-being and to community access to medical care when clinicians are subjected to aggression from co-workers. Furthermore, there is the potential for the risks to be professionally terminal, with significant cost to the community when highly trained clinicians decide to leave their profession altogether.

Workplace aggression in clinical medical practice is an important professional and public health issue, and one that is shared with other health providers, especially nurses (1, 19-21). With the aging of the health workforce and the growing reliance on international medical graduates, both in Australia and the rest of the developed world, a failure to address this important occupational health and safety concern may lead to ongoing challenges in recruiting and retaining medical practitioners, especially in less populated regions and other areas of need. The results of this study provide important information for legislators, policy makers, health services and the medical profession, particularly in terms of the need to more effectively prevent and minimise workplace aggression and its consequences in clinical practice settings. This may ensure both a safer environment for clinicians and service users, and adequate access to medical care into the future.

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Learning objectives

Participants will.

1. recognize that workplace aggression is a common feature of clinical medical practice, and is a significant professional and public health issue.
2. recognize that workplace aggression can impact adversely on clinician health and well-being, and workforce participation intentions.

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Psychological and work functioning among workers in the health care sector experiencing serious violent acts: Are there sex differences?

Paper

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Perspective: Research

Background and context

Workers from the health sector are at a particularly high risk of facing workplace violence because their duties involve different risk factors such as contact with the public, particularly with people who are emotionally distressed or unstable. However, very few studies have explored the frequency with which “severe violent acts” (SVA; e.g., being a direct victim or a witness of physical or sexual assault, death or injury threats, etc.) occur.

Methodology

This study was carried out as a web survey between January 2011 and October 2012. It sampled 602 workers from the health and social service sectors within the province of Quebec in Canada. These included managers, health care professionals, nursing staff, and administrative workers. The questions asked were related to acts of violence they might have been victims of or witnessed during the past 12 months and their repercussions.

Findings

This survey confirmed that workplace violence is indeed a problematic reality to be reckoned with in these sectors: 76% of workers surveyed said they had been victims and/or witnessed different types of workplace violence during the past 12 months, with a mean of 14.5 acts during this period of time. The results indicate that the number of men who were victims of or witnesses to violent acts, or both, was proportionally higher than that of women (86 % vs. 72 %). This study focused particularly on the 162 respondents (27%) who reported to have been exposed to SVAs. The most frequently reported SVA were those in which workers were victims of (31%) or witnesses to (36%) physical violence, followed by death threats (victims 7%, witness 6%). Victims of and witnesses to SVA at work reported to suffer from similar repercussions. Men and women reported the same types of repercussions but in different proportions. Thus, while irritability affected both men and women (50%), more women than men reported having experienced hypervigilance (56% vs. 37%), avoidance (45% vs. 28%) and difficulty concentrating (41% vs. 25%). Violence can also have repercussions on work functioning. Among workers exposed to at least one SVA during the past 12 months, the majority of respondents (49%) reported having experienced no consequences at work in relation to the most disturbing event. However, this proportion was greater for men (60%) than women (39%). The result most often mentioned for both men and women was a decline in productivity (15% men; women 25%), followed by absences for men (13%) and a work leave for women (17%). Analysis of the data collected in this study confirmed that violence in the workplace is a major issue for workers in the health and social services sector. Contrary to popular belief, this violence does not only affect victims, but also witnesses, as indicated by the various repercussions reported in the results of this survey. Proportionally, more women than men exposed to SVA are negatively affected by SVAs.

Implications

Future studies should document the impact of SVAs in the long term. These studies should also look at the reactions and needs of men and women who are victims of or witnesses to this type of violence as our results clearly show differences between the two sexes.

Learning objectives

Participants will...

1. appreciate that workers in the health care sector experience several types of violence from patients, including severe acts of violence.
2. recognize that witnessing severe acts of violence leads to similar psychological repercussions as being a direct victim of them.
3. Realize that severe acts of violence can affect men and women differently.

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The Syrian Crisis and its impact on pharmaceutical access

Poster

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Perspective: Research

Background and context

We explore what impact the Syrian conflict has had on the health of the Syrian population primarily through the lens of pharmaceutical access. The violence of the civil war in Syria has obviously had a hugely negative impact on the health and well-being of the population and the health infrastructure generally, and as part of this, the pharmaceutical system, in the Syria. Public health in Syria is facing huge burdens caused by an increased number of conflict-related acute injuries requiring treatment in a crippled healthcare system, a shortage of health professionals, a lack of access to medicines due to a severe reduction in the domestic production of pharmaceuticals and disruptions to the supply and distribution system, and economic sanctions that will likely lead to increased suffering for the population. Health personnel in Syria have become politicized and are targets of the war. As a result, they are often unable to work for risk of death, injury or of being kidnapped.

Methodology

Given that the Syrian Civil War is ongoing, we relied heavily on grey literature and media reports, in addition to peer reviewed academic publications, to provide preliminary insights into the pharmaceutical system challenges in Syria.

Findings

The long term impact of this civil strife on health in Syria is unknown but the current situation suggests huge challenges ahead. We believe that effective interventions will include resupplying and maintaining the supply of human resources by providing security and safety to healthcare workers (especially in primary care) to continue to provide impartial care to the wounded and ill in Syria; filling the increased immediate demand for medical supplies while tailoring strategies for long-term supply; securing the transportation and distribution chain of medical supplies and pharmaceuticals where feasible throughout Syria; and reducing the risk of falsified pharmaceutical products entering Syria due to lack of quality control regulation, the potential for opportunistic suppliers engaged in war-profiteering behaviour, and porous national borders. Long-term reconstruction of the healthcare system will require significant and sustained international support and a coordinated effort focused on primary level care for chronic and major public health problems.

Implications

Using lessons learned from past conflicts in Kosovo, Iraq, and Afghanistan, policymakers in the international community should be encouraged to understand what interventions work best to help bring back health to the population.

Learning objectives

Participants will...

1. understand the impact of conflict and violence on the health of the Syrian population.
2. understand the challenges of healthcare provision during the conflict.
3. will be able to gain knowledge from lessons learned from past conflicts in Kosovo, Iraq, and Afghanistan, understand what interventions work best to help bring back health to the population.

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Violence, mental disorders and the health care system in the United States: 1950-2014

Paper

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Perspective: Policy

Violence is a critical issue in 21st century general health care systems in the United States. Over the last sixty years, the mental health care system has failed to provide adequate services for people with severe mental disorders and substance abuse disorders. One of the major reasons for this is the failure of the mental health system to adequately address the fundamental relationship between violence and mental disorders. This paper will review the relationship between mental disorders and intentional injuries over the last sixty years using a public health perspective.

This perspective is clarified in the World Health Organizations' (WHO) World Report on Violence and Health, 2002 that defines violence as: "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation." (1) The three main categories of violence are self-directed, interpersonal and collective. This paper will address the relationship between mental disorders and self-directed and interpersonal violence (violence towards others) focusing on three major issues:

The first section will examine the relationship of types of mental disorders to violent behavior to self and others as well as the contemporary clinical assessment and management of violent behaviors. The second section will examine three major reasons for the minimization of the relationship between violence and mental disorders. In the third and final section of this paper, the consequences of the failure of mental health systems on the general health care system will be examined.

Section I

In the fifth edition of the Diagnostic and Statistical Manual (DSM-5) of the American Psychiatric Association, a Mental Disorder is defined as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning." (2)

Many of the symptoms of mental disorders are so severe that they affect how a person performs in the world around them. Thus, these severe symptoms – cognitive problems, psychotic symptoms, mood swings, depression, anxiety, anger, impulse control problems, obsessions and compulsions- can be associated with problems forming relationships; problems obtaining and keeping employment; problems providing for the necessities of life like food, clothing, shelter and medical care; as well as destructive behaviors towards self or others. (3,4)

The severe psychotic mental disorders have always been associated with violence towards self and others, but they have historically been fairly rare and their total contribution to societal violence has been minimal. In the textbooks of psychiatry in the 19th and early 20th centuries, a primary concern of the severe psychotic disorders was violence towards self and others. In 1892, it was estimated that 22% of people with severe mental disorders had violent tendencies. (5) Before deinstitutionalization, long-term hospitalization was the primary management for people with severe mental disorders and violent behaviors.

In final third of the 20th century, however, the number of mental disorders expanded significantly into non-psychotic disorders including substance abuse disorders like intoxication. The major reason that mental disorders have become intimately associated with the majority of all societal intentional injuries is the dramatic expansion of the DSM from the first edition in 1952 to DSM 5 in 2013 and the subsequent exponential increase in numbers of non-psychotic mental disorder diagnoses, especially substance abuse disorders. (2)

All mental disorders have an increased risk of suicide especially the mood disorders and the substance abuse disorders. (6) Violent behavior towards others is associated with symptoms of anger, revenge, paranoia, hallucinations, impulsivity, mood swings, cognitive impairment, depression, mania, shame, severe anxiety and sadistic impulses. All psychiatric disorders increase the risk of violence towards self and others to varying degrees with the vast majority of disorders being associated, primarily, with an increased risk of violence to self. (4,6,7,8)

Studies over the last thirty years have clearly shown the increased risk of violence towards self or others in most of the mental disorders. A summary for the severe mental disorders follows: "The results of the present

investigation concur with those from other studies of subjects born after World War II, and treated in an era when mental health services consisted of short periods of hospitalization, anti-psychotic and antidepressant medications, and services in the community of varying kinds and intensities. . . . numerous studies of patients discharged from psychiatric wards into the community and assessments of mental disorder among convicted offenders all support the conclusion that persons who will develop major mental disorders or who already have these disorders are more likely than non-disordered persons to commit crimes and crimes of violence.” (9)

Substance abuse, extremely common in many mental disorders, increases the risk of violence towards self and others in any diagnostic category. For example, in the influential MacArthur Study (10) the one-year rate of violence towards others in the Major Mental Disorder group without substance abuse was 17.9%. When substance abuse was added to this group the violence rate nearly doubled to 31.1%. In the Mental Disorder, Substance Abuse Group that included the non-psychotic mental disorders, the violence towards others rate in a year was 43%. Other significant findings included that physical abuse as a child was highly associated with violence towards others after hospital discharge. Those with the most intense level of abuse were generally the same patients who committed the most violence. In this study, 66% of patients committed a violent act causing injury or an aggressive act without injury in the year after hospitalization.

The societal management of violence is accomplished primarily through both the mental health system and the correctional system. The transformation of jails and prisons into long-term mental health facilities has been shown in numerous studies published since the 1990s. The failure of the mental health system is clearly reflected in the huge numbers of incarcerated mentally ill patients. In 2012 there were 356,268 inmates with severe mental illness in jails and prisons compared with 35,000 patients in state hospitals. (11) A 2009 study showed that the prevalence of severe mental disorders in jails was 3 to 4 times that of the general population's. (12)

The actual practice of psychiatry requires the clinical assessment of the risk of violence. (4,8) The clinical finding of imminent risk of harm towards self or others carries clear clinical and legal expectations. Each state in the United States has laws that address the issues of violence and mental disorders and describe the requirements needed for involuntary commitment. People with imminent risk of harm are generally hospitalized either voluntarily or involuntarily. Thus the assessment of violence risk drives placement and treatment. In terms of treatment; medications, therapy, case management etc. are all utilized to decrease the intensity of symptoms associated with violence risk such as psychosis, mood swings, anger or depression. For voluntary treatment in hospitals, managed care companies authorize payment based on the violence risk assessment both before hospitalization and during hospitalization.

Acute symptoms associated with violence are only half of the clinical equation in violence management. The other half is the chronic symptoms such as treatment resistant depression and psychosis or permanent cognitive dysfunction. If not treated and managed appropriately these conditions can and do result in violence towards self and others. Assessing, managing and minimizing these types of behaviors by controlling the symptoms associated with them is what the clinical practice and history of psychiatry is all about.

Section II

The minimization of the relationship between violence and mental disorder has three reasons. The first reason was a series of misinterpreted research studies from before the 1960s that seemingly proved that mental disorders were not associated with violence towards others or criminal behavior. (13) These studies were extremely influential during the early decades of deinstitutionalization in redefining the relationship between mental disorders and violence towards others. Influenced by these early studies of discharged patients from state hospitals, violence was redefined as injurious behavior directed towards other people not directed towards oneself. Separating suicide from homicide was one of the first major steps in the minimization of the relationship between violence and mental disorders. Suicide is unequivocally an intentional injury. It is an act of violence.

There are no histories explaining why this separation occurred, but it is likely that the momentum that was building to empty the state hospitals of their huge population resulted in the question: What would the violent impact be on society by releasing hundreds of thousands of patients into the community who essentially had been treated in locked up settings for years? The major concern became not suicide but the risk of homicide and criminal behavior.

The handful of studies – mentioned above - conducted in the 1920s to the 1950s on discharged patients and criminal behavior became relevant as they had asked this question and found that most patients who were discharged or paroled from state hospitals had a lower rate of criminal arrests and of violent behavior than the general population. The following quotation is reflective of the interpretation of these studies: “Actually it has been demonstrated that the incidence of crimes of violence (or any crime) is much lower among former mental patients than in the general population.” (14) Because these early studies were greeted as scientific proof that mental disorders were not associated with violent behavior towards others, they were used to both accelerate the closure of state hospitals and to change the involuntary commitment statutes. The belief that people with severe

mental disorders were less violent than people without a mental disorder accelerated the exodus of people with mental disorders from state hospitals and discouraged the use of psychiatric hospitalization.

The second reason for the minimization of the relationship between violence and mental disorder was that the anti-psychiatry movement beginning in the 1960s inverted the relationship between patient and provider. Rather than see the history of psychiatry as a history of a component of the medical profession addressing the behaviors of severe brain disorders that included violent behaviors towards self and others, psychiatry was transformed into the part of the medical profession that supposedly both enslaved and tortured patients. The psychoanalyst Thomas Szasz was the person most responsible for this development. In a series of books beginning in the 1960s he conducted an unrelenting attack on psychiatry. (15,16) He argued that mental illnesses do not exist. These non-existent illnesses were created by psychiatrists to imprison and torture individuals who “have problems with life”. Involuntary treatment, especially hospitalization, was a human rights violation directly comparable with the Nazi treatment of Jews. He believed psychiatrists caused patients to become violent by taking away their rights, hospitalizing them, giving them bad drugs and torturing them. His writing tremendously influenced the other anti-psychiatry camps, helped to alter the legal landscape of treatment and questioned the legitimacy of mental disorder diagnoses.

Szasz’s influence on blaming violence associated with people with mental disorders on psychiatrists and the mental health system remains today. This is seen in the 2014 policy statement of the National Alliance on Mental Illness (NAMI). (17) “NAMI’s public policy platform recognizes that most acts of violence or dangerous acts by people affected by mental disorders are the result of mental health systems’ treatment failures.” It is important to note that when it comes to suicide NAMI and the majority of the research literature state that over 90% of people who commit suicide have a mental disorder. (6) The mental disorders associated with suicide, especially substance abuse, are the same disorders associated with violence towards others. Rather than acknowledge the association of mental disorders with violence towards others NAMI labels these people with mental disorders and aggressive behaviors “mental health system treatment failures”.

The third reason for this minimization of violence is to minimize the costs by payers of mental health services for comprehensive psychiatric services that would reduce the risk of violent behavior. The contemporary payer model is primarily a managed care model. (18,19,20) This model emphasizes care in the “least restrictive setting”—a complex euphemism that emphasizes human rights issues of maximizing choice on the one hand and on the other discourages expensive psychiatric hospitalization and other expensive treatments with the goal of minimizing expenditures and maximizing profits.

Psychiatric hospitalization, supervised housing, residential substance abuse treatment, supported employment programs, day programs, intensive outpatient programs and Assertive Community Treatment are proven methods of increasing compliance with treatment and decreasing violent behaviors. (21) These levels of care are expensive. Managed care payers provide only fragmented levels of these types of intensive community care. In essence, by limiting hospitalization, by not paying for a wide variety of evidenced based programs for the severely mentally ill, managed care increases the risk of violent behavior. Violence, a central risk factor in mental disorders, is minimized by payers in order to save money.

Section III

The combination of the near total emptying of long term state hospitals and the exponential expansion of mental disorder diagnoses has made the issue of violent behaviors associated with mental disorders not only a central concern of psychiatric and mental health systems but also of first responders, emergency room departments and general hospitals. All are significantly involved in the violence management of people with mental disorders. Violence is four times more common in health care settings than in other industries. (8,22,23)

Emergency departments have been transformed in the last thirty years into front line receiving facilities for people with mental disorders who are in crisis. It is estimated that in psychiatric emergency room visits in the United States 20% to 50% might involve patients who are agitated. (8,22,23) Agitation – excessive verbal and physical activity – is a common precursor to violent behaviors. Agitation is extremely common in crisis situations of most psychiatric disorders. In the general hospital, the emergency department is probably the highest risk place for violent behavior. This transformation of Emergency Departments of medical centers into receiving areas for psychiatric patients is reflected in emergency departments’ significant rise in assaults directed towards their staff. Patients with repeated suicide attempts or threatening behavior towards self or others are now the bread and butter of the Emergency medical and psychiatric system with none of these repeaters ever going into long term inpatient care because it simply does not exist.

Intensive Care Units often provide medical services for people with deliriums or status post suicide attempts. Chapters in Intensive Care Unit textbooks include sub-sections on all psychiatric medications and most illegal substances since overdoses have become so common. (24) Code Grays – a term used in some medical facilities to alert security to a violent patient – are common on the floors and emergency rooms of general hospitals. Discharging patients with combinations of severe medical disorders and mental disorders has become very problematic because of the lack of step-down facilities that will take them. Many are simply discharged to their families who are overwhelmed with caring for complex, unstable mentally and medically ill patients.

Conclusion

Mental disorders are intimately associated with intentional injuries: violence towards self and violence towards others. Nearly all the mental disorders increase the risk of violence towards self and others with specific diagnostic categories such as the non-psychotic externalizing disorders having a particular risk of increasing harm to others. (2) The exponential increase in the non-psychotic mental disorders has significantly increased the total societal impact of these disorders on total societal violence towards self and others. The minimization of the relationship between violent behaviors and mental disorders has resulted in a failed mental health system which is extremely fragmented and funded by payers who fail to provide the necessary services to assist in managing violent behaviors in the community. The inadequate services for the adult mentally disorder population has directly resulted in overwhelmed Emergency Departments and first responders in particular and medical health systems in general. The increase in violence directed towards health care workers is directly related to the failure of a comprehensive mental health care policy and programs in the community.

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Learning objectives

Participants will...

1. appreciate that mental disorders, especially substance abuse, and their inadequate community based management are a major contributing factor for the violence in the general health care system.
2. Learn that violence in the health care system cannot be adequately addressed without addressing the fundamental problems in the mental health care system.

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Bullying: Lateral or horizontal violence experienced by nurses

Poster

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Perspective: Organisational

Background and context

Workplace bullying occurs mainly in many professions and workplaces including nursing. In nursing literature, workplace bullying is often called as lateral or horizontal violence. Bullying is a common concept that is described as situations in which an individual is persistently treated in abusive manner over a period of time, with a feeling of not being able to counterattack or defend him or herself against the abuse. The common behaviors of bullying include but not limited to sabotage, infighting, scapegoating and excessive criticism. The purpose of this article is to examine available nursing literature on workplace bullying, to develop an understanding of scope of this issue in order to identify possible solutions.

Methodology

Comprehensive literature review was carried out to explore the scope of bullying amongst nurses. Approximately 42 articles from last 10 years were retrieved through extensive searching, manual data extraction from periodical and electronic databases were accessed including Google Scholar, Elsevier (Science Direct), Research Online, Pubmed using MeSH terminology, CINAHL, journals and chapters on bullying amongst nurses. Two review authors independently assessed research article quality and extracted data.

Findings

Literature evidently highlights that workplace bullying amongst nurses is a common phenomenon yet complex in nature and it exists in at all levels in nursing. It can be comprehensively understood by considering individual, societal and organizational factors, norms and practices. There is negative impact on physical, psychological and emotional wellbeing of nurses that has experienced bullying at their workplace. Beside impact on wellbeing it has also shown that the performance of those nurses that have experienced bullying is greatly affected resulting in decreased positivity, less work motivation, inability to concentrate, diminished productivity, non-retention, lack of commitment to work, poor relationship with patients, supervisors and colleagues. Literature also suggests that bullied nurses had significantly higher levels of emotional exhaustion, lowered levels of mental health and depression as compared to non-bullied nurses.

Implications

The phenomenon of bullying has important implications for nursing research since it is a critical issue and not much has been done to investigate strategies that might help overcoming this issue. It is suggested that effort at individual and administrative level is required to decrease the incidence of bullying. Nurses in leadership position need to focus on reasons of occurrence of bullying and identifying ways to reduce it. They should be aware that bullying is preventable by ensuring fair system implementation. There is strong need that the Nurses who have experienced workplace bullying needs to identify ways to address this issue at their level. Ultimately the role of organization is central to reduce bullying. However, further investigation is needed on this issue to identify effective strategies especially in context to developing countries where health care delivery structure has many loop holes.

Learning objectives

Participants will...

1. will be able to examine available nursing literature on workplace bullying.
2. will be able to develop an understanding of scope of this issue and identify possible solutions.

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The experience of workplace violence among nurses in general hospitals in southeast Nigeria

Paper

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Perspective: Practice

Introduction

Workplace violence is a recognized hazard of working in the health professions and especially among nurses (Kingma, 2001; Hegney, Plank, and Parker 2003; Gerberich et al, 2005). The presence of nursing personnel in various sections of the hospital where distressed patients receive care increases the chances of their exposure to abuse and other forms of aggression from patients and their relatives (Kwok et al, 2006). Contextual factors like staff shortages, long waiting times, being attended in overcrowded settings, stress arising from various sources and certain patient and staff characteristics contribute to the occurrence of these phenomena.

The experience of violence in the workplace impacts negatively on the quality of care, health and wellbeing of staff, and their overall productivity (Gates, Fitzwater, and Succop 2003). The emotional toll of workplace violence on staff is considerable. International studies have documented the experience of burnout, anger, fear and frustrations by staff (Oweis and Diabat, 2005) decreased morale, and dissatisfaction with the job, and diminished quality of life among affected personnel (Gerberich et al, 2004; Hesketh et al, 2003).

Sometimes some individuals quit the nursing profession on account of experiences of workplace violence (Sofield and Salmond, 2003). Problems in clinical communication, inattention, and impaired concentration and effects of anger and other emotional reactions on the part of the staff result in errors of judgment (van der Linden, Keijsers, Eling, and van Schaijk 2005) mistakes in care, negative and uncaring attitude towards patients, all of which could contribute to negative care outcomes experienced by patients and resultant client dissatisfaction with services (Farrell, Bobrowski, and Bobrowski 2006; Janis 1993).

Even though, this is a very important occupational health issue, there is a dearth of documentation on the extent of workplace violence among nurses in southeast Nigeria.

Aims

The aims of this study were:

1. To determine the frequency of workplace violence experienced by nurses in south east Nigeria.
2. To describe the psychosocial correlates of experiencing workplace violence.
3. To determine the demographic characteristics of individuals who experienced workplace violence, and
4. To examine the effect on organizational perception of experiencing workplace violence.

Methodology

This cross sectional study was carried out among nurses working in two teaching hospitals located in southeast Nigeria. Practicing nurses who had worked for at least one year were invited to participate in the study. Although we surveyed 420 nurses working in Abakaliki and Parklane teaching hospitals, we were able to retrieve 380 questionnaires in various stages of completion, and of these, only 358 could be analyzed because they were completely filled. This gives a final response rate of 85.2%. Only participants who had qualified as nurses for longer than one year were included in the survey. The participants were recruited through their unit heads who invited them to participate on the basis of their availability and willingness to participate in the survey. The participants were assured of confidentiality and of the anonymity of their individual responses, and informed consent was obtained from each of the participating nurses.

The data collection was undertaken by means of semi-structured questionnaire designed by the investigators following a review of the relevant literature. The questionnaire was self-administrated and sought to elicit data on the different facets of the experience of workplace violence within the preceding 12 months, including whether the violence was of the physical or psychological type, and the socio-demographic characteristics of the participants. In addition, we used structured and validated psychometric instruments like the Centre for Epidemiologic Studies Depression Scale (CES-D), 5-item version (Radloff, 1977; Bohannon, , Maljanian, Goethe 2003), provided data on depression; the Emotional Strain Scale (Caplan, Cobb, French, Van Harrison, and Pinneau 1980) to collect data on the extent of psychosocial experiences, anxiety and irritation, among the staff. Furthermore, data on the organizational perception of the individuals who had experienced workplace violence were collected using selected questions aimed at understanding the work environment, emotional climate and extent of worker satisfaction.

The statistical analysis was performed using SPSS statistical software (version 20). Descriptive statistics were provided as well as using the Chi squared test for comparison of proportions and t test or ANOVA for comparison of means. The level of statistical significance was set at $P < .05$.

Results

Males constituted only 18.4% of the 358 nurses and the mean age of the participants was 3.4 ± 7.9 years (Range 19.0 – 60.0 years) Also, 67.3% were married and 23.2% had bachelors degree in addition to their R.N. certificates whereas the remaining (76.80/0) had R.N. qualification only. The mean duration of working as nurses was 9.3 ± 6.7 years, whereas the mean duration of working in the respective institutions was 6.0 ± 5.4 years.

The reported frequency of physical violence was 9.8% (35 of 358) in the preceding 12 months whereas that of psychological violence was 42.5% (152 out of 358). Patients accounted for the perpetration of most cases of physical violence (65.7%) and their relatives were involved in 17.1%. Co-workers accounted for the rest (17.20/0). On the other hand, patients accounted for 46.7% of the psychological abuse, their relatives 28.9% and members or staff 24.3% (co-workers, supervisors and management).

The experience of physical violence was associated with younger age of staff ($p < .05$), shorter duration of working as a nurse ($p < .05$) and shorter duration of affiliation with the institution where the staff works ($p = .012$). Being located in the emergency and in-patient departments was associated with victimization with respect to physical abuse, but this relationship fell short of statistical significance ($p = .160$). On the other hand, the experience of psychological abuse did not show any significant statistical relationships other than the setting of work; it was more prevalent in the in-patient location ($p = .016$).

The impact of the experience of workplace violence on the adaptive functioning of the staff was also explored in this study. Individuals that had experienced physical violence had higher anxiety scores (mean = 8.29 ± 2.32 versus 7.49 ± 2.04 ($p = .031$)), higher depression scores (mean = 8.34 ± 2.99 versus 7.24 ± 2.54 ($p = .017$)), but similar irritation scores (5.63 ± 1.80 versus 5.57 ± 1.92 ($p = .862$)) in comparison with the individuals who had not experienced physical violence. On the other hand, no statistically significant differences were found between individuals who had experienced psychological abuse in respect of anxiety, depression, and irritation scores and those who had not experienced it.

There appeared to be some association between the experience of workplace violence and the staff perception of the working environment. For instance, a higher percentage of individuals that experienced psychological violence disagreed with the statement, "Reports of workplace violence from other employees are taken seriously by management," than those who had not experienced it (49.5% versus 34.1% ($p = .003$)). Similarly, 50.5% of the individuals that had experienced workplace abuse versus 33.3% of those who did not experience it, disagreed with the statement, "Management in this organization quickly responds to episodes of violence among staff," ($p = .001$). In relation to victims of physical violence, similar percentages of the victims and non-victims (9.8% each) disagreed with the statement, "Reports of workplace violence from other employees are taken seriously by management." On the other hand, 13.2% of the victims of physical violence versus 6.0% of the non-victims disagreed with the statement "management in this organizational quickly responds to episodes of violence among staff," ($p = .022$).

Related to this, 10.8% of the victims of physical violence versus 7.3% of the non-victims disagreed with the statement, "In general, I don't like my job." ($p = .304$). Whereas 18.1% of the victims of physical violence versus 6.3% of the non-victims disagreed with a related statement, "All in all I am satisfied with my job," ($p = .001$). Also 18.8% of the victims of physical violence versus 7.0% of the non-victims expressed disagreement with the statement, "My colleagues at work sympathize with me when I am in a difficult situation," ($p = .001$).

The percentages for victims versus non-victims of psychological abuse were 41.8% versus 44.0% ($p > .05$) for disagreeing with, "In general, I don't like my job," 47.6% versus 40.3% ($p > .05$) for disagreeing with, "All in all, I am satisfied with my job," and lastly, 56.5% versus 38.1% for disagreeing with, "My colleagues at work sympathize with me when I am in a difficult situation," ($p = .003$).

Discussion

The extent of workplace violence observed in this study (9.8% for physical violence and 42.5% for psychological abuse) is high and quite consistent with the findings of similar studies in the developing countries.

Patients and relatives are the perpetrators of most cases of workplace violence, even though the co-workers, supervisors, and management are also significant contributors to the problem. These findings agree with the thrust of the established pattern of observations in other work settings.

The variables that were associated with workplace violence in this study were younger age of the staff, shorter duration of nursing experience, and shorter duration of affiliation with the respective institutions. In addition, working in the in-patient setting showed some degree of clustering of cases of violence. Unlike the findings

from other parts of the world, there was no significant association between workplace violence and gender, marital status and being located in the outpatient department.

The experience of workplace violence impacted on the mental health and wellbeing of the staff victims. This is evidenced by the significant interactions between being a victim and scoring higher on anxiety and depression scales. This is concordant with the findings of several international studies. The absence of significant interactions with respect to the irritation scale is rather surprising and counter-intuitive. It is also noteworthy that being a victim of workplace violence is associated with negative perception of the work climate, the management and even diminished levels of satisfaction with one's job. All these are congruent with the findings of reduced morale and negative perception of the work climate observed from different international research projects on workplace violence.

Conclusion and recommendations

Workplace violence is a significant but largely neglected occupational hazard among nurses working in the general hospital setting in southeast Nigeria. The conduct of studies to explicate the extent of this problem and its determinants will go a long way towards improving wellbeing and care outcomes of the affected staff. Moreover, there is need to understand better the psychosocial impacts of being victims of workplace violence through appropriately designed qualitative and quantitative empirical studies.

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Learning objectives

Participants will...

1. realize that violence in health facilities is increasing in Nigeria.
2. learn that violence in health facilities is associated with stress and negative psychosocial outcomes.
3. understand the necessity that there is need to increase awareness of the problem and initiate steps to address it, especially given its impacts on the wellbeing of the victims and the perception of the work environment.

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Workplace incivility in a large Metropolitan Healthcare Organization

Poster

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Focus: Research

Background

Healthcare today is in a constant state of transformation. Hospital systems are challenged to improve productivity and contain costs. Factors such as occupational stress, difficult working conditions, unresolved conflict, lack of leadership, as well as the increased complexity of healthcare can foster the development of disruptive and uncivil behaviors. All of these factors have a direct impact on work performance, patient safety, and the physical well-being of those providing or supporting the care given to patients.

Methodology

The objectives of this study were to: 1. assess the prevalence of incivility within a large metropolitan healthcare organization, 2. determine differences in the frequency of incivility within select occupational groups, and finally 3. examine the relation between incivility and productivity, organizational commitment, job satisfaction, and workplace stress. The study was a cross-sectional, correlational design, using survey methodology. Data were collected from employees working in one organization consisting of an acute care facility, outpatient centers, and ambulatory locations. The study population included direct and non-direct patient care job categories. It also included physicians, employed by the organization and independent practitioners.

Findings

Statistically significant findings were identified for each of the research questions and hypotheses. Andersson and Pearson's (1999) theoretical framework was used to explain workplace incivility. Study findings include:

- Occupational groups differ in their perception of incivility.
- Workplace incivility negatively relates to productivity, organizational commitment, and job satisfaction.
- Workplace incivility positively relates to workplace stress.

Implications for Practice

Future research should focus on identifying occupations that report higher levels of exposure to incivility within the healthcare. If the healthcare field were to isolate those that may be at higher risk for the detrimental effects of this behavior, patient safety would certainly be enhanced. Research in the operationalization of interventions addressing incivility education and management are also lacking and would serve the healthcare community as well. In healthcare, the primary focus must always be the patient. A major component of that focus is assuring safe care. Equipping a workforce with the social-interactive tools to recognize and manage incivility within the workforce is one important mechanism of providing safe care to patients.

Learning objectives

Participants will...

1. be able to discuss the risk that incivility in healthcare settings has for patient safety.
2. be able to compare the perceptions of incivility by different occupational work groups.

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The lived experience of Iraqi nurses who live and work in communities impacted by war or terrorist threat

Poster

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Focus: Research

Background

Over the last two decades Iraq has endured three international wars, 13 years of economic sanctions, dictatorship, foreign occupation, and acts of terrorism. For professional nurses practicing in Iraq, expectations have been that professional life continues “as usual;” caregivers are to function as if the stress of political unrest and personal insecurity does not have personal impact. Results of an extensive review of the literature review emphasize the lack of published research exploring the lived experiences of nurses living and practicing in communities that experience war and terrorist threat. These gaps make development of supportive structures, policy, and educational interventions impossible.

Methodology

The purpose of this phenomenological investigation is to describe the lived experiences of Iraqi nurses who have experienced the realities of war as both citizens and practitioners in Iraq. Hour-long phenomenologic interviews were conducted with 10 male Iraqi nurses who met the inclusion criteria of: Possessing a degree in nursing, lived and practiced nursing in Iraq during a time of war or terrorist threat, and are able to communicate in English or Arabic. Data analysis was ongoing utilizing Giorgi’s approach.

Findings

Two main themes and seven subthemes emerged from data analysis. Main Themes-Living under the Shadow of War and Violence: A Daily Routine and the Shield of Adaptation and Resilience. The first theme, Living under the Shadow of War and Violence, had five subthemes, Impact on Personal Life, Effects on Physical Well-Being, Influence on Mental Health and Emotional Well-being, Impact on the Delivery of Nursing Care, and Lost Sense of Personal Safety. The second theme, The Shield of Adaptation and Resilience, yielded two subthemes, Faith- Based Hope and Commitment to a Profession of Care

This research highlights a number of outcomes from traumatic experiences faced by Iraqi nurses on a daily basis and their tragic multidimensional effects. The first theme confirmed that armed conflicts and terrorism are two sides of the same coin, which is death and suffering. Nurses are in a unique position as human advocates to help people in crisis. However, the heavy responsibility of caring and advocating for citizens of a distressed community while also experiencing this same trauma is a heavy burden. Continuous trauma not only affected their physical well-being, but also social integration, nursing practice quality, and psycho-mental health. Major symptoms of PTSD such as flashbacks, unexplained anxiety, horrific nightmares, and insomnia were evident. These findings beg development and intervention before such symptoms trigger a pandemic among caregivers, which has the potential to negatively affect the quality of nursing care. As portrayed by the second theme, even without a secure practice setting Iraqi nurses adapted to their environment using faith- based resilience and professional commitment. Nonetheless, nurses also needed professional and formal support to continue performance of their professional role while holding the responsibility of caring and advocating for traumatized members of a community to which they were members.

Recommendations

Results from this phenomenological study are expected to inform and guide “caregivers of caregivers” in healing the trauma of war and terror. This study confirms that nurses living and practicing in communities continually impacted by violence lose their sense of security and suffer the consequences of prolonged and constant stress. Establishing work environments that assure physical safety and provide treatment for stress related disorders are imperative to maintain quality health care delivery.

Learning objectives

Participants will...

1. be able to critically evaluate the effects of war and terrorism on nurses living in these communities.
2. have information on how to develop interventions to mitigate stress-related trauma.

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Identifying the incidence and the impact of Type II violence in an acute care hospital

Poster

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Focus: Organisational

Background

Located in Wilmington, Delaware, Christiana Care Health System is a trauma one hospital with over 1000 patient beds. Within the organization, data are collected, but in different databases. These are: monthly restraint and assault reports; occupational safety claims; risk management reports; and educational data regarding de-escalation trainings. Each data base is in a silo; some data are recorded by case numbers, some by patients' medical record numbers, some records were kept only by social security numbers. Discerning data patterns is not feasible when the data are segregated in silos, as this impedes the development of a strategic plan to decrease workplace violence, specifically Type II violence. Type II violence is defined by the United States' Occupational Safety and Health Administration (OSHA), a Division of Labor. Type II violence occurs when the perpetrator is a customer receiving services (e.g. a patient in a hospital) and assaults employee.

Methodology

This performance improvement project is focused on Type II violence. Data from security records were reviewed to determine incidences of violence that fit the category of Type II violence and the subsequent injuries. Injuries included: hitting, biting, spitting, kicking, and verbal assaults to staff. The security database was analyzed to determine staff resources involved in Type II violence in the hospital setting. The types of employees being injured, along with lost and / or restrictive days of work were examined via review of occupational safety claims data. Education records related to classes on de-escalation techniques were analyzed to determine if staff members who were injured had attended these classes.

Findings

Records were initially reviewed by a graduate student and validated by two doctoral prepared nurses. There were 175 reported security calls in 2011 at Christiana Care campus and 115 (66%) of the records were reviewed. Of these, 47% reflected Type II violence, resulting in 24 staff injuries (physical). In further analysis, staff had 121 restricted days and 72 lost days of work. Notably, one employee had 85 restricted days for duty and a second employee had 31 restricted days for duty. Most assault incidences involved a considerable number of staff, ranging from a minimum of 2 security officers. Our analysis revealed that as many as 12 staff members (security, nursing, and physician) were involved in one violent episode. Few staff members who were injured had attended the system wide de-escalation classes prior to being assaulted.

Implications

Based on this analysis, it was determined that verbal assaults typically preceded physically assaults. More education on recognizing signs and symptoms of escalating violence is indicated, as well as de-escalation strategies. Findings will be used to inform best practices and the system's operating goals. Hospitals and health systems need to consider analyzing data bases that they have available to determine the extent of workplace violence in their organizations. This will allow them to develop strategies to decrease workplace violence, such as system level de-escalation classes and other violence prevention initiatives.

Learning objectives

Participants will...

1. be able to describe the incidence of Type II Violence.
2. be able to discuss the physical, psychological, and financial impacts of Type II Violence, in an acute care hospital.

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Aversive authority: Aggression towards health care professionals in the emergency department of Dutch hospitals

Paper

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Perspective: Research

Abstract

Aggression and violence towards health care professionals is a common occurrence in the Netherlands. Central to this study are the taken-for-granted meaning making processes and everyday experiences of the medical staff in the emergency department. The preliminary qualitative findings are based on approximately 300 hours of observations in a large hospital in the Netherlands. The policy measure to reduce aggression through assertive and authoritative interventions by the medical staff paradoxically perpetuates professional insecurities. The socialization in the professional norms of 'not refusing care' and 'caring' clash with the normative demand of an increased authoritative stance by the medical staff in situations of aggression. Nurses and doctors feel vulnerable due to these ambiguous professional demands by the management, contributing to averseness and reluctance in aggressive situations.

Keywords: Hospital, emergency room, aggression, violence, authority, health care professionals and medical staff.

Learning objectives

Participants will...

1. have an understanding of doctors and nurses' socially constructed meanings of "aggression" and "violence" in the emergency department.
2. be able to analyze and identify how variations in meanings of "aggression" between the hospital management and the medical staff fosters unwanted professional outcomes.

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Chapter 5 - Examples of strategies and initiatives which enhanced cultures of security

An interdisciplinary approach to manage violence in a community hospital

Paper

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Perspective: Practice

Keywords: Not for profit hospital, interdisciplinary team approach, electronic medical record

Introduction

A critically ill patient presents to the Emergency Department (ED) and is admitted to intensive care. His past history is unknown. On day two, he is in active delirium tremors. On day three, the patient assaults a nurse. A chart review reveals no documentation that any aggressive behavior ever occurred. This scenario plays out daily in many American hospitals. Each year, 9 of every 10,000 healthcare professionals working in acute care, and 25 of every 10,000 working in long term care suffer job related injuries requiring time off from work. 1 The type of violence most often reported in hospitals is verbal aggression. 2 The perpetrators of violence, include patients, family members, and visitors. 3 The Joint Commission notes a steady increase in the number of violent crimes in health care settings. 4 A review of the literature supports the increased prevalence of workplace violence, yet few studies have been conducted on interventions to reduce violent events. 5

Holy Cross Hospital (HCH) in Fort Lauderdale, Florida is a 579 bed, Magnet® accredited, community hospital in an urban area known as a prime resort location. HCH admits a high number of patients with substance abuse and behavioral health issues, thus complicating their acute medical conditions. HCH has successfully initiated a multi-tiered, interdisciplinary approach to reduce the incidence of violence directed at staff by patients and guests.

Problem

In 2012, HCH leaders became aware of the rising concerns of staff about their safety. Staff felt that their working environment was increasingly dangerous, and they were concerned about the lack of a consistent, effective response when they called for help. In response, a group reviewed data about violent events that took place at the hospital in 2012. At the time, there was no consistent process in place for documenting violent events in the medical record. The group decided the best way to find data would be to review Code Strong calls. A Code Strong is an internal hospital procedure where an overhead call is placed requesting assistance in a situation perceived to be dangerous. After careful analysis, the group determined a total of 152 Code Strong calls were made in 2012. The actual number of violent incidents was probably higher, as nurses often do not report incidents of violence or potential violence. 6 When ED nurses were asked, they disclosed that violent incidences were rarely reported. It was concluded that incidences of violence was a significant problem. Hospital administration decided it was time to take action.

Methodology

The first step was to form the Task Force for the Prevention of Patient Violence, an interdisciplinary team consisting of an ED physician, a psychiatrist, the patient safety officer, a nursing supervisor, clinical practice specialist, staff nurses, an employee health nurse, a pharmacist, an intensive care physician, a clinical informatics specialist, and the director of security. The Task Force members met regularly for one year to develop an action plan. Understanding that an effective action plan would require administrative support through the expenditure of hospital funds, the Task Force presented a proposal to the executive team. Over time, top administrators

including the Chief Operational Officer (COO), the Chief Medical Officer (CMO), and the Chief Financial Officer (CFO) became actively engaged in making this project a success.

The Task Force members set a measurable target of reducing Code Strong events by 25% within one year. The action plan began with an informal survey of nursing and security associate perceptions of the existing Code Strong program. Both Security and Nursing associates expressed concerns that the current system of calling a Code Strong was flawed. The officers were unsure of their role, the nurses felt they were left alone, and both groups felt policies were confusing and contradictory. Many nurses felt powerless to respond to verbal violence, and they perceived that the hospital expected them to accept verbal abuse as part of the job. This is not uncommon. Similar concerns were reported in a focus group study of 71 ED employees conducted at three hospitals in the Midwest.⁷ The Task Force members utilized the survey results to further clarify its goals. It was decided to:

- Rewrite the hospital's violence policy
- Develop a systematic process to obtain immediate assistance
- Educate associates
- Track and trend data
- Develop a means to alert staff to the possibility of a violent individual before a violent event occurs.

The Task Force members realized that some aggressive events require a more robust response than others. In order to avoid "alarm fatigue", it was decided to develop three levels of response to violent events.

Type of Code	Appropriate Use	Level of Response
Code Assist	Low risk events (verbal abuse, wandering patient)	Security
Code Strong	High risk events (physical aggression)	Interdisciplinary team
Code Strong with Intensive Care Physician	Very high risk events (extreme physical aggression/ assault).	Interdisciplinary team plus physician who can order immediate sedation as needed

Associates required education on the changes to the violence policy. Task Force members provided this education by review of policy changes through attending unit-level staff meetings, and an article in the hospital's safety newsletter. In addition, hospital associates were required to complete the following education:

- All hospital associates: a one hour online education module on violence prevention
- All direct patient care associates: a two hour live seminar. This "hands on" seminar included participant practice of techniques used to escape a violent encounter, such as how to break free from a choke hold.
- All Code Strong responders: an eight hour intensive violence education program. Code Strong responders include security, nursing supervisors, ED associates, and engineering associates. The eight hour education program stressed prevention of violence, but also included specific physical training to bring a hostile patient and potential victims to safety.

After completion of the education, it was time to collect new data. A data collection tool was developed to track every reported potentially violent event that occurred after January 1, 2013. Unit-based specialists reviewed the charts of all patients involved in violent events that occurred, and conducted debriefings with associates after the event. The process of debriefing was invaluable. Associates were able to explain the situation, review their actions, and explore alternate responses. After a review of multiple Code Strong events, it became evident that patients who displayed violent behaviors fell into three distinct categories:

- Physiological alterations (hypoxia, pain, electrolyte imbalance)
- Delirium
- Acute alcohol withdrawal.

Data and trends were graphed and presented each month at the Task Force meetings, and at the hospital's Patient Safety Council meetings.

The final task was to develop a process for alerting hospital associates when a potentially violent person was admitted to an inpatient unit. Patients with a history of potentially dangerous behaviors are now referred to a newly created committee called the Violence Prevention Advisory Committee (VPA). The VPA is authorized to electronically flag the charts of these potentially dangerous patients and add a permanent note which advises staff of the potential for danger, and provides guidance on how to best manage the patient during future visits.

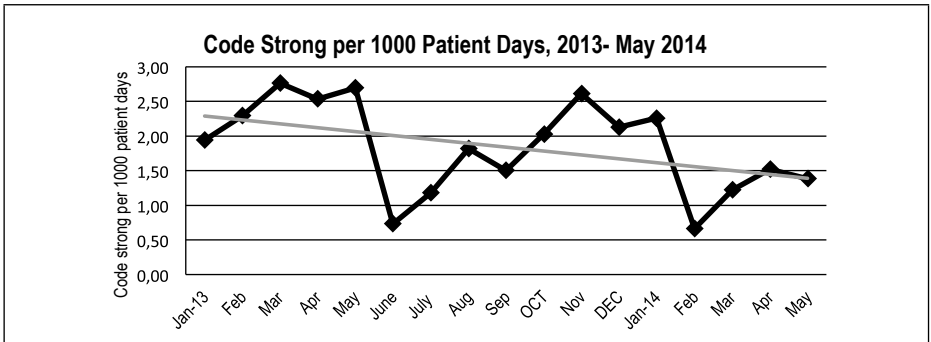
The VPA takes this task very seriously, understanding that a permanent addition to a person's medical record has legal and ethical considerations. VPA members include: an

Emergency Department physician, psychiatrist, Nursing Supervisor, Clinical Practice Specialist, Risk Manager, and the Director of Security.

The VPA meets monthly. An agenda item is the review of records of any patient who has had 2 or more violent events and any patient who is specifically brought to their attention. The group assesses each case to determine if the patient behavior is an ongoing threat. If the patient is assessed as a violent individual who is likely to be a threat on his next admission, the group votes to tag his electronic medical record (EMR). Only the chair of the VPA may enter this data. The tag is visible in the History section of the EMR and remains on the EMR for subsequent visits. The tag reads: "History of violence against staff" A narrative box opens when you click on the tag, revealing a paragraph composed by the VPA that describes past behavior and offers suggestions for promoting safety at the next visit.

Results

The initial goal was to reduce patient on staff violence as defined by "Code Strong" by 25% in 2013. Initial data from 2012, widely believed to be an underestimate of the number of violent events, was 152 events or 1.59 events per 1000 patient days. In 2013, the hospital recorded 2.04 events per 1000 patient days, an INCREASE. However, our 2013 data was far more accurate, as nurses increased reporting potentially violent activities and Emergency Department nurses reported these events for the first time. Over time, there is a downward trend in "Code Strong" or "Code Strong with intensive care physician" events per 1000 patient days.



Nurses anecdotally report that they feel more confident that the hospital is actively protecting their safety. The relationship between nursing and security has developed to one of better trust.

Initially, the intensive care physicians worried that nurses would call them un-necessarily. In 2013 the "Code Strong with intensive care physician" was used 18 times. In every instance, the patient was extremely dangerous. The physicians agreed that every call to them was justified. Year to date in 2014 (January – May), only 4 "Code Strong with intensive care physician" events have occurred. It is important to note that it is rare that a "Code Assist" event escalates to a "Code Strong". Many patients successfully respond to a uniformed security person who sets behavioral boundaries. Nurses are increasingly comfortable calling Code Assist for verbal abuse.

The VPA has added the "Violence Against Staff" tag to the records of 17 patients. Most of these persons are multiple substance abusers. Emergency Department nurses have stated they saw the tag and used it to plan care when a tagged patient returned to the hospital at a subsequent time.

Implications for Practice/ Future State

1. The 3 tiered alert system is effective in responding to aggressive behavior. It is an effective use of human resources, assuring adequate and appropriate response to each type of threat.
2. De-briefing the staff after a violent/potentially violent event continues to be of value. The team has opportunity to discuss the successful elements of the intervention and review how things might have been better handled.
3. Implementation required administrative commitment at the highest administrative levels. This commitment needs to be ongoing, as violence prevention education is required for all newly hired associates, and refresher classes need to occur on an ongoing basis. .
4. Most patients who act in a potentially violent manner can be separated into three distinct groups
 - Physiological alterations
 - Delirium
 - Acute alcohol withdrawal

5. The future goals of the Violence Prevention Advisory include developing both a delirium protocol and an opioid withdrawal protocol.
 - a. Literature supports a nurse led initiative that focuses on anticipating patient need, offering distraction activities to delirious patients, and, as far as possible, avoiding activities that further agitate the patient.
 - b. Alcoholic patients who have tendency to violent behaviors during withdrawal often suffer from multiple addictions. Patients with opioid addiction require a different approach to allow the patient to gain control.
6. A challenge for the future is to have the violence tag in the EMR be more universal to the variety of EMR software platforms in use. As physician offices use an EMR different from the hospital, the team is working with Information Technology to be able to flag the charts of violent patients in a way that alerts office personnel to potential danger,

This project has not stopped patient on staff violence. However, the hospital has found that the value of a diverse, interdisciplinary team, structured processes and established goals has provided a path to a safer hospital experience.

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Learning objectives

Participants will...

1. be able to describe how a tiered alert system can be effective in managing aggressive patient behavior.
2. Be able to explain how an interdisciplinary violence management team, including physician team members, promotes staff and patient safety.

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Conducted Electrical Weapons (CEWs) within a comprehensive use of force model for healthcare security-The Hennepin County Medical Center experience

Workshop

*Jeffrey Ho, Michael Coplen, Martin Williams
Hennepin County Medical Center, Minneapolis, USA*

Perspective: Practice

Abstract

This presentation involves Mr. Martin Williams, Mr. Michael Coplen and Dr. Jeffrey Ho of the Hennepin Health System (Minneapolis, MN) where they serve as the Security Consultant, Security Director, and Security Medical Director respectively. They have been directly responsible for developing a robust and comprehensive institutional use of force policy for the main urban hospital campus, Hennepin County Medical Center. Within this is contained a section for CEW use that they successfully guided through administrative and clinical review several years ago. The result has led to a model policy, multiple demonstrable employee and patient safety benefits, a peer-reviewed research paper on the subject, and successful audit by state and federal oversight authorities. During this presentation, they will discuss what they learned, what worked and what improvements have been made along the way. This presentation will include demographic data, administrative data, and clinical data that will be useful to any audience that is interested in this subject or attempting to set up a similar program. This presentation will ask the attendees to discuss the operational security shortfalls in their own systems and provide an interactive discussion with the presenters on potential solutions and some advisement on what has been found to work within the healthcare setting.

Learning objectives

Participants will...

1. understand the need and utility for a comprehensive healthcare security use of force policy.
2. recognize the benefit of having conducted electrical weapons as an available tool within that policy.

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Legal education and respectful workplace policies: A quantitative content analysis

Paper

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Perspective: Education and Training

Keywords: Bullying, Harassment, Violence, Abuse, Regulations, Acts, and Codes

Abstract

This review aimed to examine Respectful Workplace Policy in Canada, and how its provincial counterparts make available legal education to resolve or diminish workplace bullying. The study is based on the assumption that to understand fully the delivery of legal education, the broader context of respectful workplace policy building must be considered. Findings established that the Canadian government mandated that each province is responsible for ensuring that each of its health authorities or regions establishes Respectful Workplace Policy. Several government regulations exist to help employers with policy-making that direct harassment and bully-free work environment. Other findings from the study suggested these complaints of bullying did not have a separate policy; as an alternative, bullying was placed as a subgroup of ancillary behaviors; harassment, disrespect, and abuse. This review can help all parties better understand the responsibility of legal education together with policy-making and conflict resolution required to resolve complaints workplace bullying. Quantitative and descriptive analysis determined that there is a difference in respectful workplace policy across provinces as to how policy defines and refers to workplace bullying.

Legal Education and Respectful Workplace Policies: A Quantitative Content Analysis

A significant dimension of a Respectful Workplace Policy is the delivery of its legal education. Legal education involves informing employees about workplace policy and guidelines that constructively support and direct the nurse toward resolving conflict in respectful and constructive ways. The purpose of this quantitative content analysis study is to examine Respectful Workplace Policies for similarities and differences in bullying content. An examination of Respectful Workplace Policies should reveal no difference and provide a means for educating nurses on workplace bullying.

Background

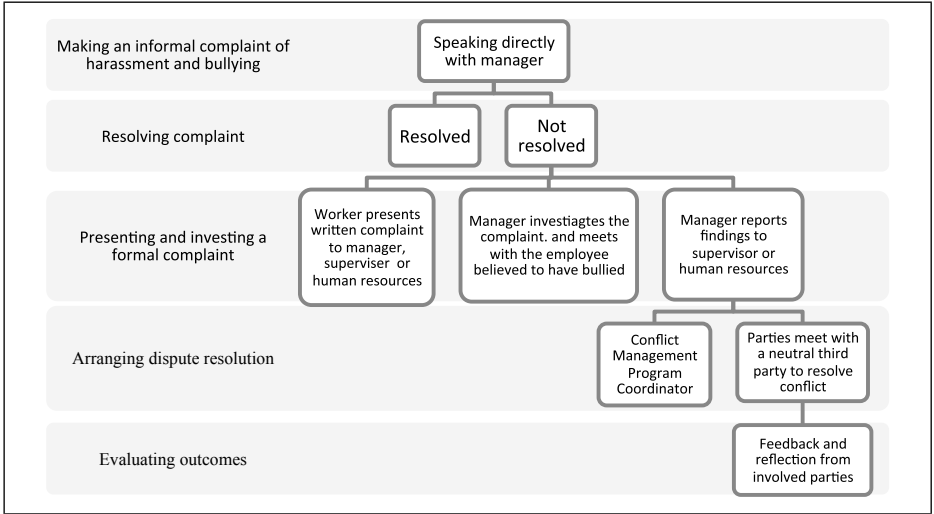
In Canada, several options exist to assist the employer and nurse confronted with a dispute impasse or deadlock. Options for resolving a deadlock may include conciliation, a conciliation board, mediation, arbitration, and alternate dispute resolution (Government of Nova Scotia, 2013). Alternate dispute resolution has been found to be more cost effective in both time and money for resolving workplace conflict (Government of Canada, 2011).

Yamada (2011) suggested that disputes resolution is more constructive and acceptable when used in situations that include workplace bullying and targeted harassment. Dispute resolution includes starting with a problem, gathering general information, coming together and making an agreement, identifying what works and what did not, and using learning goals that ask questions and identifies the parties' concerns (Department of Justice, 2013). Together these measures become the basis of respectful workplace policies and delivery of legal education. Figure 1 presents the steps for informal and formal reporting harassment and bullying in the workplace; making, resolving, presenting and investigating complaints, resolution, and evaluation (Rucker, 2012).

The Canadian Institutes of Health Research (2012) reported that 40% of Canadian workers have experienced some bullying on a weekly basis. In 2008, the Government of Canada introduced regulations to prevent violence in the workplace; regulations that protect the fundamental right of workers and employers (Human Resources and Skills Development Canada, 2011). Under the Canada Labour Code "Every Canadian worker has the right to be treated with dignity and respect" (p. 1).

According to the Human Resources and Skills Development Canada (2011), a requirement of the employer is to assess and evaluate the workplace for risk and potential for workplace violence. The employer's obligation to the worker is to develop a workplace policy that provide training; establish controls to prevent violence; evaluate the effectiveness of policy, measure policy at least every three years and revise it as needed. The employee is responsible for respecting others, speaking up about harassment, and reporting violence, and moving away from a power imbalance. Prevention of violence in the workplace is a collective responsibility of employers, nurses, unions, and government whose objective is to create a workplace culture where bullying is absent.

Figure 1: Harassment and bullying complaints resolution algorithm: Making, resolving, presenting and investigating the complaint, resolution, and evaluation.



Contrary to realizing a lessening of bullying behavior in the workplace, healthcare providers are witnessing an increase in these actions among their employees (Canadian Institute of Health Research, 2012). Nurses are increasingly BULLYING BY RULES; for example, reporting coworkers for observed breaches in policy and procedures, break in isolation protocols, improper hand washing technique, unfinished patient care, and incomplete documentation (Rocker, 2008, 2012). Other bullying behaviors include withholding information, harsh innuendos and criticism, undermining the value systems of others, using positions of power to control the actions of others, yelling at co-workers, and placing others under pressure to meet impossible deadlines (Rocker, 2008).

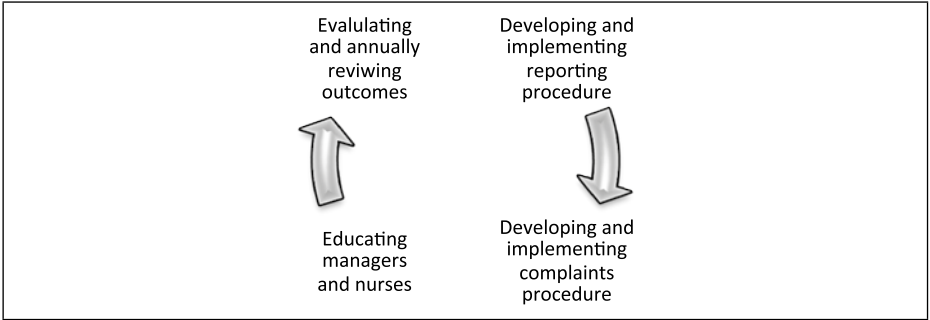
These repeated, and unwanted unconstructive interactions, power disparities, and actions can negatively affect the nurse’s performance, patient outcomes—and loss of the nurses’ sense of worth (Rocker, 2008). A paradigm shift needs to occur whereby nurses’ move away from their “backpack of hidden advantage” in which their rite of passage, nurses eating their young, and negative vertical/horizontal behaviors are no longer accepted as the norm but as bullying. Nurses are without doubt victims of their own social order, power imbalances, and chain of command (Lee & Chang, 2012; Zelek & Phillips, 2003).

Research Question and Hypothesis

Research Question: How do respectful workplace policies differ in content?
 HO: There is no difference in the type of content included in respectful workplace policy.
 HA: There is a difference in the type of content included in respectful workplace policy.

Conceptual Framework

After examining respectful workplace policies, the following Legal Education Model was developed to provide a framework for coaching, training, and instructing nurses on their responsibilities associated with workplace bullying. Collectively these steps become the structure and composition of legal education. Steps in the model include (a) developing and implementing reporting procedures; (b) developing and implementing complaint procedures; (c) educating managers and nurses; and (d) evaluating and annually reviewing outcomes.
 Legal Education Model: Supporting a Bully-Free Work Environment



Definitions

Although numerous regulations have contributed to the foundation of respectful Workplace Policy; only a few policies defined workplace bullying. For example, Island Health (2013) defined bullying as “any repeated or systematic behavior, physical, verbal or psychological including shunning, which would be seen by a reasonable person as intending to belittle, intimidate, coerce or isolate another person” (p. 6). Equally, Saskatoon Health Region (2011) defined bullying as “repeated, health harming mistreatment by one or more people by verbal and/or physical abuse, threats, intimidation, humiliation, work interference, sabotage, exploitation of known vulnerability, or combination of any of the above” (p. 2).

Search Strategy

Collection of research materials included information from government, education, and healthcare websites, CINAHL, and EBSCOhost. Inclusion criteria incorporated only federal and provincial data acquired from public domain. Exclusion criteria included federally-regulated worksites such as transportation, communications, crown corporations, and banking.

Literature Review

In 1867, the Canadian government delegated responsibility for healthcare and education to its provinces (Parliament of Canada, 2012). Each provincial jurisdiction is responsible for delivery of its healthcare and education in which they receive funding from the federal government through transfers payments. Because of increasing media and public attention to workplace intimidation the federal government has mandated that each of its 10 provinces and three territories develop Respectful Workplace Policy; policies that embrace education and training (Government of Canada, 2008; 2011).

Respectful workplace policies are derived from government acts and regulations. For example, these regulatory governances (n = 60) can be mutually reinforcing or interdependent to the delivery of legal education. As a result, the framework and underpinnings of legal education are often mutually exclusive from other provincial-territorial policies. Table 1 provides a summary of various acts (n = 31), codes (n = 10), commissions (n = 6), regulations (n = 7), coalition (n = 1), charters (n = 3), and policies (n = 2) that contribute to make respectful workplace policy.

Table 1: Summary of Acts, Codes, Commissions, Regulations, Coalition, Charters, and Policies used to Establish Respectful Workplace Policy

<p>British Columbia (BC) Human Rights Code of British Columbia (Protection from Discrimination) BC Human Rights Coalition Occupational Health and Safety Regulation Freedom of Information and Protection of Privacy Act Canadian Charter of Rights and Freedoms</p>	<p>Government of Canada Canadian Human Rights Act Canadian Human Rights Commission Canadian Labour Code Violence Prevention in the Workplace Regulations</p> <p>New Brunswick (NB) New Brunswick Human Rights Act Criminal Code New Brunswick Health Rights Commission</p>	<p>Ontario (ON) Occupational Health and Safety Act Ontario Human Rights Code Bill 168 Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace) (2009) Ontario Human Rights Tribunal Ontario Human Rights Commission</p>
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Alberta (AB) Alberta Human Rights Act Alberta Human Rights Commission Criminal Code (Canada) Health Professions Act (Alberta) Occupational Health and Safety Act and Regulations (Alberta)	Newfoundland (NL) Article 4 of the Newfoundland and Labrador Occupational Health and Safety Act Articles 22 & 23 of the Newfoundland and Labrador Occupational Health and Safety Regulations Canadian Human Rights Act	Quebec (QC) Civil Code of Quebec Occupational Health and Safety Legislation Quebec Charter of Rights and Freedoms
Saskatchewan (SK) The Public Service Act Occupational Health/Safety Act Corrective Discipline Policy Occupational Health and Safety Regulations The Public Service Act The Saskatchewan Human Rights Code of Conduct	Nova Scotia (NS) Nova Scotia Human Rights Act Civil Service Act and Regulations Nova Scotia Human Rights Commission Occupational Health and Safety Act Criminal Code of Canada	Prince Edward Island (PE) Provincial Human Rights Act Prince Edward Island Human Rights Commission Canadian Charter of Rights and Freedoms Employment Standards Act
Manitoba (MB) The Manitoba Human Rights Code Civil Service Regulations The Civil Service Act Freedom of Information & Protection of Privacy Act Personal Health Information Act The Workplace Safety/Health Act Labour Relations Act (Manitoba)	Nunavut (NU) Workplace Harassment Policy Nunavut Human Rights Act Canadian Human Rights Act Nunavut Freedom of Information and Protection of Privacy Act Nunavut Public Service Act and Regulations	Yukon (YU) Yukon Human Rights Act Canadian Human Rights Act Public Service Act Northwest Territory (NT) Northwest Territories' Human Rights Act Northwest Territories Human Rights Commission Workers' Safety & Compensation Commission

Note. (n = 60)

A review of the literature found that federal and provincial governments have developed respectful workplace policy mutually exclusive of one another (Alberta Health Services, 2013; SHR, 2011). Mainly, information on Respectful Workplace Policy centers on harassment, disrespect, and discrimination in relationship racial, sexual, and gender issues (Miedema, Easley, Fortin, Hamilton & Tatemichi, 2009; Vessey, Demarco & DiFazio, 2010). Missing from the literature is inclusive data linking respectful workplace to reduced workplace bullying.

Lovell and Lee (2011) and Stagg et al. (2013) suggested that caring for nurses affected by bullying is a huge burden for the healthcare industry--both financially and loss of worker productivity. Accreditation Canada noted that Stanton Territorial Health Authority, North West Territories (NT) has addressed the issue of bullying by adding a model of workplace bullying to its respectful workplace training program (Stanton Territorial Health Authority 2010/2011 Annual Report, 2011). For the purpose of this report Table 2, provides an employer and employee framework to follow when seeking resolution from workplace harassment or bullying (VIHA, 2009).

Table 2: Responsibility of Employer and Employee for Resolving Workplace Conflict

Providers of education	Responsibilities
Employer educates all employees about discrimination and harassment, its prevention, and eradication using Respectful Workplace Policy and Human Right Legislation	Supervisor, Manager, Director, Physician Leader or Executive are responsible for providing employees with knowledge of Respectful Workplace Policy
Human Resources Consultants	Guides managers through the application of the policy Provides coaching, in-service training, and uses internal or external expert intervention to bring knowledge to the workplace
Conflict Management Program Coordinator	Shares responsibilities with Human Resources Consultants Receives complaint initiated through provincial Human Rights Tribunal Appoints qualified internal and external mediators
Executive Director of People and Organizational Development	Decides whether time limits for filing formal complaints should be extended Approve the engagement of an investigator or mediator for formal complaints of harassment. Handles the appeal process (written and received within 30 days of a decision)

Methods

In this study, public documents were analyzed using content analysis methodology. Newman (2003) defined content analysis as “a technique for examining information, or content, in written or symbolic material.” This

methodology was used to examine and study systematically content information relative to legal education from respectful workplace policy. The intended audience for the policies was nurses, student nurses and other healthcare workers. Only policy dated from 2009 and later was examined for similarities and differences relevant to attending to workplace bullying. A non probability purposive sampling was selected from a public list (N = 620) of Canadian health systems, regions, authorities, faculties, and training centers (Wikipedia, 2014).

More than one examiner read the policies and analyzed them according to a scale based on the four intents of the Legal Education Model. The policies were classified as no material, minimal material, addressed, not addressed, relevant, or not relevant to the intended audience. As a result, a subset of samples (n = 13) was selected using a table of random digits—one from each province and territory to complete the study. The confidence level was 95% with an alpha set at .05.

Findings

Findings from the content analysis established that healthcare regions throughout Canada used respectful workplace policy as an intermediary for providing legal education to employees (Newfoundland Labrador Canada, 2013; Island Health, 2014). Figure 2 presented themes (a) awareness; (b) measures; (c) supports; (d) legal compliance; (e) prevention; (f), classifications; and (g) commitments, used by policy makers for shaping employer/employee obligations.

Figure 2 Hierarchy: Themes identified in respectful workplace policy.

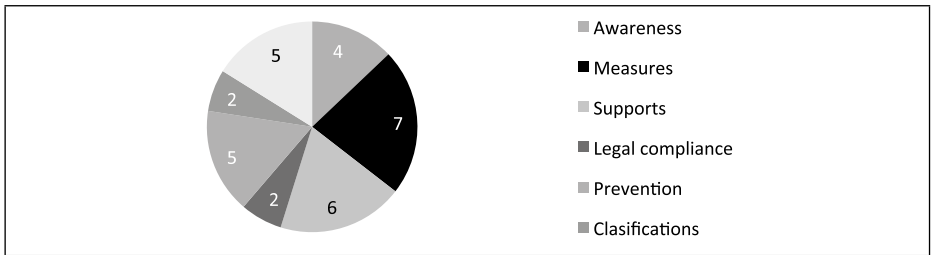


Figure 3 presented an overview of the organization, legal education, management, and employees’ workplace accountabilities. These themes varied from organization to organization. Some organizations held the employee responsible for his or her conduct, whereas, others gave the responsibility to managers to ensure and provide a respectful workplace environment. Legal education varied from training programs to staff completing on-line training courses.

Figure 3 Themes: Responsibilities of the organization, legal education, management, and employees.

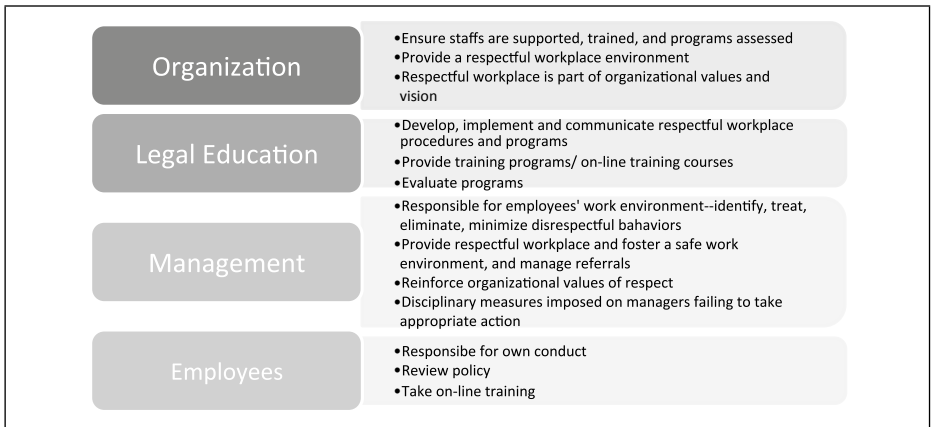


Table 3 presented frequency and percents from policy content in provinces with population > 1,000,000 (n = 6) and provinces with population < 1,000,000 (n = 7). Provinces and territories with a population greater than 1,000,000 people included ON, QU, BC, AB, MN, SK and less than 1,000,000 were NS, NB, NL, PE,

NT, YU, and NU. Outcomes for provinces with population > 1,000,000, 5 (35.1%) focused on preventing and reducing the risks of disrespectful workplace behaviors, and provinces with populations < 1,000,000, 4 (28.5%) concentrated on duties and responsibilities relative to respectful workplace.

Table 3: Descriptive Statistics: Categories found in Provinces and Territories with population > 1,000,000 and population < 1,000,000

Category	Population > 1,000,000		Population < 1,000,000	
	f	%	f	%
Awareness	2	14.29%	2	14.29%
Processes/Procedures	3	21.43%	3	21.43%
Support/Promote/Facilitate	2	14.28%	4	14.29%
Complying with Legislative requirements	1	7.14%	1	7.14%
Prevention/Reducing Risk	0	0%	5	35.71%
Definitions and Defining behaviors	2	14.29%	0	0%
Duties and Responsibilities	4	28.57%	1	7.14%
Totals	14	100%	16	100%

Note. (n = 13)

To test the hypothesis bullying/cyberbullying content and harassment, abuse, violence and the discrimination content were used. The t-test and Mann-Whitney tests were used. T-test was used to determine if there was a relationship between bullying content and other content presented in respectful workplace policy. Because $p < .05$ the results were significant ($t = 2.33, p < .028$). The results were validated. Based on these findings sufficient evidence existed to reject the null hypothesis; no difference exists in the content included in respectful workplace policy. The HA was accepted.

The Mann-Whitney U-Test, a nonparametric two tailed T-test, was also used to test the hypothesis without making the assumption that values about the specific distribution of the groups were normally distributed. In Table 4 Mann-Whitney U-Test was ($Z = -2.88, p = .004$ for bullying and cyberbullying content and harassment, abuse, violence, and the discrimination content. The relationship was significant ($p < .05$) and did not happen by chance. Once more, based on the findings, sufficient evidence existed to reject the null hypothesis that no difference exists in the type of content included in respectful workplace policy; the HA was accepted.

Table 4: Mann-Whitney U-Test Measures of relationship between Bullying and CyberBullying Content and Harassment, Abuse, Violence, and Discrimination Content

	Z-score	2-Tailed P-value	U-value	Critical Value	Significant
Ordinal by Ordinal Bullying and Cyberbullying, and Harassment, Abuse, Violence, and Discrimination	-2.8838	0.00398	18	33	$P \leq 0.05$
N of Valid Cases	(n = 43)				

Note. a. Correlation is significant at the .05. b. Not assuming the null hypothesis.

Implications for Practice

The most critical insights derived from this study were the lack of policy content directing nurses, confronted with workplace bullying, as to how to search for information and seek resolution. Bullying content was often found embedded in a subgroup of ancillary behaviors; such as, harassment that was described as behavior that is not respectful toward others. Nurses have an immediate need to know when the situation happens; asking for support, speaking up, saving evidence, and knowing where to go for support and services (Nova Scotia Canada, 2014). Management must be aware of apprehension and fear that nurse’s and student nurse’s experience when confronting a workplace bully. To improve legal education educators need specific information on how to lecture nurses about bullying and cyberbullying, as opposed to having it amalgamated with harassment, violence, abuse, and the discrimination content.

Limitations and Future Research

Limitations of this study were only used data available from Canadian sources. Second, no research has been reported on the perspective of individuals seeking and resolving bullying issues, and in particular cyber and relational bullying. Further research is needed to evaluate the impact of policy on bullying and explore the unexplored frontiers of bullying; for example, cyberbullying and relational bullying present in team nursing.

Conclusion

Strategies for respectful workplace legal education have its roots in regulations and policy. Each Canadian province and territory is responsible for regulating, creating, and maintaining a respectful workplace policy that is supportive to both employers and employees. Employees are encouraged to address disrespectful behavior when it happens, support colleagues, refuse to participate in disrespectful behaviors, and observe self awareness of their own behavior role. Managers are responsible for providing a respectful workplace that supports a safe work environment. Conversely, policy continues to challenge the boundaries of ever changing delivery of legal education.

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Learning objectives

Participants will...

1. have a basic understanding of strategies used by staffs confronted by workplace bullying.
2. be able to identify factors that contribute to legal education and support a respectful workplace.

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Post-seclusion intervention: a reflexive practice?

Paper

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Perspective: Research

Keywords: Restraint seclusion, Aggression, Mental Health Care, Reflective practice Post-seclusion review

Introduction

It has been suggested that, after an incident in which a patient has been placed in seclusion, a post-seclusion review should be conducted to ensure the continuity of care. The post-seclusion review is usually proposed for monitoring the effects of seclusion among patients and the caretakers, and to prevent the recurrence of the procedure.

Although present in all guidelines and best practice management of aggression, (Bonner, 2008; Fisher, 2003; Huckshorn, 2004; Needham & Sands, 2010; Taylor & Lewis, 2012), post-seclusion review (PSR) is not an intervention systematically found in all settings (Needham & Sands, 2010). Qualitative studies examining the perspective of patients and nurses identified the need for a follow-up after a control measure that can be lived, such as a trauma (Kontio et al., 2012; Bonner & Wellman, 2010, Larue et al., 2013). Moreover, the absence of this kind of return would increase the distress among patients (Mayers, Keet, Winkler, and Flisher, 2011).

The presentation offers a critical review of the literature on any form of intervention occurring after seclusion. The different models of post-seclusion review are discussed in relation to their potential to foster a reflective practice.

Methods

The sampling process has identified 156 articles from CINAHL and Medline database using the keywords “post-seclusion”, AND/OR “debriefing”. Twenty-five articles were selected because they explained the concept and process of PSR. A manual search from identified articles has completed the review (n = 7) for a total of 32 articles.

Results

Intervention models for post-seclusion review

Several designations refer to this concept, which has never been clearly defined, but for which some models have been developed: post-event discussion (Fisher, 2003), post-seclusion debriefing (Needham & Sands, 2010; Ryan & Happell, 2009), debriefing procedures (Huckshorn, 2004; Lewis et al., 2009; Maguire, Young, & Martin, 2012), postincident review (Bonner & Wellman, 2010), post-situation analysis (MSSS, 2011), witnessing (Taylor & Lewis, 2012), post-seclusion counseling intervention (Whitecross, Seary, & Lee, 2013), immediate feedback and post-incident review (ASSTSAS, 2006). To clarify the different types of intervention, a typology of post-seclusion intervention has been proposed based on the target of the intervention: the patient, the caregiver or both (Goulet & Larue, submitted). Among these models of PSR, the potential for reflective practice is however undeveloped.

Post-seclusion return for caregivers

The first type of PSR focuses on caregivers. Since the emphasis is generally placed on monitoring the protocol and on the security of the caregiver, it is therefore more of an organizational return than a clinical one. In a Finnish study, focus groups composed of nurses (n = 22) and physicians (n = 5) were used to explore the need for a training course in managing aggressiveness (Kontio et al., 2009). Participants mentioned the possibility of a PSR as an opportunity for peer support, promoting the better management of aggression. Kontio et al. (2009) are the only ones that discussed a return on seclusion as a learning experience for the caregivers, in which it is possible to identify the concept of “reflection on action” that Schön (1983) had identified to promote the professional learning of a practitioner based on their clinical experiences.

Post-seclusion return for the patient

Some of the identified interventions target patients (Bonner, 2008; Bonner & Wellman, 2010; Needham & Sands, 2010). Thus the aim is to assist the patient in managing his feelings, and help them seek out the causes that led to the loss of control of their emotions and behaviors. It is crucial to do a follow up with the patient, but by itself it does not allow a systemic intervention with the caregivers and the establishment. Although it permits an adjustment of the treatment plan according to the discussion between the nurse and the patient, it is unlikely to influence the practice of the team. Furthermore, no study discusses the PSR as an opportunity for a reflective practice for the nurse or even for the patient. The PSR would then be a therapeutic intervention where, in a

situation in which a patient has lost control of their behavior or emotions, the nurse could help them by teaching them how to manage their aggressiveness.

Post-seclusion return for caregivers and patients

A follow up intervention involving activities for both the patient and the caregivers has also been developed (Fisher, 2003; Huckshorn, 2004). Several activities have been suggested: a post-incident review with the care providers involved, a formal analysis 24 to 48 hours after seclusion with the clinical team, and a patient debriefing. One of the objectives is the improvement of practices, but the authors do not discuss how the PSR can help in this situation. This type of intervention approach in a reflective practice enables us to understand the interventions as a privileged moment in which everyone involved has the opportunity to grow from their experiences and from questioning their practice.

Whatever the target of the PSR, few studies discuss the potential for a reflective practice that this kind of intervention can bring. This complex procedure allows the professional to learn from every situation and thus improve their practice. The PSR is also an occasion in which both the practitioner and the patient can gain perspectives on their interactions in order to better understand their respective involvement. The PSR could thus be the starting point for identifying the needs of the patient, as well as the accompanying training the caregiver will need to adequately help said patient.

Debriefing to reflective practice

The analysis establishes that the origins of post-seclusion intervention are twofold; debriefing in psychology and reflective practice in nursing. Initially, the PSR originated from the field of psychology with the concept of debriefing, which promotes the emotional expression of a traumatic incident in order to reduce the adverse psychological consequences (Mitchell, 1983). Over time, the term debriefing gradually integrated the every-day language and its use has spread to the field of mental health. It is in this context that nurses have embraced the concept of emotional exchange between caretakers, and they realized that in addition to leading to lowered stress levels, debriefing with other mental health nurses favored their reflective practice (Bell, 1995). This expression of the emotions felt by the nurses would lead to a critical analysis of clinical practice, to explore the relevance of therapeutic skills used and the promotion of safe practices (Morante, 2005). Therefore, nurses have integrated the original dimension of debriefing (emotional exchange), in the reflective practice dimension. It is in this broader meaning that nurses use the concept of debriefing: an emotional exchange leading up to the reflective practice of caretakers. In this context, it is a feedback exercise on clinical experience that integrates knowledge previously lived. It then allows verbalization and integration of experiential knowledge.

In short, think about the PSR as the contextualization of debriefing to control measures, which enables us to understanding its full potential; to support the development of the skills of the nurses and the caregivers to reduce measures of seclusion and restraint.

Discussion and conclusion

Several models of PSR were identified in the literature, yet few of them discuss the transformative potential of PSR, thinking of it as a form of reflective practice. In order to consider the most important factors in the seclusion decision, which is the interactions between the patient and the caretaker, as well as to produce a significant learning experience for the patients and to enhance the skills of those involved in the management of aggressive behavior, it therefore makes sense to choose an intervention model that influences the different actors involved: the patient and the treatment team. The PSR therefore has the potential to participate in the reflexivity of the patient, the nurse, as well as that of the organization. Optimally, this reflexivity should foster a culture change from a unit to a comprehensive and holistic perspective, which would lead to preventive interventions that promote patient recovery. The PSR thus constitutes a form of reflective practice incorporating both the treatment team and the patient. Accordingly, the PSR is widely recommended to stimulate critical reflection on the practice, which is essential for improving the prevention of seclusion events. Although to our knowledge the PSR was never presented as a therapeutic intervention, we believe that this type of intervention can help the patient develop their capacity for compartmentalization, which is often impaired in people with a mental health disorder. This therapeutic action becomes an opportunity for patients to reflect and promotes their empowerment in the context of aggressive escalation.

Firmly anchoring the PSR in a nursing perspective and in a reflective practice can only help prevent the risk of aggression, which will lead to toward fewer control measures. Thus, as well as having the opportunity to improve the experience of care surrounding the seclusion for patients and for nurses, the PSR can also contribute to the continuous improvement of the quality and safety of care surrounding the management of aggressive behavior.

Acknowledgements

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Learning objectives

Participants will...

1. know the conceptual origins of post-seclusion intervention.
2. understand the purpose of the intervention based on its target.
3. Be able to integrate reflective practice as a central component of post-seclusion intervention.

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Minimization of the consequences of radicalization in vulnerable potentially violent individuals in mental health care

Workshop

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Perspective: Education and Training

Keywords: Mental Health care practitioners, polarization, radicalization, early identification, prevention, counter-radicalization interventions

Introduction and background

Radicalization is a concept that is difficult to define. Radicalization is often associated with terrorism, extremism and fundamentalism. Worldwide, there were several incidents of people with mental health problems that were involved in extremist violent acts. For example in the Netherlands Pim Fortuyn (2002), Theo van Gogh (2004) and the Royal Family were attacked by radicalized lone actors (2009). As mental health problems seem to make people more vulnerable for polarization and can be seen as an (extra) risk factor in radicalization processes. It is therefore important for everyone working in mental health care settings to be aware of these risks and to be able to recognize potential radicalization from its earliest stages. That makes polarization and radicalization an urgent social issue which first-line professionals may face with. Mental health services can have a crucial role in the recognition of early signs of radicalization and may also contribute in the de-radicalization process of potentially violent individuals. This aspect has however not yet been incorporated in the formal training of mental health care professionals, leaving many professionals in the stressful situation of seeing high risks but not knowing how to act accordingly.

Frontline workers that are confronted with such circumstances often face confidentiality dilemmas and risk management issues. Frontline workers that are involved with polarization and radicalization by their patients have to deal with socially “high pressure” situations: the potential risk for society is high and would justify safety measures, however the aspect of mental illness involved means the patient’s primarily needs care and should be treated according to medical guidelines, e.g. with respect to privacy and sharing information with other professionals. Also the “value” of radical claims or behaviour needs to be assessed taking the patients’ mental health issues into account. This is a difficult process, especially for those without specialised training. Due to this, radicalization by people with mental health problems are also highly ambiguous situations. Different professional dilemmas evolve such as the awareness of the possibility of radicalisation by patients, the privacy of patients in early identification processes in multidisciplinary teamwork and the development of de-radicalization interventions.

Therefore the promotion of awareness and multi-stakeholder information processes needs to be in place. Frameworks need to be in place to prevent public tragedies, the exploitation of vulnerable individuals and massive burden for clinicians. Therefore a synthesis of good practices in this area is facilitated by the European Commission (Internal Affairs). In 2012 the EU funded the Radicalization Awareness Network was established to connect experts to serve the health care sector across Europe in a three year time frame. This expert group developed a stepped care radicalization de-escalation model and tailor made trainings to address to circumstances of these specific escalation stages. During the workshop three realistic case scenarios are presented and jointly analyzed. In addition to this the available training material is discussed with the participants.

Throughout Europe courses have been developed to raise awareness and understanding among first liner workers for individuals who may be vulnerable to radicalization. First line workers having been identified as a key group that can make an important contribution to this issue are teachers, youth workers, community police workers, child protection workers, (mental) health care workers - are in direct contact with vulnerable people at risk for radicalization. In contrast to policy makers for example, first liners – potentially – have the ability to recognise and refer individuals who may be vulnerable to radicalisation. However, they do not always have a good understanding of radicalisation, know the warning signs, or understand what to do in response. Therefore, a form of training to raise awareness and developing skills in order to help prevent is required (EU, 2013).

Course development

Trifer–ISI developed with Radar Advies an awareness course for first line workers in mental health care. This course focuses on the signs and characteristics of polarization and the development of radical ideas in combination with psychological vulnerability. Through early identification of these signals, patterns and characteristics of these processes can set these ideas, taken and shared. The workshop will contribute to the recognition and identification of vulnerable individuals at risk of radicalization. The course aims to:

- Raise awareness among first line mental health workers about the signals and processes that might indicate (a risk of) a worrying development of a patient. A development that might indicate a process of radicalisation or the vulnerability of the patient. The training es about individuals who, for different reasons, threaten to become violent against society or authorities.
- Instruct mental health workers on the possibilities that are available, and even sometimes obligatory, to share information with other professionals, and waive patients confidentiality in a proper way. This is along with existing procedures and protocols for internal (collegial consultation) and external consultation.
- Stimulate an attitude of early approaching and interventions, similar to the existing protocols for suicide and depression.

Course characteristics

The characteristics of the training course are:

- A one day training course for mental health professionals.
- It is based on existing professional expertise on violence and aggression.
- It starts from cases which mental health care workers can relate to and preferably cases coming from the participants themselves.
- The experiences and expertise of participants are incorporated in a professional framework.
- Our main model of working de-escalating is introduced, as one of the models and instruments for better risk assessment.

Working methods

Trifler-ISI and Radar Advies are developing a test basis of an evidence-based model and a Trifler own practice-based model to create a working model for frontline workers in mental health care that should help them to interpret the behavior of patients. Following the phase of interpretation work was done to create preventive de-radicalizing interventions. This model is also practice-based now. By involvement of the field of front line workers and organizations and continuous action research into the feasibility of the model we want to make a first step towards working with more evidence-based models and methods (Figure 2).

Figure 1: Practice-based de-escalating technics model by Trifler

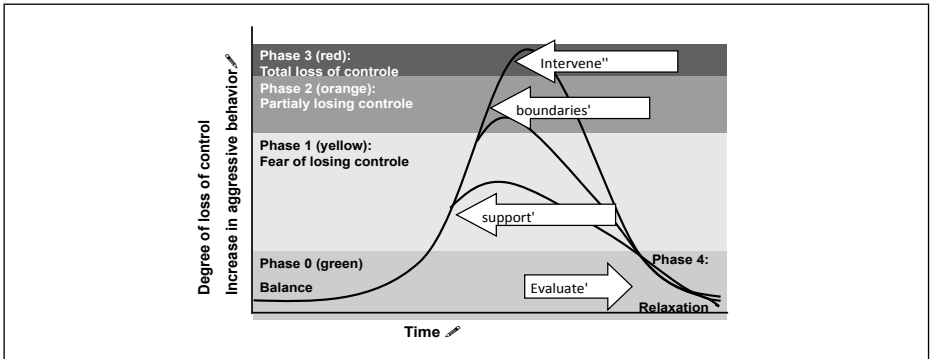
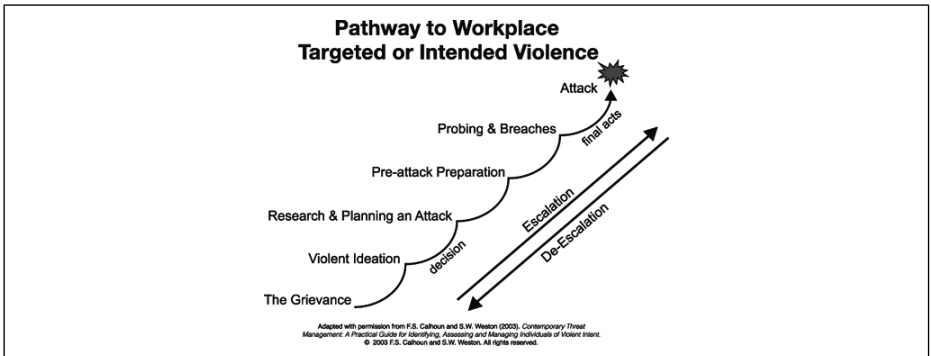


Figure 2: Evidence-based model by Calhoun and Weston



Adapted with permission from F.S. Calhoun and S.W. Weston (2003), Contemporary Threat Management: A Practical Guide for Identifying, Assessing and Managing Individuals of Concern. © 2003 F.S. Calhoun and S.W. Weston. All rights reserved.

The two models are being placed in the context of the following 22 protective and threatening factors and helps to interpretate behavior patterns of clients/patients who are vulnerable potentially violent. The 22 protective and threatening factors are the results of meetings with experts:

Engagement

1. Something must “do” with feelings of resentment and injustice.
2. Perceived need to defend against threats.
3. A need for identity, meaning and connectedness.
4. A desire for status.
5. A desire for excitement, adventure and camaraderie.
6. A perceived need for domination and control over others.
7. Sensitivity regarding indoctrination.
8. A desire for political and/or moral change.
9. Opportunistic involvement.
10. Family or friends involved with extremism.
11. Transitional life situations (redundancy, relationship breakdown).
12. Susceptibility to being manipulated and controlled by others.
13. Relevant psychological problems.

Intention

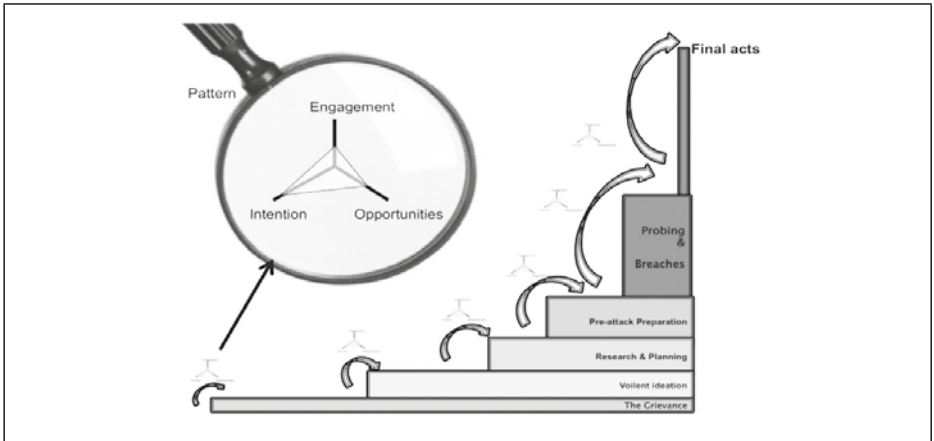
14. Over-identification with an interest group or ideology.
15. Strong “us versus them thinking”.
16. Dehumanization of the enemy.
17. An attitude that justifies violence.
18. Violent funds for the purpose.
19. Violent goals.

Opportunities

20. Own knowledge and skills or competencies.
21. Accessing networks, money or resources.
22. Criminal history.

The practice-based model by Trifier-ISI that is used in the awareness course for mental health care workers by early identification and prevention of radicalization is shown in Figure 3.

Figure 3: Practice-based model by Trifier-ISI



Discussion

Our work and our models and methods are in a state of ongoing process. We are involving first line workers, managers of organizations in the mental health care to participate in our action research in working with early identification and prevention of radicalization. Our action research is based on evaluations, trail-and-error and looking for multidisciplinary dialogue with professionals in the working field. We have worked on these models

for more than two years now and would like to involve you in this dialogue and talk with you about your professional experiences with radicalization in vulnerable potentially violent clients. This information will be used to perfect this practice-based model. We would also like to talk to directors, supervisors, managers about the managerial topics if first line workers are dealing with early identification and prevention of radicalization. Last but not least, we would like to establish a network that is willing to gather information using this framework for its further development as an evidence-based model of early identification of potentially radicalising individuals in mental health settings.

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Reader

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Workshop programme

This workshop focuses on the signs and characteristics of polarization and the development of radical ideas in combination with psychological vulnerability. Through the early identification of these signals, patterns and characteristics of these processes can set these ideas, taken and shared. The workshop will contribute to the recognition and identification of vulnerable individuals at risk of radicalization and offers awareness and tools for preventive interventions. Both the safety of the client and public safety are paramount.

Learning objectives

Participants will...

1. develop an awareness of radicalization by potentially violent individuals in mental health care.
2. learn about the development of good practice pertaining to the early identification and prevention as well as the counter radicalization for vulnerable individuals.

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Five-Step-To-Change and crisis develop model for de-escalating techniques

Poster

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Perspective: Education and Training

Background and context

The five-step-to-change is a new technique of working around the topic of aggression. It is a multidisciplinary way of working around the topic of aggression and developing de-escalating techniques. The approach is client focused and also the direct system of the client is included.

Methodology

The method was developed out of two methods: practice based evidenced and evidenced based practice. The method is in the Netherlands a 'best practice' in one of the child and adolescence psychiatric hospitals. The Crisis Develop Model (CDM) is one of the models we utilise within the Five-step-to-change method. The CDM is a model that helps early identification of tense raising by psychiatric patients.

Learning objectives

Participants will...

1. have knowledge on the early identification of tense raising by psychiatric clients.
2. will learn communicational and physical de-escalating techniques in psychiatric care.

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Organizational strategies to support a culture of safety

Paper

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Perspective: Organisational

Background and context

Violence in the health sector is a multifaceted issue that commands national and international attention. Workplace violence was addressed by a state of Minnesota task force white paper with recommendations for health care institutions. While the consequences of disruptive, aggressive and violent patients toward employees are potentially serious, barriers prevent resolution of this problem.

Methodology

An appraisal of the current organizational structure for violence prevention was prioritized by institutional leadership. Utilizing the Workplace Violence Checklist by OSHA, an appointed workgroup conducted a review. Both environmental and personnel preparedness issues were identified as potential contributors to workplace violence and addressed through written procedures and practice resources. Leadership decision groups requested assurance that concerns surrounding logistics and stigmatization of patients were a primary focus prior to approval and implementation of these resources.

Findings

Further support of a violence-free culture necessitated a two-pronged approach with resources to a) manage patient behavior and b) support staff. Resources to manage patient behavior required the development of institutional policies and procedures to identify potentially violent patients, assess the level of risk they pose to the workforce, and mitigate poor outcomes related to aggression/ violence. Specifically, this included interventions such as a coordinated multidisciplinary approach to patient behavior, a process/guideline to direct development of a discoverable behavior treatment plan, and an indicator door card. Resources to support staff and advocate for their safety involved several components including provision of a continuum of aggression conceptual framework, de-escalation training, an emergency behavior management team, leadership response/debrief to patient aggression and quick-reference education resources.

Implications

The key for providing a safe environment is a coordinated approach, supported by institutional leadership. Leadership personnel must understand that front line staff are the most affected by aggression and violence, yet it remains under-reported. Increased reporting of violence may improve following staff education on behavior management, yet this intervention alone is inadequate. It is imperative that organizations also establish patient behavioral expectations and set a tolerance threshold to violence. In addition, delineation of employer and law enforcement support is imperative for staff to feel protected in the practice setting. This level of support necessitates discussions by organizational management about the pros and cons of various approaches to identify and attend to violent patients. Successfulness of approaches may be tracked with data related to assault rates and predictive variables for patient aggression and assault. Embarking on this process indicates organizational recognition of the far-reaching importance of a culture of safety.

Learning objectives

Participants will...

1. understand the importance of coordinated leadership support in promoting a culture of safety.
2. identify two aspects of an organization's environment and personnel in assessing patient-staff safety.
3. identify two specific organizational resources to support staff caring for the violent patient.

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A comparison of tools and strategies for assessing the physical environment for workplace violence prevention programs

Paper

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Perspective: Organisational

Background and context

Attributes of the physical environment can create an opportunity for workplace violence and can also increase the risk of serious injury or death. Environmental risks are particularly important when health care providers work alone either in a medical facility or in the community. Assessing the physical environment is considered a key element of workplace violence prevention programs in healthcare and social services. The United States (US) Occupational Safety and Health Administration (OSHA) includes the assessment of the physical environment as an essential element of a comprehensive workplace violence program. Wide variation appears to exist in the instruments used, making standard recommendations difficult for health care organizations to consistently apply. This study reviews environmental checklists and identifies a common framework.

Methodology

A review of the literature as well as a review of published and non-published environmental check lists was undertaken. Tools that were developed specifically for police vulnerability assessments, environment of care checklists for mental health, suicide prevention checklists, and the promotion of healing environments were included in the comparison. A novel framework which incorporated crime prevention and security, healing health care environments, worker participation and occupational safety concepts was developed by the authors for organizing the environmental assessment and customizing it to the healthcare work and caregiving environment. Strengths and limitations of approaches and documentation were also reviewed.

Findings

Multiple tools from published studies, governmental sources and the US Veterans Health Administration (VHA) possessed overlapping constructs including access control, visibility, security hardware and technology, patient privacy and comfort, duress alarms and communication systems and furniture and material considerations. Most of the tools addressed features of the physical environment, but rarely included specific guidance for scoring or judging quality. There was limited guidance for the qualifications of those conducting the environmental assessment, the frequency of assessment, how the findings should be utilized and communicated, and the best methods for evaluation of the physical environment controls. Discussion of the role of front line health workers, processes for deciding which technology to use and evaluation of the effectiveness of these decisions was also limited.

Implications

After reviewing the instruments, we recommend development and application of a common checklist of environmental concerns consisting of the seven elements identified in our review for management when considering new construction, renovations of existing space, and facility security procedures. We also provide a process where front line healthcare workers participate in the environmental assessment and collaborate with management to address hazardous situations. The checklist may be useful as a central component in workplace violence prevention programs.

Learning objectives

Participants will...

1. Be able to list the environmental risk factors for workplace violence and injury.
2. Be able to discuss the strengths and limitations of existing tools for assessing the physical work environment and critique the proposed approach from the standpoint of their work or organizational setting.

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“It’s All about Communication” versus “De-escalation”: A description of two interventions to reduce patient aggression against healthcare workers

Paper

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Perspective: Research

Keywords: Communication skills training, de-escalation, aggression, violence, healthcare workers, patients

Introduction

Violence by patients against healthcare staff is a common occurrence (Hills, 2008). The number of incidents has increased and also the severity of the impact can cause profound traumatic effects on the victims (Jacobowitz, 2013). There is research about the impact of such violence and interventions to reduce the nature, intensity and impact of violence (Pekar & Gillespie, 2014; Swain & Gale, 2014). Although reports of the nature and source of violence and aggression are numerous, the effectiveness of non-coercive measures in the prevention and minimization of workplace violence remains unexplored (Muralidharan & Fenton, 2012).

A very underreported and unsupported group is the community support workers (Anderson, 2006; Campbell, McCoy, Burg & Hoffman, 2013; Gale et al., 2009). There are minimal studies on violence faced by community support workers. The study by Gale, Hannah, Swain, Gray, Coverdale and Oud (2009) in New Zealand reported that patient aggression among community support workers was common and caused distress. With the shift in focus of service provision from hospital based care to community based care, the levels of aggression faced by community support workers is definitely on the rise. The total number of reported assaults by patients on mental health staff in hospital settings for 2010-2012 was 4821, more than doubling between 2010 and 2012 (Burns, 2014). This is only the tip of the iceberg as not all aggression experienced by healthcare staff at work is reported. These figures were collected from individual DHBs and not accurate as the Ministry of Health does not keep national data on reported incidents of workplace violence. Moreover, majority of the studies focus on hospital based settings especially mental health and emergency settings where violence is most reported (Privitera, Weisman, Cerulli, Tu, & Groman, 2005) and the violence in community settings remains unexplored. This re-iterates the need for more research focused on the community and effective violence reduction interventions.

NGOs in New Zealand

Non-governmental organisations have a long, well established record of contribution to New Zealand’s health and disability service delivery. Ministry of Social Development (2008) stated that “As a market-driven ethos began to shape the relationship between government and the non-profit sector in the late 1980s, purchase of services through contracts became the preferred mechanism for transferring resources from the state to non-profit organisations and for delivery of services by these organisations” (p. 28). Health and Disability NGOs include a wide range of organisations that provide flexible, responsive and innovative frontline service delivery (Tennant, O’ Brien & Sanders, 2008). Diverse services are offered in primary care, mental health, personal health and disability support services, and include specific services such as Māori and Pacific providers (Harrison, 2010). Harrison (2010) describes the economic and socio-cultural benefits of NGOs as “Suitable as a nexus of innovation, at comparatively low cost and risk, while engaging non-government resources in service delivery. NGOs are a diverse, well established sector, with strong community networks and perceived value, providing scope for Maori and Pacifica development and self-governance” (p.14).

NGO support work has evolved from early unpaid and voluntary work through carer/support positions, to increasingly professionally qualified and recovery-focused career positions. Within this paradigm, patients work in partnership with their community support workers, towards pre-agreed goals (Harrison, 2010). Support workers work within a particular service philosophy and require appropriate training. However, due to limited funding arises the real challenge for NGOs in terms of providing appropriate training to support staff (Harrison, 2010). This also impacts on the recruitment and retention of qualified professionals and experienced personnel (Tennant, O’ Brien & Sanders, 2008; Harrison, 2010). This is re-iterated in the quote by Associate Health Minister Dr. Jonathan Coleman during the National Outcomes Forum by TePou in June 2012: “Given that NGOs are an important link in providing good services, the capacity to measure inputs, outputs and outcomes as a way of demonstrating value for money is as important for NGOs as it is for DHBs.” Therefore, here lies the

needs for provision of appropriate training to this group of healthcare workers on how best to avert and resolve crises stemming from patient aggression.

“It’s All about Communication”

Development of “It’s All about Communication”

A survey by Gale, Hannah, Swain, Gray, Coverdale & Oud (2009) in New Zealand gives evidence to the high rates of violence against community support workers in residential supported accommodation. 44% of the participants in this survey had no qualifications and a minority of the support workers had an appropriate qualification for health and disability support work. Communication style was identified as a predictor for aggression setting aside all the other known factors that trigger aggression. Another survey of medical students by Mackay, Hannah and Gale (2009) re-iterated the association between hurried, non-confident and anxious communication style to an increase in the risk for assaults from patients. The problem of aggression and violence faced by community support workers is worsened with restrictions such as lack of personal alarms, panic buttons, immediate access to qualified healthcare professionals and crisis management teams and having to work in isolation at times (Gale et al., 2009). This accentuated the need for more research to identify and develop interventions for community healthcare workers (Swain & Gale, 2014). Hereby, Gale et al (2009) suggested the development and delivery of communication skills training as a suitable intervention to reduce support workers experiences of aggression.

Swain and Gale in 2012 developed a group based, structured educational package called “It’s All about Communication”. This was a fully scripted set of four 50-75 minutes sessions with a workbook and DVD illustrative examples. The communication skills package was developed on the basis of years of experience teaching communication skills to medical students, previous research and clinical expertise. The exemplars on DVD were enacted by professional actors and these exemplars were based on true clinical situations but de-identified and modified to ensure privacy. A facilitator’s guide and a participant guide were also developed (Swain & Gale, 2014).

Components of “It’s All about Communication”

“It’s All about Communication” consists of four sessions to teach some of the most essential communication skills. The sessions are structured from basic to complex. The first session focuses on the very basics of communication. The session starts with an ice breaker to set the scene for the training session. This is followed by two short sections on verbal and non-verbal communication in which participants are asked to work in pairs and discuss and then followed by a group discussion coordinated by the facilitator. The section on verbal and non-verbal communication is reinforced using a video focused on the different tones of voice. The next section is about body language which includes posture, proximity, touch, body movements, facial expressions and eye contact. This is followed by a section on how to ‘mirror’ and show empathy. The importance of body language and empathy along with verbal and non-verbal communication are discussed in a scenario that is displayed on DVD.

The second session of the Communications Skills Training focuses on how to manage discomfort within a team, group dynamics, use of open and closed questions, empathy and setting an agenda. All these sections include visual examples of scenarios on DVD and discussions as a group. The third session focuses on control and structure, working in pairs, difficult situations and worries and concerns as members of a team. This session requires the participants to work in pairs and then have larger group discussions along with examples from work that are displayed using the DVD. The rationale behind working in pairs initially before group discussions for the participants is to give them a feeling of the reality of working with someone who may have different opinions to themselves. The final session consists of three sections. This includes what to do when things go wrong, when communication breaks down and taking care of ourselves that are supported by reality based scenarios displayed using the DVD. Alongside with the teaching, discussion and videos, participants work on their workbooks as well.

Instruments of measurement for “It’s All about Communication”

To measure the effect of the intervention package, “It’s All about Communication”, questionnaires were used. The questionnaire consisted of four sections- demographic profile, Perception of Patient Aggression Scale (NZ modified) (POPAS-NZ), Kessler -10 and Impact of Events Scale- Revised (IES-R). The participants were asked to complete the questionnaire before the training was delivered and then to complete the three scales immediately after training, one month post and two months post training.

- **Demographic Profile**

The demographic section gathered information about the gender, ethnicity, age, working hours, educational qualifications, specific aggression management and communication skills training, ethnicity and nature of the client group the participants worked with. These specific demographics can show any potential link between age, educational qualifications and impact of job specific training.

- **POPAS-NZ**

The Perception of Patient Aggression Scale (POPAS) is a brief outcome scale for interventions around the perceived level of violence. It is the modification of the POAS (Needham, Abderhalden, Dassen, Haug &

Fischer, 2004). The POPAS-NZ includes 12 questions related to the experience of violence in the previous year.

- **Kessler-10**

The Kessler Psychological Distress Scale (K10) is a simple measure of psychological distress. The K10 scale involves 10 questions about emotional states each with a five-level response scale. The measure can be used as a brief screen to identify levels of distress (Kessler et al., 2003).

- **Impact of Events Scale- Revised**

This is a measure of emotional distress from an event in the week of the survey. High scores have been correlated with clinically significant Post Traumatic Stress (Creamer, Bell & Failla, 2003). It is intended to be used as a screening tool, not a diagnostic test (Weiss, 2007)

Results of the Trial of “It’s All about Communication”

The data from the open label trial were analyzed using IBM SPSS version 20. All the three outcome measures (POPAS- NZ, IES-R and Kessler-10) were significantly right skewed and therefore the medians were reported to define the central tendency and non-parametric testing conducted. The results of the trial to determine the effectiveness of “It’s All about Communication” reported a decrease in the experience of aggression following training in communication skills among community support workers. It also showed a reduction in emotional distress and increased mental wellbeing as analyzed from the Kessler 10 and IES-R. The POPAS-NZ showed a statistically significant difference in the scores at each time period. There was also significant difference in the IES-R scores between baseline and each of the three time frames, post, one month post and two months post intervention. For the Kessler-10, though there was no significant difference between baseline and post and one month post scores, there was a significant difference between baseline and two months post score. The communication skills training seemed to have an immediate effect after the course and then the effect increased over the next two months. The overall rating of the training was excellent (Swain and Gale, 2014). However, this was not a controlled study and there was no measure of the communications skills before and after the training.

De-escalation

Development of De-escalation Training package

Although the intervention package “It’s all about Communication” was rated by participants as excellent, it requires being trialed against already available best practice to determine its superiority and impact in minimizing patient perpetrated violence against healthcare workers. The standards of practice within New Zealand for management of aggressive behaviours of patients are based on best practice rather than evidence-based (Gale et al., 2009; Swain & Gale, 2014). Based on guidelines by TePou, de-escalation is proposed as the first line of intervention when dealing with crisis (Te Pou, 2012). There are no national guidelines for de-escalation and restraint in New Zealand (Te Pou, 2012). Each of the District Health Boards (DHB) has their own guidelines on de-escalation training. However, the basic techniques are similar and drawn from National Institute of Clinical Excellence (NICE) guidelines (2005). De-escalation is the most widely used intervention to resolve crisis across the healthcare sector and can be used in both hospital and community settings (Te Pou, 2012). Clinical practice also re-iterates that de-escalation can prove to be the most effective method in minimizing violence and aggression if used appropriately and in a timely manner (Doughty, 2005). It is for these reasons that de-escalation training has been chosen as the best practice that “It’s All about Communication” should be trialed against.

Principles of De-escalation

De-escalation involves the use of various psychosocial short-term techniques aimed at calming disruptive behaviour and preventing violent behaviour from occurring (Dix, 2001). Every effort needs to be taken to avoid confrontation. This can include talking to the patients, often known as verbal de-escalation, moving them to a less confrontational area, or making use of a specially designated space for de-escalation (Dix, 2001). The staff member needs to observe for signs and symptoms of anger and agitation, approach the person in a calm controlled manner, give choices and maintaining the patient’s dignity (Dix, 2001; NICE, 2005). De-escalation techniques also emphasise the therapeutic use of one’s own personality and relationship with the person as a method to interact therapeutically with the patient (Dix, 2001; NICE, 2005).

Based on the principles of de-escalation, a structured educational package focused on de-escalation techniques is being developed as the control package. This is also a group based training adapted from de-escalation practices across New Zealand within the mental health services of the different DHBs. The de-escalation package will also be scripted and structured and delivered as weekly sessions over four weeks using a DVD to illustrate examples from practice.

- **Components of De-escalation Training**

The de-escalation training will follow the traffic light system through the four sessions. The first session will include discussions on meaning of aggression, reasons for aggression, signs of aggression and measures to prevent aggression from escalating. The discussion will be in pairs and then wider group based along with DVD illustrated examples from clinical situations. This session is the orange phase as it is the phase

when healthcare workers need to identify early warning signs of patient aggression and intervene early to prevent escalation of potentially dangerous behaviours. The next two sessions focus on the green phase of active de-escalation. The topics of training include skills for effective de-escalation like honesty, confidence, non-judgmental and non-authoritarian approach and empathy, when to call for help, body skills, verbal and listening skills. The final session focuses on when to set boundaries, stop de-escalation and progress to the next level of interventions and the importance of debriefing. This is the red phase as you enter this phase when active de-escalation has been unsuccessful.

• **Instruments of measurement for “It’s All about Communication” and De-escalation Training**

The instruments to collect the data will include a questionnaire which includes 5 sections- demographics, POPAS-NZ, Kessler-10, IES-R and Interpersonal Communication Competence Scale (ICCS). To determine long term impact, the follow-up period will be up to 6 months. The data will be collected at baseline, immediately after training, one month post, three months post and six months post training. The ICCS has been included to measure communication competence before and after the training. A recent review of communication measures by Ang, Swain and Gale (2013) recommended the Interpersonal Communication Competence Scale (ICCS) (Rubin & Martin, 1994) for interventions that focus on communication skills.

Table 1: Outline of “It’s All about Communication” versus De-escalation Training

Session	“It’s all about Communication”	De-escalation
1	Icebreaker Non Verbal cues Verbal cues Body language Mirroring	Icebreaker What is aggression Reasons for aggression Signs of aggression Measure to prevention escalation of aggression
2	Managing Discomfort Group Dynamics Open and closed questions Empathy Setting agendas	Skills for effective de-escalation Call for help Switch ON your skills
3	Control and Structure Working in pairs Difficult situations Worries and concerns	Body Skills Verbal skills Listening skills
4	What to do when things go wrong When communication breaks down Taking care of ourselves	Set Boundaries Into the RED zone Debrief

Conclusion

Training needs to be sensitive to the needs of patients and staff that are subject to aggression and violence. Training that focuses on communication and de-escalation skills to understand and resolve crisis is useful to both patients and staff. Though, best practice states that psychological interventions like de-escalation and communication should be used as first interventions of choice to manage and resolve crisis, there is limited evidence on the effectiveness of communication skills and de-escalation. This warrants the need for a controlled trial to determine the effectiveness of Communication Skills Training as a suitable violence reduction strategic measure and De-escalation has been chosen as available best practice as it is widely applicable to all healthcare settings.

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Learning objectives

Participants will...

1. gain insight into the estimates of aggression towards healthcare workers in New Zealand and the nature of training provided nationwide.
2. be able to identify the importance of de-escalation and communication skills training and describe its significance as a violence reduction strategy.

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Reducing restrictive practices in healthcare settings: No more talk, time for action

Workshop

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Keywords: Restrictive practices, seclusion and restraint, culture change

Perspective: Practice

Background and Context

Objective strategies to reduce restrictive practices have been proposed for 10 years, yet the number of injuries that result from the use of restrictive practices continues to increase in human services programs in the United States. (Janocha & Smith, 2010) It is estimated in the medical field that the gap between research – what we know – and what we do in practice is 17 years. (Targonoski, 2010) “Best Practices” statements have been developed in a number of different states and human service sectors, but have had little or no impact on actual service delivery. (LeBel et al, 2010) During the years between the time research has established the pathway to safety for all people in human services and this present time, individuals served and staff have been injured and, in some cases, killed. The time for talk is well past and what is needed now is action that is a process that can be replicated when the participant stops reading this paper or walks out of a workshop.

Methodology

Key indicators from Six Core Strategies to Reduce the Use of Seclusion and Restraint Planning Tool (Huckshorn, 2005) and Checklist for Assessing Your Organization’s Readiness for Reducing the Use of Seclusion and Restraint (Colton, 2009) have been updated and integrated into an approach based on the principles of Positive Behavior Support to change the behavior of staff at an individual and a corporate level. An approach to move beyond staff training and use a staff development approach was implemented with careful measure and correlation of staff development activities and reductions in specific target behaviors. Positive outcomes require an organizational commitment where training forms part of a multi-element strategy in order to achieve safety for all people. In this way, we are able to move from staff training to staff development. Training approaches typically focus on meeting minimum requirements present in regulatory and other standards, while staff development deepens and broadens the skills of staff to respond to changing and complex issues in the workplace. Building on the work of Professor David Allen (Allen, 2009) workshops were held for organizations in Wisconsin and Florida to solidify the cultural changes needed in order to achieve the goal of reducing restrictive practices. Nine steps were identified to support organizations to achieve restrictive practices.

Those steps are

1. Committing the organization – Changing organizational cultures is the most important step in this process, and therefore is the first step. Peter Drucker, one of the earliest and best known organizational management theorists, is reported to have said that “culture eats strategy for breakfast.” Without a change in the culture, organizations have, in the past, started a change process, only to see it fail because the toxic organizational culture ate it for breakfast. The leaders of an organization will need to build a core team of champions for change. By committing the organization, and then supporting that commitment, leaders can support the long term process of reducing restrictive practices. At a minimum, culture change takes 2-3 years, and must be supported in the ups and the downs of the process. (Dawson, 2010)
2. Collecting baseline and ongoing data – It is a truism that you cannot where you are going unless you know where you have been. Data informed practice is one of the key principles presented in Six Core Strategies to Reduce the Use of Seclusion and Restraint (Huckshorn, 2005 *ibid*). Baseline data tells you where you are, and without it, sound decisions are difficult to make. One of the organizations participating in this project had reduced seclusion and restraint significantly in 2011 and 2012, and after changes in leadership positions, the use of restrictive practices increased. It was this knowledge of baseline data that empowered leaders to take up the challenge to change. Central to the process of collecting data is the message given to staff that while we want to reduce the use of seclusion and restraint, we want to achieve this goal in a way that does not increase the risk of injury to the individual served, other consumers, and staff. Without this message, staff may perceive that restraint is a “bad thing” and not restrain when restraint may be the least amount of interaction needed for safety at that particular moment.
3. Conducting an environmental audit – Primary to this stage is ensuring that known individual environmental triggers such as heat, noise, crowding etc., are identified and addressed where appropriate. Additional is the fabric of the physical environment. While it is accepted that issues of challenging behavior may impact how

an environment is decorated and maintained the principle is that it should be, even if this requires a creative approach. Where creative adaptations are employed appropriate materials of suitable strength and safety should be employed.

4. Ensuring the whole organization is trained in the principles of Positive Behavior Interventions and Supports (PBIS) – There is a large and growing body of knowledge about how to use PBIS to make humane changes in the lives of people, while at the same time minimizing the use of restrictive practices. (Carr, E.G., Dunlap, G., Horner, R.H., Koegel, R.L., Turnbull, A., Sailor, W., Anderson, J., Albin, R., Koegel, L.K., & Fox, L. (2002). *Journal of Positive Behavior Interventions*, 4(1), 4-16.) That information must be not only given to staff, but their competency to implement PBIS approaches to behavior change must be developed and enhanced.

At the same time, we must find ways to use those same behavior change tools with staff. “You can only give what you have” is a common saying that describes the principle that to change the behaviors of others positively, you must experience those principles being used on you by your supervisors, managers, and administrators.

5. Ensuring those individual served in need of PBIS assessments and interventions receive them – One of the key methods to reduce the use of restrictive practices is to ensure that people who need behavioral assessments receive them. Not every assessment will lead to a plan, but without an assessment, there can be no plan. One the assessment has determined a need, a plan must be implemented. In most American states, providers have 30 days to develop a plan once a need is identified. Without such a plan, safety for all people cannot be provided for anyone.
6. Ensure that all staff are trained in ethical approaches to reactive management – The National Staff Development and Training Association has developed a Code of Ethics for Training and Development Professionals in Human Services (Curry et al, 2004). The Code identifies six areas to be addressed:
 - beneficence and non-maleficence;
 - learning, development, self-awareness and self-actualization;
 - human service leadership;
 - individual uniqueness, cultural diversity and competence;
 - self-determination; and
 - integrity.

While not specifically directed at teaching the prevention and, if necessary, use of restrictive practices, these six areas can and should be incorporated into staff training and development in the areas of restrictive practice. Each organization should integrate these six ethical areas of concern into their policies and procedures regarding the use of restrictive practices. From an ethical perspective, the term “imposed a restraint” is preferable to “implemented” or “applied” a restrictive practices, as we are engaging in a restrictive practice. There are times that to not impose a restraint can be more dangerous to the person and/or others than to impose a restraint, and we must be clear about the need for safety for all people. From an ethics perspective, no one person or group has a higher right to safety than another. We will treat all people with dignity and respect at all times, especially if and when restrictive practices are needed to ensure the safety of all stakeholders in human service settings.

7. Identify proactive and reactive strategies for managing stress – In many state and federal legislations surrounding the use of restrictive practices, organizations are required to prevent, de-escalate, and if necessary, intervene in order to ensure the safety of all people in human service settings. (Children’s Health Act of 2000). Proactive elements that lead to prevention and/or de-escalation are to be identified in each organization, and restrictive practices cannot be used unless less restrictive interventions have been determined to be ineffective in providing for the safety of the person and/or others.
8. Establish a quality assurance system for monitoring service inputs and outputs – The key areas identified above are all service inputs. Training, supervision, leadership, data collection, ethical practices, environmental audits, and PBIS assessments and plans are inputs designed to increase safety. Rather than just measure the absence of risk, however, we must learn to measure the presence of safety related behaviors. (Bowen & Privitera, 2012) When we measure the presence of the positive, we are better able to reinforce behaviors that we wish to see. Positive reinforcement is much more effective at changing behavior than punishment. (Skinner, 1953) By focusing on the presence of the positive, Quality Assurance will be viewed in a different light than is presently the case.
9. Celebrate success and take remedial action where necessary – As stated earlier, culture change in organizations takes at least 2 or 3 years to accomplish. Celebrating small successes is critical, as people can get demoralized if success is measured in larger, global terms. Likewise, remedial action is often delayed, as managers and supervisors in human service settings tend to avoid confrontations. Avoiding conflict, or accommodating the needs of people are the two highest responses to conflict among managers in human services, as measured by the Thomas-Kilmann Conflict Mode Instrument. When remedial action is not taken on a timely basis, the behaviors that should be remediated are instead reinforced, and it becomes more difficult in the future to address the behavior. (Longo, 2010)

Findings

Organizations using this tool as a guide for comprehensive change have demonstrated significant reductions in the use of seclusion and restraint as well as injuries to staff and individuals served. A comprehensive report identified key indicators of success and continued steps to build on success with the goal of the eventual elimination of restrictive practices through preventative approaches and a methodology to change behavior using Positive Behavior Support.

One of the organizations involved in the study added a concept to leadership of a “blameless culture.” When finding the root cause of incidents, there was no effort to find blame or fault with any one person. The focus was on how to learn from the present in order to change future interactions and to assume that what happened in the past was the result of the best actions of the staff. Remembering that we can only give what we have, as members of the team supporting individuals receiving services, we can, must, and will support each other at all times, and in all ways.

Implications for practice, research, education and training: Providing a structured format that can be easily replicated has the potential to change practice in all human service settings. Staff training generally meets minimum regulatory expectations, while staff development both deepens and broadens skills to empower staff to address a broad range of issues using principle based education. Further research is needed to measure the success in cultures other than the United States.

Brief Description of Achieving 50% structured active participant involvement: The presenter will use small group participation to structure participation by using select tools from several of the nine stages used to achieve reductions in restrictive practices.

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Learning objectives

Participants will...

1. be able to identify the nine stages of reduction in restrictive practices.
2. be able to delineate the role of leadership in the process of reducing restrictive practices.
3. have adequate knowledge to describe proactive and reactive strategies for reducing stress.

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Support of healthcare personnel with behavioral emergencies in medical settings

Paper

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Perspective: Practice

Background and context

Violence against health care workers presents an occupational hazard that impacts the same individuals who are called to care for others. The far-reaching effects of workplace aggression include absenteeism, fear, and decreased productivity. Consistent with institutional priorities, a behavioral emergency response team (BERT) was developed in response to disruptive patient behavior. The goal of BERT is to collaborate with medical providers to safely manage urgent behavioral situations occurring on inpatient non-psychiatric practice areas.

Methodology

Team membership consists of a Registered Nurse (RN), security officer and, when needed, a psychiatric resident. Training for BERT members included an instruction on medical unit/emergency room environments, medically-complicated disorderly behavior and simulation center training. At commencement, BERT information was distributed to hospital settings via organizational announcements and education venues. BERT oversight was maintained through quarterly data review and role evaluation with institutional leadership. A workload measurement system captured time allocation among categories of patient care, consultation, and work coordination. Satisfaction surveys from BERT service users endorsed its value.

Findings

The BERT role evolved from an emergency-only based response to comprehensive service provision. These services included consultation with medical staff to brainstorm pre-emptive interventions for difficult patients, attendance at individual patient multidisciplinary care conferences to establish consistent behavioral expectations among providers, side by side support to medical nurses to role model approaches with intensely difficult patients, and assistance to patients relocated from emergency room boarding. Standardized practice-related presentations for medical staff development were used to deliver education. Core education topics focused on awareness of conditions contributing to violent situations, limit setting, engaging patients, and use of delirium and alcohol withdrawal protocols. Debriefing was emphasized due to provider trauma, particularly related to instances of readmitted patients. Specialty issues that arose involved critically ill patients who received dual services from both BERT and the Rapid Response Team (RRT) and unique developmental circumstances with pediatric patients.

Implications

Administratively, development of BERT had fiscal and procedural implications. As the role expanded, it required financial support for 24/7 coverage. Procedural guidelines to care for individuals at risk to harm themselves or others were written. Due to the urgency of incidents, BERT needed readily available departmental resources such as legal, ethics, security, and psychiatry. Access to and utilization of these resources was imperative to extend a consistent response to the complex patient. The BERT service is an institutional strength in resource management; and, to further establish its value, research opportunities include analysis of predictive factors for violent behavior, effect of interventions on specific patient conditions, and cost savings evaluation.

Learning objectives

Participants will...

1. identify two strengths, in terms of resource management, brought to an organization by developing a Behavioral Emergency Response Team (BERT).
2. identify three specific BERT interventions that support personnel who deal with violent patients.

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The validation of the East London Modified Broset (ELM-B): A new instrument to predict the use of seclusion in acute psychiatric settings

Paper

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Perspective: Practice

Keywords: Broset Violence Checklist; seclusion; violence; psychiatry

Abstract

Background. Violence is common on acute psychiatric wards. Although seclusion is usually employed as last resort treatment to contain high risky behaviors, its implementation is clouded with uncertainty due to the lack of pragmatic psychometric tools. The Broset Violence Checklist (BVC) is a reliable and validated instrument to predict imminent violence, it is not used to assess the appropriateness of the use of seclusion.

Methods. Developed an 8-item modified version of the BVC, the East London Modified-Broset (ELM-Broset). It was retrospectively analyzed for its sensitivity and specificity with regards to secluding high-risky psychiatric inpatients ($n = 43$; incident $n = 313$), and to compare it to the BVC for the same inpatient group. Data analyses were carried out using logistic regression and ROC Curves.

Results. The ELM-Broset showed good accuracy in predicting the use of seclusion with a sensitivity: 88.2%; specificity: 76.3%; AUC = 0.88; $p < 0.000$; 95% C.I. [0.83, 0.94]; as compared to the predictive value of the standard BVC: sensitivity 82%; specificity: 55%; AUC = 0.74; $p = 0.000$; 95% C.I. [0.66; 0.82]. Pairwise comparison of the ROC curves showed a statistically significant difference: $\Delta = 0.148$; SE: 0.022; $p < 0.0001$; 95% C.I. [0.10, 0.19]; with large effect size: $Z = 6.63$.

Conclusions. The ELM-Broset is a sensitive and specific psychometric instrument which can be used to guide the decision-making process when implementing seclusion for high risk psychiatric inpatients.

Introduction

Violence is common on acute psychiatric wards (Abderhalden et al., 2006). Although the employment of appropriate conflict-resolution techniques by staff can improve safety (Bowers et al., 2006), the effect size of these techniques is not sufficient to create safe wards. In some circumstances, a patient's disturbed behaviour leaves little room for therapeutic engagement and seclusion becomes an unavoidable therapeutic choice (Gaskin et al., 2007). However, the use of seclusion as a therapeutic tool is controversial and criticised by many (Frueh et al., 2005) due to the potential violation of human rights in vulnerable adults, and who experience it as traumatic and distressing (Georgieva et al., 2012).

The decision to seclude a patient is affected by clinical, ethical, legal (Beer et al., 2008), and emotional factors in the treating team (Bonner et al., 2002). All these elements make the decision-making process fragmented and ad hoc, thus potentially leading to excessive use, i.e. abuse (Kaltiala-Heino et al., 2003). This may go some way to explain the different rates of seclusion across different countries. One of the reasons for such variability is arguably the lack of validated procedures that guide the clinical decision-making process.

The East London modified-Broset (ELM-Broset) was developed as a new seclusion prediction and decision-making instrument based on the existing Broset Violence Checklist (BVC). The BVC is a well-known and validated risk assessment tool (Almvick et al., 2000) and was used as a benchmark instrument to compare the utility of the ELM-Broset. The two instruments were compared in its sensitivity, specificity, and false prediction rate (FPR) in a sample of acutely violent patients.

Methods

Participants

The samples consisted of 43 inpatients (males, $n = 32$; female $n = 11$) consecutively admitted to Millharbour (Male) and Rosebank (female) Psychiatric Intensive Care Units (PICUs) at Tower Hamlets Centre for Mental Health (London), over a year period. Table 1 lists the selection criteria for the sample at study.

Table 1. Selection criteria

Criterion	n
Incidents	
Initial	332
Final	313
Out-of-Area (only Male PICU)	13
Insufficient clinical data	5
No incidents during admission	4
Outliers (ELM-Broset ≤ 3)	10

Note. Out-of-area: referrals from external hospitals.

Psychiatric assessment

A Psychiatrist (FL) and a Registered Mental Health Nurse (DMJ) were responsible for the retrospective ratings. For the purpose of this research, an incident was defined as any clinical event that led to an interaction between a patient and a staff which involved the use of de-escalation techniques (verbal and/or physical) and/or the administration of sedative medications.

Psychometric tool

The ELM-Broset (Figure 1) is an 8-item checklist based on the 6-item BVC, which follows the same compilation rules (see Almvick et al., 2000 for detailed reference).

Figure 1: The East London modified Broset (ELM-Broset)

Ward	
Rater	
Patient	
Date	
Descriptor	Present
Confused	
Irritable	
Boisterous	
Verbal Threats	
Physical Threats	
Attacking Objects	
Response to De-Escalation	
PRN Compliance	
Total 0/8	

Note. See text for description.

The main differences between the two tools are the inclusion of two additional items for the ELM-Broset: 1) response to de-escalation; and 2) compliance with PRN (pro re nata) medications. If these prompts are not followed, patients will be scored as "1" for each item. The total possible score on the ELM-Broset is 8, while the maximum score on the BVC is 6. While the latter, BVC, is a prediction tool of violence occurring within 24 hours following an assessment, the ELM-Broset is a decision-making tool to be used at the time an incident has already occurred or is taking place.

Data analysis

Parametric and non-parametric analyses, along with effect size (ES) of the differences, were done. Sensitivity, specificity, and false prediction rate (PFR) of each of the two scales were estimated using Receiver Operating Characteristics curves (ROC) with overall performance of the curves expressed by the Area Under the Curve (AUC) index, with estimation of the coordinates of the curve for each tool. Pairwise difference between the AUCs was calculated.

Results

Demographic and clinical variables

Table 2 shows the main characteristics for the sample in the study. Only age was significant different between male and female participants with medium ES (Cohen’s *d* = 0.5), and this has expected face validity.

Table 2. Demographic and clinical data

Descriptor	Non-Secluded	Secluded	p	ES
Age* (years)	31.9 (8.8)	27 (5.5)	0.031	0.5
Sex (n, %)				
Male	18 (66.7)	2 (12.5)	ns	-
Female	9 (33.3)	14 (87.5)	ns	-
Ethnicity (n, %)				
Caucasian	5 (19.2)	6 (37.5)	ns	-
non-Caucasian	21 (80.8)	10 (62.5)	ns	-
Diagnoses (% of total)				
SCZ spectrum	44.2	16.3	ns	-
Affective	7	11.6	ns	-
PD Spectrum	7	4.7	ns	-
Antisocial traits (n, %)				
present	13 (56.5)	7 (46.7)	ns	-
non-present	10 (43.5)	8 (53.3)	ns	-
Borderline traits (n, %)				
present	3 (13)	3 (20)	ns	-
non-present	20 (87)	12 (80)	ns	-
History of seclusion (n, %)				
present	3 (11.1)	4 (25)	ns	-
non-present	16 (59.3)	5 (31.2)	ns	-
unknown	8 (29.6)	7 (43.8)	ns	-
Substance Abuse past 2 weeks				
present	13 (48.1%)	10 (62.5%)	ns	-
non-present	4 (14.8%)	3 (18.8%)	ns	-
unknown	10 (37%)	3 (18.8%)	ns	-
Note: Means and (standard deviations). ES = effect size; Ns = non-significant. Statistics: * Δ scores: -0.02, Bca 95% CI [0.54, 9.14] significant $t(41)$ 2.24, $p = 0.031$, Cohen’s $d = 0.5$.				

Psychometric tools

The results of the logistic regression model are reported in Table 3. Although three of the BVC predictors were not significant (confused, irritable, and boisterous), these were still included part of the ELM-Broset as these factors were judged to aid the team discussion for the appropriateness of seclusion. Of the 313 incidents, 34 led to seclusion (M = 5.76; SD = 1.1), while 279 did not (M = 3.63; SD = 1.24). This difference, -2.13, Bca 95% CI [-2.53, -1.73], was highly significant: $t(311) -9.55$, $p < 0.001$, Cohen’s $d = 1.8$. AUCs, sensitivity, specificity, and FPR were calculated using ROC analyses (Fig. 2). The difference between the two AUCs (Table 4) was highly significant: $\Delta = 0.148$; SE = 0.0224; 95% CI [0.104, 0.192], $p < 0.0001$; $z = 6.63$. The coordinates of the curve (Table 5) show the sensitivity and FPR for the ELM-Broset is superior when compared to the BVC at all threshold levels. For the ELM-Broset, the best trade-off is achieved at a threshold score between 4 and 5 (sensitivity = 88%; FPR = 23.7%).

Table 3. Coefficients of the model predicting whether a patient was secluded

Factors	p	95% CI for Odds Ratio		
		Lower	Odds	Upper
Confused	0.41	0.26	0.66	1.73
Irritable	0.59	0.16	2	26.2
Boisterous	0.55	0.46	1.4	4.26
Attacking Objects	0.01	2.22	6.51	19.1
Physical*Verbal Threats	0.00	4.82	14.4	42.9
PRN Compliance* Response De-Escalation	0.00	5.5	18.4	61.1

Note: Goodness of Fit Model X2 (8) = 77.9; p < 0.000; Nagelkerke's R2 0.44.

Table 4: AUC values

Area Under the Curve					
Tool	AUC	Std. Error	p	95% CI	
				Lower	Upper
ELM-Broset	0.889	0.028	0.000	0.834	0.943
BVC	0.74	0.042	0.000	0.658	0.823

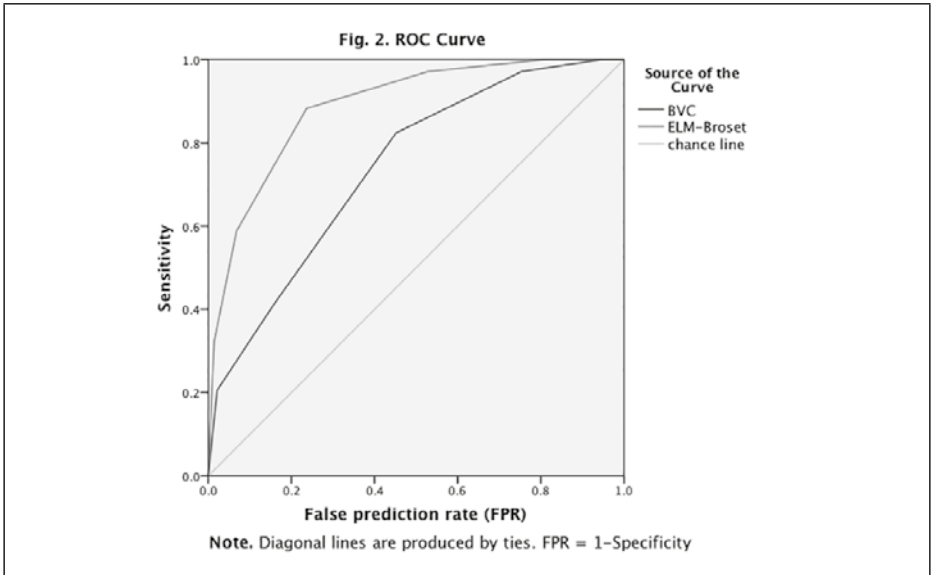
Note: See text for description.

Table 5: Coordinates of the curve

Tool	Cut-off	Sensitivity	FPR
ELM-Broset	0.00	1.000	1.000
	1.50	1.000	0.975
	2.50	1.000	0.814
	3.50	0.971	0.527
	*4.50	0.882	0.237
	5.50	0.588	0.068
	8.00	0.000	0.000
BVC	0.00	1.000	1.000
	1.50	1.000	0.95
	2.50	0.971	0.753
	*3.50	0.824	0.452
	4.50	0.412	0.158
	5.50	0.206	0.22

Note. Cut-off positive if ≥ 0 . FPR = False Prediction Rate. (*) Indicates best trade-off.

Figure 2: ROC curve



Discussion

This is the first seclusion decision-making and prediction tool available to date. The preliminary results of this retrospective study have shown that three descriptors significantly predicted the occurrence of seclusion in a sample of acutely disturbed patients, namely aggression towards objects, verbal and physical aggression, and inability to take directions from staff. Disorder of thinking (confusion, disorientation), irritability, and boisterousness did not significantly predict the outcome although in line with Almivick et al's findings (2000), the presence of these attributes increases staff's alertness for impending risk of violence. This is in keeping with clinical experience that irritable and loud patients are not necessarily secluded, while there is increased concern leading to seclusion in the presence of damage to property, and verbal and body language aggression.

Clinically significant incidents leading to seclusion scored significantly more than those not leading to seclusion, with very large effect size as measured by the ELM-Brosset. The BVC was less discriminatory for these same incidents leading to the different outcomes. This highlights the ability of the ELM-Brosset tool to discriminate between degrees of disturbance in violent patients and the ROC plot indicated good precision as compared to the BVC. This is further reflected in the differences of sensitivity and FPR at each threshold point (Table 5) of the two tools. At a threshold (cut-off point) between 4 and 5 sensitivity and FPR were significantly better for the ELM-Brosset than for the BVC. This threshold score on the ELM-Brosset also confirmed that the threshold to secluding on the local PICUs was high, which dispels the concerns raised by the possibility of a FPR of 23.7%. This means that according to the ELM-Brosset's metrics, almost a quarter of patients could be secluded without reasonable justification. This, however, is due to one of ELM-Brosset's limitations with the classification process used by the retrospective analysis. The system classifies as "true positives" those who are secluded with a high score, as opposed to those with a low score who are not ("true negatives"). The seclusion of a patient with a low score (for instance, a patient who punches a nurse and is immediately secluded, might score as low as 4) will be seen by the classification as a false positive when this is indeed a true negative (i.e., the patient needed to be secluded). This limitation indicates the need to further refine the current scoring system, but did not lead to high numbers of inappropriate seclusions.

In conclusion, the ELM-Brosset is a quick and easy to use tool for the prediction and decision-making for those starting or indeed discontinuing seclusion. The simplicity and utility can guide the decision-making process thus minimizing emotional factors affecting the final decision, while enhancing confidence in the team around seclusion being a treatment option. Future directions will include a prospective study and a bigger sample size.

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To patients on the PICUs, because their sufferance was not been endured in vain, but will help the recovery and quality of care of others coming into mental health hospitals. The study was sponsored by the East London NHS Foundation Trust.

Learning objectives

Participants will...

1. be able to identify clinical, ethical, legal, and emotional factors that can cloud the decision-making process around the use of seclusion.
2. be able to inform the clinical decision around the use of seclusion and discuss it within a team in a rational and consistent way. Specifically the participant will be able to confidently interpret and employ the East London modified-Broset (ELM-B) in a clinical scenario involving the use of seclusion.

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An assessment of preventing and managing aggressive behavior in a US state hospital system

Paper

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Perspective: Education and Training

Background and context

In the United States, the primary and often sole strategy for preventing health care worker injuries from assaultive patients/clients is training in the prevention and management of aggressive behavior. While evidence suggests that training may reduce risks to staff, research into what training content and processes ensure safe, effective, and acceptable practice is severely limited. In the absence such evidence there is agreement among experts that training at all levels of prevention should be participant centered and include learning outcomes that are informed by a thorough risk assessment about the patient population, the staff/provider population, and the physical and social environment in which the interaction between them takes place.

Methodology

In 2012, the Maryland Department of Health and Mental Hygiene (DHMH) in partnership with American Federation of State, County, and Municipal Employees (AFSCME) convened a one-day participatory workshop attended by 26 direct care workers, union representatives and administrators. The purpose of the workshop was to review and offer recommendations for improving staff training in the Preventing and Managing of Aggressive Behavior (PMAB) being utilized by DHMH facilities (hospitals and residential centers). The workshop focused on the management of aggressive behavior and included a demonstration and review of all approved physical intervention techniques taught as part of the mandatory two-day training. In advance of the workshop each institution conducted a three year review of the staff injuries and examined the PMAB techniques applied in each incident. These data were presented and discussed at the beginning of the workshop.

Findings

Participants were initially asked for criteria for the selection and use of physical intervention techniques and offered the following: safety of client and staff, legality/approval by certified bodies, low complexity, efficacy, appropriate for population being cared for, type and level of behavior exhibited. Staff noted that no matter how good the instructor, not everyone walks out of the training with the same knowledge. In general, staff reported that the majority of the techniques on which they were trained were satisfactory yet they expressed serious concerns that the simulated training exercises did not adequately prepare them to manage assaultive behaviors in crisis situations. There was also much discussion about the nature and frequency of refresher/practice sessions. In addition, staff reported discordance between the number of staff needed to safely perform physical intervention techniques and how they are applied when needed on the unit.

Implications

Findings from the workshop were used to inform the revision of DHMH's PMAB training. Specific recommendations included: policy and training regarding the minimum number of staff needed to safely perform each maneuver; simulation of real life experiences to the extent feasible; and monthly refresher/practice sessions.

Learning objectives

Participants will...

1. be able to describe the critical elements of training to manage aggressive patient behavior.
2. be able to assess staff participation when developing and revising training in managing aggressive patient behavior.

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Safety tips and strategies for providers making home visits

Workshop

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Perspective: Practice

Abstract

This workshop will offer strategies to develop a culture of safety in your organization and offer direct tips on the dos and don'ts while working in the field.

In the past decade there has been a tremendous increase in the effort to increase access to services by moving the loci of services out of office based professional building to the homes and none traditional community sites. Particularly, these efforts to increase access to services has targeted hard to reach and difficult to engage clients and families who present with multiple health and psychosocial needs. These efforts encompass a variety of health care services including mental health, nursing, PT, home health and the like.

These efforts have exposed health care professionals such as: Social workers, nurses, PTs, home health, care manager professionals and a cadre of other providers to new risks. As professional venture out into the communities where the clients live they are exposed to increased safety risks safety risks: mugging, assault and physical violence and in many cases not from the clients we are offering care.

The workshop will offer a perspective on what an administrator as well as direct healthcare providers need to know to better insure the safety while providers are making home visits and assist them in developing strategies including training, supervision and support systems to better ensure the safety of the direct care providers.

Learning objectives

Participants will...

1. gain a basic understanding of the possible risks and the need for a company strategy to limit them.
2. gain a basic understanding of the dos and don'ts while providing home based care.

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Safe and confident employees, makes safe and confident patients - Why does the Therapeutic Management of Aggression (TMA) have an effect?

Paper

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Perspective: Practice

Background and context

Therapeutic Management of Aggression (TMA®) is a systematic way to prevent, handle, treat and follow up aggression and violence. TMA is used in all the units in the in Stavanger University Hospital, Division of Psychiatry. The method has been in a continuous development since 1993. The main focus is to prevent aggression.

Methodology

The physical techniques are developed for getting out of possible aggressive and violent situations. They can be used by everyone. There is a daily focus on TMA in all psychiatric units and wards by discussions and training on techniques. Our basic attitude is "See others as you want others to see you" including patients, employees and relatives. TMA is based on the vision that all patients should feel that they are taken care of with respect and dignity. Everyone, patients, peers and staff, should be safe when they stay or visit our departments. To ensure this, it requires a fundamental understanding of human dignity, what happens between people in crisis, and how we can turn a difficult situation and provide safety to everyone affected.

The TMA education program contains a mandatory course for 3 days for all employees in the psychiatric division. The TMA instructor education course last for 5 days. The 3 days mandatory course for all employees consists of a combination of theory and practical techniques and we organize approximately 7 courses per year. The theoretical foundation is based on social psychological principles where prevention, communication, ethics, attitude and understanding aggression and violence are the main focus. We also offer lessons externally partners; for example acute emergency somatic units, paramedics, schools and municipalities (social security offices).

Findings

From 2008 to 2013 we have reduced the use of restraint by 64% and violence against employees with 42%. We have an ongoing research on how systematic focus on TMA has an effect on short term absence.

Learning objectives

Participants will...

1. have an understanding of how safe and confident employees make safe and confident patients, and how this concept of training can prevent aggression and violence;
2. have an understanding of how the Therapeutic Management of Aggression is a method to prevent, handle, treat and follow up aggression and violence.

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Aggression and violence towards health care workers in a Psychiatric Department in Italy

Poster

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Focus: Education and Training

Background

Violence at work is one of the major concerns in health care activities. Although international scientific studies and prevention programs have been conducted in order to deal with aggression and violence towards health care workers, activities of research and implementation of practical intervention programs are still scanty in Italy. The Department of Psychiatry of Bolzano (Italy) adopted a de-escalation model developed by the Institut für Professionelles Deeskalations-Management (ProDeMa®). This model includes interventions of evaluation, prevention, theoretical and practical trainings aimed to prevent or reduce patients' aggressive behaviour towards health care workers. Findings from the retrospective questionnaire-based survey, conducted as a part of the program of prevention of aggressive behaviour on the workplace, are presented here.

Methods

A retrospective questionnaire-based survey on workplace aggression was conducted at the Department of Psychiatry of Bolzano. Health professionals, including psychiatrists, psychologists, nurses, social workers and clerks, were interviewed by using the 11-item questionnaire developed by the Institut für Professionelles Deeskalations-Management (ProDeMa®).

Findings

A total of 165 out of 211 surveyed workers completed the questionnaire (response rate 78%). The survey assessed frequencies and types of aggressions, and situations and behaviours that could produce or prevent the aggressions. The one-year total number of verbal aggressions (VAs) was 9766, with 36% (mean number 51 per worker) at the REHAB, 27% (mean number 43 per worker) at the OUP and 37% (mean number 106 per worker) at the INP, respectively. The one-year total number of physical aggressions (PAs) was 1502, with 7% (mean number 1.6 per worker) at the REHAB, 4% at the OUP (mean number 1.0 per worker) and 89% (mean number 39.2 per worker) at the INP, respectively. Finally, the one-year total number of injuries (INs) was 200, with 7% (mean number 0.2 per worker) at the REHAB, 14% (mean number 0.4 per worker) at the OUP and 79% (mean number 13.3 per worker) at the INP, respectively.

Implications for practice and research

Our project of de-escalation management in psychiatric care is still in progress. Based on our data, verbal aggressions are very common at all facilities and units of our Department, while physical aggressions and injuries are more frequent at the inpatients unit. We are organizing a theoretical and practical training for all psychiatric professionals in our Department aimed to prevent or reduce aggressive behaviour of patients. At the conclusion of the training, we will repeat the questionnaire-based survey in order to evaluate the efficacy of the program in terms of reduction of violence. Moreover, we are collaborating with different psychiatric and social institutions in order to spread this program in other public and private psychiatric and social services of our region. The implementation of a theoretical and practical intervention program of de-escalation could be helpful to reduce workplace violence for all professionals at the psychiatric healthcare.

Learning objectives

Participants will...

1. have an understanding of the frequencies and types of aggressions and of the situations and behaviours that could produce or prevent the aggressions at work place during a year in a Psychiatric Department in Italy.
2. have a basic understanding of the theoretical and practical training for all psychiatric professionals that we are implementing in our Psychiatric Department to prevent or reduce aggressive behaviours of patients.

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Third party violence risk factors: An open website to its evaluation and prevention

Poster

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Focus: Practice

Abstract

Workplace violence coming from a third party is an important psychosocial stressor in the Healthcare sector. This problem does not emerge as an unavoidable or uncontrollable natural process, but as a phenomenon that can and should be forecasted and prevented. From this background assumption, we designed in 2006 the website www.violenciaocupacional.cat a computerized system allowing online and on time registering information about such violent incidents against Catalan healthcare professionals.

For its development, the project was supported by the Catalan Society of Work Safety and Medicine, by Prevent Foundation, by Autonomous University of Barcelona, and by the Spanish Ministry of Education and Science (SEJ2004-06680/PSIC y SEJ2007-63686/PSIC research projects). Throughout the years and so far, have come to actively engage in the project about 75 Catalan health centers in which have been working between 36,000 and 42,000 professionals.

In this database, we collected, from 2006 to 2014, nearly 7,000 incidents reported by the online Occupational Violence Questionnaire. This tool provides a map of who is attacking whom, where, when, how, for which subjective reason, and with what consequences.

The incidence of the phenomenon varies by type of service. Mental Health has the highest incidence rate (16842.11), ahead of Primary Care (5903.94), Health Care Associate (5277.69) and Hospital Care (1559.16). The main subjective reasons mentioned for the violent act set the timeout of care, the deficit in the quantity or quality of the information received, questioning the type of care or treatment received from the healthcare professionals, the unwanted medical discharge and state of agitation of the patient.

Currently, we are involved in the design and implementation of a comprehensive primary prevention project that includes reporting and investigating violent incidents and types of aggressions that should allow healthcare professionals to spiral of assessments and interventions in this field. So we've established a working group with representatives of the involved institutions in the project and commission of experts have identified that weight of 28 and weighted risk factors for onset of violence handled in the study, categorized turn in 4 dimensions: (a) Policy (management of risk prevention in the enterprise, procedures and protocols, notification and registration, evaluation and prevention, etc.) (b) Organization (resources, leadership, structures and work practice times, etc.) (c) Environment (physical ecosystem, access, pollutants, sensing and actuation systems, etc.) (d) Individual (preparation of the working staff, medical, psychological and legal support, etc.). On this basis, we designed a customizable risk semaphore for each institution, assistance and workspace, in order to anticipate the most likely to assess it and severe risks and preventive measures prioritize and apply in each case.

Learning objectives

Participants will...

1. Appreciate the merits and efficiency of an online data base on workplace violence.
2. Have knowledge on the resulting primary prevention programme.

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Psychological health and well-being of serving and discharged military personnel

Poster

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Focus: Practice

Background

Adaptation to the varied demands of the military service, sounds as if some of the characteristics inherent in the military personnel are also observable in the civilians. But the restriction of the military organizational environment, allows for an inadequate adjustment to the psychiatric casualties among military personnel in times of peace as well as war. This calls for an investigation of psychophysiological symptoms in the form of health consequences of change that may be brought from civil life to military service or vice versa. It is known that vocation can serve as an agent of personality change.

The question that comes to mind is, would the military service lead to such change from service to being discharged into the civilian life? Moreover, regimentation which is characteristic of military service creates what might be called military personality. A major problem is that regimentation is aimed at finding out if there is a distinctive military personality in countries where the military has assumed so much significant roles in national security and politics. That is why this study examined if conditioned or prolonged regimentation which is characteristic of military life eventually creates a permanent personality characteristic.

Method

The participants comprised 120 male subjects including 40 serving and 40 discharged military personnel (which both constituted the experimental groups) and 40 civilians (which constituted the control group). The mean ages of the groups are: 36.05, 40.53 and 31.75 years respectively. Their mean years of formal education were: 10, 8.93 and 10.6 years respectively. The Adjective Checklist (ACL) was used to measure the following personality traits: communality, dominance, autonomy, aggression, endurance, personal adjustment, self concept and military leadership. The Psychophysiological Symptoms Checklist (PSC) was used to measure the subjects' psychological health and well-being.

Findings

Analysis of data revealed that serving military personnel had higher mean scores in measures of autonomy, aggression and self-concept. Civilians had highest mean scores in measures of communality, endurance and military leadership. They also have the highest mean score in psychological health and well being which is indicative of poorest health status. The One-way ANOVA results did not reveal any significant difference in any of the 9 measures among the 3 groups ($F = 3.07$, $df = 2/117$, $p > .05$). The results show that regimentation in the barracks did not lead to permanent change in basic personality.

Implications

This implies that discharged military personnel should find it relatively easy to adjust to civilian life soon after leaving the barracks. Moreover, the physical exercises that are characteristic of the military life, promote psychological health as revealed by the low scores of the discharged and serving military personnel. Another implication is that a good militia can be produced in times of emergency.

Learning objectives

Participants will...

1. realize that patients may undergo personality changes after the onset of emotional problems.
2. appreciate that patients may undergo personality changes after experiencing a change of government or that of government policy issues such as the withdrawal of free medical services.

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Workplace violence in the health sector of government and private hospitals in Kathmandu, Nepal

Poster

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Focus: Research

Abstract

The present study is first exploratory study in violence in health sector in Kathmandu. The objective of the study was to acknowledge different kinds of violence, risk factors, and respondents' opinions to violence. To built effective policies and strategies to create safe work environments in hospital settings. A hundred of Nepalese respondents (56 female and 41 male) were surveyed using questionnaires issued by the ILO, ICN, WHO and the PSI. The majority of respondents were nurses (55%) of 25-29 years from government hospitals and full time workers. Violence is under-reported because of no encouragement. 14% of respondents report physical violence, followed by psychological violence then 17% verbal abuse, 11 % bullying, and 5% sexual harassment and threats. Opinions regarding workplace violence emphasized male dominance culture, ignorance, and gender roles. Contributing factors for psychological violence are over workload, individuality, mentally disturbance, low-self-esteem, attitude, jealousy, work stress, and family background. Further, the most important measures to reduce violence were education, awareness programs, monitoring, leadership, security, shift change, good interpersonal relationship, transparency and proper health policy. This study will contribute to the development of intervention programs in workplace violence and provide better quality of daily life activities.

Learning objectives

Participants will...

1. learn of contributing factors for psychological violence in hospitals in Kathmandu.
2. appreciate that the dissemination of information regarding workplace violence must be multifaceted, targeting policy makers, health care centers and the general community.

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Chapter 6- Examples of initiatives which promote and preserve wellness in environments of potential aggression and violence

Quality of initial therapeutic alliance as a predictor of violent behaviour among psychiatric inpatients: A prospective cohort study

Paper

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Perspective: Research

Keywords: Therapeutic alliance, therapeutic relationship, Psychiatric violence, inpatient violence, psychiatric aggression

Abstract

Aim

A prospective cohort study to evaluate the 'Quality of Initial Therapeutic Alliance' as a predictor of violent behavior was conducted among patients admitted in an acute psychiatric ward of a tertiary care hospital at New Delhi.

Methods and Materials

Hundred patients consecutively admitted to psychiatric ward were assessed using two standardized tools; Helping alliance questionnaire (HAQ-II) for quality of initial therapeutic alliance and Overt Aggression Scale (OAS) to record the violent incidents for the first seven days of admission into the ward.

Results

Twenty six patients exhibited violence during their first week of hospital stay. In all 38 violent incidents were reported during 700 patient days and the rate of violent incidents was 5.4%. The mean therapeutic alliance score of patients who were violent (65.42 ± 24.10 ; $n=26$) was significantly lower than that of patients who were non-violent (82.88 ± 16.71 ; $n=74$) during hospital stay. The lower the quality of initial therapeutic alliance, the higher the risk of patients acting out violence during the first week of hospitalization. The model resulting from the binary logistic regression revealed that the therapeutic alliance ($OR=0.961$, $p=0.006$) and preadmission violence ($OR=10.8$, $p=0.001$) were predictors of violent behavior even when other variables were controlled.

Conclusion

The study findings stress the importance of quality of therapeutic alliance in prevention of acts of violence by patients with mental illness admitted to an acute psychiatric ward.

Introduction

Rates of violence among mental health patients peak at time of admission to the hospital [1,2]. In psychiatric units, there has always been a need to consider and manage violence from patients directed towards others. To prevent harm to others, coercive measures such as restraint or seclusion are sometimes taken which patients often describe as a traumatic experience [3,4]. Violence committed by acute psychiatric inpatients represents an important and challenging problem in clinical practice [5].

An act of violence refers to a display of violent behavior. These sets of behavior include: 1) verbal aggression 2) physical attack such as biting, hitting, kicking and spitting; 3) destroying and breaking things; 4) self-attack or suicide such as striking one's head against wall or by hurting oneself with sharp objects. The therapeutic alliance, also called the helping alliance or the working alliance, refers to the relationship between a health professional and a patient. It is the means by which the professional hopes to engage with patients and effect change in them [6,7]. In psychiatric treatment, the interpersonal interaction is the core of practice, making the therapeutic relationship a fundamental element of mental health care. In psychiatric treatment, a good therapeutic alliance is positively associated with fewer hospitalizations, better treatment outcomes, lesser dropouts, better work performance and adherence to treatments [8,,9,10].

During the last decade, research on violence has increased and knowledge about different aspects of violence by patients in psychiatric unit has grown. Foster C et al. estimated that a nurse would have a one in ten chance per year of receiving any kind of injury as a result of patient aggression [11]. In psychiatric settings, 86% of aggressive incidents were preceded by some form of aversive stimulation by the staff to the patient [12]. Environmental manipulation is important aspect of therapeutic environment. Therapeutic alliance is important for creating therapeutic environment by treating team [13]. Beauford et al evaluated the relationship between therapeutic alliance and violent behavior among psychiatric inpatients and reported that the patients with good therapeutic alliance displayed less number of violence than that of patients with poor therapeutic violence [14].

Although situational variables are widely acknowledged to influence the risk of violence by patients with mental illness, most past research has been limited to patient attributes and has neglected the interpersonal context in which violence occurs. Mohanan et al. stressed a need to assess a new type of situational risk factor, the quality of the initial therapeutic alliance between the treating team and patient, as a predictor of the risk of violent behavior during short-term hospitalization (Monahan and Steadman 1994) [15]. This study was designed to assess the role of quality of therapeutic alliance as a predictor of risk of violent behavior among psychiatric in-patients with an objective to assess the quality of initial therapeutic alliance between a patient having a mental disorder and the treating team. The outcome of this study may determine the role of initial therapeutic alliance as a predictor of risk of violent behavior by psychiatric inpatients.

Methods and Materials

This observational prospective cohort study adopted a consecutive sampling method. Hundred patients who were admitted to the acute care psychiatric ward and stayed at least seven days in ward of All India Institute of Medical Sciences (AIIMS), New Delhi, during study period enrolled in the study.

Three questionnaires were used in the study: 1) Structured questionnaire for demographic profile and selected personal variables was developed the researcher; 2) The Helping Alliance Questionnaire-patient version (HAQ-II; patient version), developed and revised by Lester Luborsky et al [16], a 19-item self-reported Likert scale that measures the strength of patient-therapist alliance; 3) Overt Aggression Scale (OAS) was a standardized questionnaire developed by Stuart Yudofsky, M.D [17], designed to assess observable aggressive or violent behavior rather than tendencies. All the tools were translated to Hindi language, pretested on local population and were found feasible and reliable. Approval to conduct the study was obtained from the ethics committee, AIIMS, New Delhi.

Data collection

The patients fulfilling the inclusion criteria were explained the purpose of the study. Patients were registered for the study and informed written consent was taken. Consent was taken from parents if the patient was a minor. Patients filled patient version of HAQ on the third day of admission. Aggression and violent behavior of the patients was recorded using the OAS for the first seven days of admission by investigator. The information regarding incident of acting out of aggressive behavior was obtained from family caregivers and staff nurses of the study unit.

Data analysis

Data were analysed by using statistical package STATA 9.0 version. For the purpose of analysis, the patients were divided into two groups named 'non-violent' and 'violent' based on observation for seven days after the admission to the psychiatric unit. The patients who acted out violence were placed in 'violent' group and remaining patients in 'non-violent' group.

Results

Socio-demographic and personal characteristics of study subjects

The mean age of the participants was 31.06±12.86 years. The socio-demographic and selected personal variables of the study participants are illustrated in the table 1.

Table 1: Frequency and percentage distribution of sociodemographic and selected personal variables of the study participants (N=100)

Socio-demographic variables of patients	Frequency/percentage
Gender	
- Male	58
- Female	42
Marital status	
- Married	39
- Never Married	55
- Widowed/Separated/divorced	6
Type of family	
- Joint family	33
- Nuclear family	65
- Extended family	2
Place of living	
- Urban	73
- Rural	27
Educational status of the patient	
- No formal education	4
- Primary education	13
- Middle school/metric	43
- Inter/diploma	18
- Graduate or more	22
Diagnosis of the patient	
- Schizophrenia	34
- BPAD	32
- Mania	3
- Depression	14
- Other psychiatric disorders	17
Mode of admission	
- Admitted voluntarily	58
- Admitted involuntarily	42
Level of insight	
- Present	19
- Partially present	46
- Absent	35
History of violence in the past one year	
- yes	51
- no	49
Number of family caregivers with patient in the unit	
- one	91
- two	9

Quality of initial therapeutic alliance

The mean initial therapeutic alliance score was 78.34 ± 20.28 (N=100) and ranged from 35 to 114 (out of possible minimum and maximum score of 19 and 114 respectively). Mean initial therapeutic alliance of 'violent' (n=26) and 'non-violent' group (n=76) was 65.42 ± 24.10 and 82.88 ± 16.71 respectively. The mean initial therapeutic alliance score of 'non-violent' groups was significantly higher than that of 'violent' group (independent 't' test, $p < 0.001$). Hence it can be interpreted that patients in 'no-violent' group had better initial therapeutic alliance than patients in 'violent' group.

Rate and pattern of violence incidents

Twenty six percent of patients showed acting out behavior during first seven days of admission. Out of 26 (26%) patients who acted out violent behavior, eight patients (31%; n=8) showed only verbal aggression and 18 patients (69%) showed physical aggression. Each of the enrolled patients was observed for violent incidents for the first week (seven days) of admission. In total, seven hundred patient days were observed for violence incidents (seven days per patient for 100 patients) and 38 aggressive incidents were reported during this period. Out of 38 violent incidents (exhibited by 26 patients), there were thirteen incidents of verbal aggression and rest

twenty five incidents were physical aggression directed to self or others. Rate of violent incidences were found to be 5.4%; 5.4 violent incidents per 100 patient days.

Table 2: Association between violent behavior and selected personal variables (N=100)

Socio-demographic characteristics of the patients	Group of patients		x ² value	p value*
	Non-violent patients (n=74) f (%)	Violent patients (n=26) f (%)		
Diagnosis of the patient				
· Schizophrenia	24 (32.43)	10 (38.46)	3.63	0.16
· BPAD	21 (28.38)	11 (42.31)		
· Other disorders	29 (39)	5 (19)		
Mode of Admission				
· with consent (admitted willingly)	50 (67.57)	8 (30.77)	10.7	0.001*
· Without consent (admitted by force)	24 (32.43)	18 (69.23)		
Level of insight				
· Present	16 (21.62)	3 (11.54)	2.38	0.30
· Partially present	35 (47.3)	11 (42.31)		
· Absent	23 (31.08)	12 (46.15)		
History of past violence				
· Yes	28 (37.84)	23 (88.46)	17.76†	<0.001*
· No	46 (62.16)	3 (11.54)		
No. of caregivers with patient in the ward				
· One	67 (88.2)	24 (92.3)	0.57‡	0.99
· Two	7 (11.8)	2 (7.7)		

*significant at 0.05 level ($p < 0.05$); †yates corrected chi-square value; ‡Fisher exact test

Association between violent behavior socio-demographic variables

Association between violent behavior of the patient in first week of admission (violent or non-violent) and their socio-demographic variables was analysed using chi-square test (Table 2). The patients who were admitted to the ward unwillingly ($p=0.001$) and had history of violence in the past (preadmission violence) one year ($p<0.001$) were associated with acting out behavior of the patient in the first seven days of stay in the ward.

Quality of therapeutic alliance as a predictor of violent behavior of patient

The variables found to be associated with violent behavior of the patients (at $p<0.05$ level) were included in logistic regression analysis as a predictor variables in predicting the violent behavior of the patients. Therapeutic alliance, Preadmission violence and mode of admission were included in the model. As summarised in Table 3, the model resulting from the binary logistic regression, therapeutic alliance (OR=0.961; 95% CI: 0.935, 0.989) and preadmission violence (OR=10.8; 95% CI: 2.77, 42.117) were still a predictor of violent behavior even when other two variables were controlled. It can be interpreted that one point increase in therapeutic alliance (continuous variable ranges between 19 to 114) will result in odds of violence occurrence by 0.961. In other words, one point increase in therapeutic alliance will reduce the chance of violence occurrence by 3.9%. Though the mode of admission (Unwilling admission) was significantly associated ($p=0.001$) with violent behavior of the patient, the logistic regression model revealed that it was not a significant predictor ($p=0.216$) of violent behavior while other two variables were controlled.

Table 3: Summary of Binary Logistic Regression Analysis predicting violent behavior of patient admitted in an Acute Psychiatric Ward (N=100)

Predictor Variable*	Odds Ratio	p	95% C.I. for OR	
			Lower	Upper
Therapeutic Alliance	0.961	0.006	0.935	0.989
Preadmission Violence	10.80	0.001	2.770	42.117
Admitted unwillingly (forced consent)	2.061	0.216	0.656	6.472

* Therapeutic alliance ($p<0.001$), preadmission violence ($p<0.001$) and admitted unwillingly ($p=0.001$) were found to be significantly associated (Chi-square test) with violent behavior of the patient and included as a predictor variable in regression analysis.

Discussion

The percentage of patients who showed violence (26%) in this study was consistent with the findings of several other studies which reported that 20-45% of hospitalized psychiatric patients were violent [8,7,18]. Rate of violent incidences were found to be 5.3%; 0.053 incident per patient-day as per the present study. Most of the acting out behavior which was physical was directed towards family caregivers, self, objects and other patients in the ward, only on two occasions, treating team members were attacked whereas verbal aggressions were directed towards treating team members, family caregivers and other patients almost equally. This finding was in contrast to the other studies done in western countries in which most of the violence incidences were directed towards staffs rather than family caregivers or other patients [19,20].

Gender of the patient had no association with acting out behavior which was consistent with several other studies that report that women were as violent as men in inpatient settings [21]. Study findings were congruent with the findings of Beauford et al [17] in which the measurement of initial therapeutic alliance was done by chart review of process recordings retrospectively, whereas in the present study, the measurement of initial therapeutic alliance was assessed directly from the patient through self-reported questionnaire which added strength to the reliability of the present findings.

The extent to which the patient and therapist work together toward treatment goals could reduce acting out of aggression. The concept of the quality of therapeutic alliance might be of more predictive value for acting out of violence by patients with psychiatric disorder. An additional benefit of focusing on the therapeutic alliance would be the amenable nature of the variable as compared to other non-amenable variables such as diagnosis, past history of violence, mode of admission etc.

Patients who get admitted to the ward unwillingly and those having previous history of violence could be a predetermining factor for violent behavior which cannot be changed whereas therapeutic alliance between patient and treating team members in the initial period of hospitalization is a modifiable factor which can prevent acting out behavior of the patients admitted to psychiatric wards.

Conclusions

The study findings stress the importance of quality of therapeutic alliance in prevention of acts of violence by patients with mental illness admitted to an acute psychiatric ward. Nursing staffs should be trained and reinforced periodically to improve their communication skills on developing and maintaining therapeutic alliance with patients. In summary, the assessment of quality of therapeutic alliance may serve as a tool to predict the risk of violence.

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Learning objectives

Participants will...

1. have an understanding of the rate of violence incidents in psychiatric wards and victims of those incidents.
2. identify predictors of aggressive behaviour of psychiatric inpatients in acute care units.
3. appreciate the importance of establishing a good therapeutic relationship patients in the initial stage of admission to the acute care psychiatric unit thereby reducing violent incidents.

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An exploration of communication processes between health care workers and ethnic minorities elders

Poster

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Perspective: Research

Keywords: Older people, ethnic minority, elders, communication, barriers, health care workers

Introduction and background to the study

International migration and ageing populations have created the need for health care research to address communication processes between ethnic minority elders and those who care for them. In the United Kingdom (UK) the minority ethnic population has increased from 8% to 16.5% from 2001 to 2011 (UK Census 2011) and is expected to keep on increasing. This will greatly increase the proportion of ethnic minority elders (EMEs) who need care. As multicultural society, the UK will experience a range of challenges as various sections of the population age since it is known that the perceptions of ageing vary across cultures. Effective communication is seen as one of the key factors in determining needs of ethnic minority elders (EMEs). However, older peoples' views of communication and how it influences their care have rarely been sought (Katz, et al 2011). In addition the government places particular emphasis in valuing diversity in health care (DH 2012). The Government's Social Care white Paper Caring for our Future: reforming care and support (July 2012) reaffirmed its commitment to hear the voices of people who use care services, as well as those of carers, to improve the quality of care and support.

Aim

The study aimed to explore factors that influence effective communication between EMEs and health care professionals.

Objectives

1. to identify factors that act as barriers to communication
2. to identify factors that facilitate communication for EMEs

Method

A qualitative approach was used for this study which involved using individual semi-structured interviews to obtain in-depth accounts of ethnic elders and health workers experiences on factors that promote communication and factors that are a barrier to communication. This method is recommended by Johnson (1996) who states that telephone and postal surveys have a poor response in researching communication issues in minority groups in the UK.

Sample

Ten Health Care Workers were selected to participate. They were aged between 23-55 years; mean age 35 years with caring experiences between and 1-20 years. Four of the healthcare workers were working in the community 6 were from nursing homes. Five ethnic minority elders were recruited to the study one was living in a nursing home and the rest were receiving care in their own homes in the community.

Ethical considerations

The study proposal was presented to the South West Wales Research Ethics Committee. It received approval as a justifiable investigation under reference number 13/WA/0096. Approval was also sought and received from the University of Hull Faculty of Health and Social Care Research Ethics Committee.

Data analysis

A thematic approach using an iterative and interpretive technique was adopted in analysing data (Spencer and Ritchie, 2003). The preliminary analysis involved extraction of emerging themes following reading and listening to the tape recorded conversations. Data from HCWs were compared with data from EMEs, and common themes grouped together.

Findings

Analysis of both EMEs and HCWs conversations revealed the following to be barriers of communication: difficulty in understanding culture, stereotyping of older people in general and EMEs in particular, pre-existing conditions that are common with ageing such as poor eyesight and deafness, insufficient training of HCWs and time constraints.

Difficulty in understanding culture

Both HCWs and EMEs indicated that difficulties in communication occurred when there was a problem in understanding others' cultures and values. This included age itself as a culture. Elders indicated that younger health workers' have a different culture to their own and vice versa. Ethnic cultural values such as religion, form of personal address and manner of speaking were also found to be barriers if misunderstood:

She's got her own beliefs, you see. I think all she needs is somebody who will just understand her as she is (HCW 9).

HCWs also felt that treating the ethnic elder with dignity includes respecting their culture:

Dignity I think when we look at the term it's when we respect of somebody's personal space and everybody when we look at people's background look at the culture (HCW 1).

Respect in terms of the way elders are addressed in some cultures is discussed by Harwood (2007) as almost veneration of the older person by using honorific terms such as "sir" or "madam" (English equivalents). This is considered respect by the older person and is consistent with traditional South Asian culture which is based on Confucianism. It is also similar to traditional African culture which is explained by the HCW in the last quote above. However, culture is not static; it changes at the individual level as well as at the group level. HCWs need therefore to be aware of this and respond accordingly when caring for ethnic elders.

Stereotyping of older people in general and EMEs in particular

Healthcare workers felt that stereotyping older people could be a barrier to communication. The following statement illustrates this point: If you have a negative attitude towards that person's dressing, that person's accent, that person's pronunciation of certain words you will not be able to communicate (HCW 9)

Stereotyping of older people is well discussed by Ryan et al (1995) in the Communication Predicament Model of ageing. In this model younger people will recognize an older person's group membership through visual cues such as wrinkled skin, grey hair and even voice. These cues then activate negative stereotypes of older people that influence the way they communicate with them.

Pre-existing conditions that are common with ageing such as poor eyesight and deafness

Common physiological conditions associated with ageing were cited by healthcare workers as barriers to communication. Deafness and poor eyesight were singled out as problematic. Healthcare workers said that if the elder had hearing problems then it was particularly difficult to communicate with them as they had to raise their voices to be heard: Most of the patients their communication can be impaired because of conditions. You need to make sure that you can form your words properly so that you talk to them face to face so that they can see you if they can't hear properly. So that they know the words... so that they know what's coming out sort of so that they can understand when you look face to face (HCW 7).

We know that senses influence communication and interaction with others. The effects of a declining vision are obvious. Most non-verbal cues used in conversation are visual and a reduced capacity to process this information makes conversations more difficult (Nussbaum et al, 2000). This is especially important to ethnic minority elders who may not understand English very well and may be more reliant on nonverbal cues.

Similarly, decreased capacity to hear as one gets older can affect peoples' ability to communicate effectively with others (Nussbaum et al 2000). The older person may experience difficulties in what to say which may lead to hesitation, word repetitions and affect the pace of conversation. They may also try to move closer to the carer which may violate the carer's personal space.

Insufficient training of HCWs

Some HCWs felt that they did not have sufficient training to care for EMEs and said that it would be helpful if cultural training was provided for them at work. However, some HCWs felt that some EMEs preferred ethnic minority carers and this has to be respected: We know that United Kingdom at the time has got a very wide range of diversity. They need actually to be educated and be aware of that. They need to understand to see they're not going to treat people who speak English at all times. So, they need to learn, understand and also be empathetic about it. (HCW 10)

They've got to get over these barriers with some other stuff... basically, I think training goes along way regarding things like that, you can never have too much training regarding ethnic minorities (HCW 5).

Williams et al (2003) also identified this problem; they provided training for HCWs on communication and reported that communication was improved after the training. HCWs in this study also identified that ethnic minority elders faced racism from other residents in the nursing homes. This is consistent with Mold (2005). Ethnic minority elders in current study expressed being discriminated against because of their race.

Language Problems and time constraints

Healthcare workers considered that language could sometimes act as a barrier to communication if the ethnic elder and the health care worker did not understand each other. Interpreters were seen as a solution in cases where they could be employed. However it was acknowledged that interpreters could not be in the home or in the community all the time as the health care worker is with the elder almost all the time and they need to know how to communicate with them. They were also aware that some elders may not want family to interpret for them as they would want to protect their privacy:

You may need an interpreter to help you to communicate with them. The problem comes because interpreters cannot be with the patient 24 hours and caring is 24 hours. So, due to the financial limitations they can only afford an interpreter at certain times. Whereas you as a nurse, you need constant communication with that patient (HCW 2).

Some HCWs felt that nursing home and residential homes are busy that some times staff considered that they have less time to communicate properly with EMEs:

In my experience, I've seen that nurses are too busy. You'd find that if a patient doesn't even speak English then you expect that patient might suffer more because the nurses would think he is wasting much of my time. (HCW 1)

Comparing two nursing homes, Holmes and Holmes (1995) reported that, in nursing homes with predominantly African American residents and African American staff, there was more joking between staff and residents then in home with predominantly European American residents and African American staff. They attributed this to the fact that sharing of the same background between the nurses and the residents gave them things in common and provided grounds for building a more effective relationship. The lack of time discussed above by the HCW seems to be particularly related to the ethnic minority elders and the lack of shared background discussed by Holmes and Holmes above could be a contributory factor as conversations may take longer for both HCW and EME to understand one another.

Conclusion

This study has provided an insight into factors that act as barriers and factors that act as facilitators to communication between health care workers and ethnic minority elders. The study has shown that at the heart of good care is a good relationship between EMEs and HCWs. This relationship needs to have mutual respect in terms of culture and values. When HCWs are aware and respectful of the values of the elder and act accordingly in the care giving situation the elder will feel respected and dignified. At the same time they will be empowered to take an active role in their care which will result in positive outcomes.

Ethnic minority elders may experience stereotyping and language difficulties. In addition, like all older people, EMEs also have the normal deficits such as deteriorating sight and hearing which come as a result of ageing. EMEs require special attention as these deficits may exacerbate the barriers of communication such as language problems.

Limitations of the study

This was a small study comprising ten health care workers and five ethnic minority elders, as such the results could have a bias to those people who had time and were willing to be interviewed. Some homes who had ethnic minorities did not give permission for the study. This could mean that some important information could have been omitted. However, these limitations notwithstanding, the findings from this study could be applicable in similar situations with improved communication between health care workers and ethnic minorities.

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Learning objectives

Participants will...

1. be aware of factors that act as barriers to communication and factors that act as facilitators to communication between health care workers and ethnic minority elders.
2. Be able to explain how communication barriers can be overcome to facilitate care for ethnic minority elders.

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“Capable and in Control” – Development and support for employees faced with violence on the job

Paper

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Perspective: Practice

Background and context

The van Mesdag clinic is a forensic psychiatric clinic in Groningen, Netherlands. All patients are convicted of committing violent crimes, at least partially due to (severe) mental illness. Expert psychological and psychiatric evaluations predict a high risk of recidivism should the mental illness go untreated. In addition, they have proven unwilling or unable to commit to and/or profit from short-term or voluntary treatment. The patients often lack recognition of their own mental illness and behavioral problems, and in turn lack motivation to change. They are therefore sentenced by the courts to mandatory, long term in-patient treatment.

Patients in the “entry phase” of treatment are either still in the motivational phase, in crisis or have shown extremely violent behavior during detention or treatment. In our clinic, patients admitted to the entry wards show the highest rate of violence towards employees. Though we take great care to minimize violence patient behavior towards employees, it cannot be prevented completely. We therefore invest in efforts to minimize the negative consequences for employees confronted with violent patient behavior: employees receive physical and mental defense trainings, security guards have an integral role in the treatment teams, incidents are evaluated and used as learning experiences and we have treatment units equipped for maximum security and intensive care.

Despite these efforts, measures of employee health and satisfaction for the entry wards show relatively negative outcomes. Turnover rates, sick leave and negative team dynamics are elevated. We propose a link between low employee health and satisfaction and a high rate of violence toward employees, exacerbated by insufficient recognition for feelings of fear and insecurity on the job. We believe that leadership styles, organizational and team cultures and traits of individual employees play an essential role in this process.

Methodology

This submission describes a current effort within our clinic. Using incident reports and evaluations and employee interviews, we identify and describe leadership styles, organizational and team cultures and individual employee traits which harbor or which ameliorate feelings of insecurity and fear on the job. This analysis is then used to develop and implement an improvement plan in our clinic, to ensure the ongoing development of helpful processes which ameliorate the emotional responses to violence on the job. These processes should become integrated in the workplace dynamics on both an explicit and an implicit level. It is not our intention to negate or disregard the natural feelings experienced by employees when faced with violence on the job. Rather, we strive to develop a working environment in which the feelings of fear, vulnerability and insecurity experienced by employees who face violence on the job are recognized and dealt with in such a way, that employees retain a sense of capability and control to ensure the safety and wellbeing of themselves, colleagues and patients. In October we will present the results of our analysis, our improvement plan and preliminary results of its implementation.

Learning objectives

Participants will...

1. Realize that feelings of fear, vulnerability and insecurity are natural responses for employees faced with violence on the job and that without proper attention, these feelings lead to a decrease in employee health, wellbeing and job satisfaction.
2. Get to know one possibility of how to develop a working environment in which feelings of fear, vulnerability and insecurity are recognized and dealt with in such a way, that employees retain a sense of capability and control to ensure the safety and wellbeing of themselves, colleagues and patients.
3. Have raised awareness for the issue described, share our knowledge and experiences, and to inspire and encourage professionals in our field of work to do the same.

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Health Sector violence at emergency departments of hospitals in Kathmandu

Paper

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Perspective: Research

Background and context

This has been universally acknowledged that violence creates major challenge within the health care sector around the world where the least developing country Nepal is not out of the crisis. Post-conflict situation and fragile transitional state capacity has resulted in chaos and violence in the country in which health sector is also severely affected. In recent five years almost every hospital in Nepal suffered by the grievances and aggression of the patient and the visitors resulting in number of physical assaults, threat and abduction of health care workers across the country. Due to unstable and transitional political situation of the country the culprit is likely to politicize the violence and the trend of providing political protection to the criminal has aggravated the crisis.

Methodology

In-depth interviews and short focus groups discussion were conducted inside and outside of the major hospitals of Nepal while collecting the information. The collected data has been used to describe the current situation of health sector violence at the emergency departments. The findings have assessed the factors that are troubling the peaceful environment of the hospitals to violent and worsening job satisfaction level within the health workers. On the other side physical injury, long waiting hours, poverty and uneducated mass of visitor and in some cases psychiatric patients also make the work place turbulent. Importantly, lack of cooperation and patience between the health workers and visitors during the treatment of the patient has further exaggerated the tension. Use of drugs and alcohols also affected the working place of hospital to be more violent. The study has critically developed the necessary measures to overcome the conflict and create a peaceful environment at the emergency departments in the hospitals.

Findings

The study found that overall status of work place environment in the of hospital's emergency departments in Kathmandu as worst. More specifically, hospital has become a major site of violence in the recent decade. The increasing trends of physical and verbal assault against health worker at their work place have decreased the job satisfaction level of the doctors and nurses. Abduction of health workers and destruction of hospital's infrastructures have inserted a great threat to the health profession as well as health service. Low income and lack of service delivery were found as a short fuse to connect many disputes in health sector.

Implications

Mushrooming numbers of privates' hospitals need regular supervision through concern bodies to ensure their quality of treatment and fees in order to guarantee the standard of health care they provide to the public, which may eventually minimize the public dissatisfaction and conflicts.

Learning objectives

Participants will...

1. have a clear understanding of the contributing factors of health sector violence at Emergency Departments in hospitals in a least developed country Nepal;
2. have knowledge on current trends of the incidence and frequency of verbal and physical assaults to the servicing health worker by patients and their relations during or/and after the treatment of patient;
3. recognize immediate mechanisms to address and resolve growing hospital violence trends.

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Approaches to addressing horizontal violence through awareness: A literature review

Poster

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Perspective: Research

Abstract

Horizontal violence in nursing is defined as acts of verbal, emotional, and physical aggression acted out from one nurse towards another nurse equal in rank. Exposure to horizontal violence poses a threat to the well-being of nurses as manifested by negative physical and psychological outcomes. Patient safety can be at risk as a result of poor communication and ineffective collaboration resulting from intimidation. Horizontal violence has been theorized to result from oppression which in nursing has historically been associated with issues of gender, hierarchical structures within healthcare settings, and lack of recognition. As a result, individuals become angry and frustrated. Unable to express their feelings towards their oppressor, they act out towards fellow staff. Oppression prevents one from being authentic to self and acting on one's own accord. In today's healthcare environment many factors can be recognized as contributing to oppression including staffing shortages, technological challenges, financial constraints, and regulatory mandates. These challenges can lead the nurse to experience stress due to the inability to care for patients at the level desired. It is undeniable that through the mechanisms contributing to oppression, the work environment plays a significant role in the creation of horizontal violence. Though strides have been made to empower nurses through models of shared governance and Magnet® recognition, individual initiatives can contribute to emancipatory methods that shed light on circumstances that lead to horizontal violence. Additionally, awareness can be raised as to incidences of horizontal violence that may have been unrecognized leading to acceptance of the behaviors.

Implications

Individual approaches to addressing the issues surrounding horizontal violence may include mindfulness-based stress reduction, reflective practice, caring-for-self behaviors, and emotional intelligence. Each of these bring forth an opportunity for raising awareness of circumstances as well as actions that need to be taken. A review of the literature in each of these areas can provide insight into how these modalities can contribute to the well-being of nurses and other health care professionals and be evaluated as a means for addressing horizontal violence in the work setting. With this knowledge, interventional studies can be designed to test the effectiveness of these modalities in addressing horizontal violence in nursing. Changes in the individual and in extension the work environment may result leading to the improved well-being of nurses and enhanced quality in care delivery.

Learning objectives

Participants will...

1. be able to describe contributing environmental factors to horizontal violence among nurses.
2. be able to identify potential approaches to addressing horizontal violence through awareness and reflection.

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Obstacles and possibilities for domestic violence interventions in health care: Frame analysis of professional's conceptions

Paper

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Perspective: Research

Keywords: Domestic violence, violence intervention, health care professionals, frame analysis, focus groups

Introduction

Domestic violence is a serious social and public health problem worldwide. There is international recognition that health care providers are in a key position when it comes to recognizing victims of domestic violence and helping them (Krug et al., 2002). However, health care systems generally have been slow to identify domestic violence. Instead, the tendency to downplay violence as a problem issue seems to be typical of the ways in which health care organizations deal with domestic violence (Husso et al. 2012, Virkki et al. 2014).

Several studies have sought explanations for the low domestic violence screening rates and lack of violence interventions (D'Avolio, 2011; O'Campo et al. 2011, Spangaro et al. 2010, Thurston et al., 2009; Todahl & Walters, 2011). It has been suggested that health care providers fail to ask about domestic violence because of infrastructure barriers: time limitations, insufficient resources, and inadequate institutional support for screening. In addition, providers' attitudes toward domestic violence and understanding of their own role in violence intervention have been claimed to have a major effect on their willingness to ask about violence (Husso et al., 2012, John et al. 2010; Minsky–Kelly et al., 2005; Robinson, 2010).

This qualitative study of health care professionals' attitudes towards domestic violence interventions aims at contributing to the discussion by focusing also on the possibilities for interventions in violence. The main research question is how the professionals see their own roles and those of others in the domestic violence intervention. Further, the study investigates how the barriers of a domestic violence intervention examined here as frames of thinking and acting, might be broken down, not simply by rejecting them but by transforming them in a more positive and fruitful direction.

Theoretical considerations, data and methods

The theoretical framework of this study is based on social interactionism which understands the phenomenon under study as something that emerges in social interaction and is, to a large extent, context-bound (Scheff, 2005). Erving Goffman's (1974) frame analysis offers a theoretical-methodological view of the ways in which the understandings of particular situations are socially constructed. Goffman used the idea of frames for labeling the "schemata of interpretation" that allows individuals or groups to perceive and understand events and occurrences, thus rendering meaning, organizing experiences and guiding actions. Frames are shared ways of understanding and interpreting different situations, and within each frame, the agents are endowed with different rights, responsibilities and duties. Through framing, people look for definitions that suit the event at hand. Different definitions of a situation call for different forms of action, and the meaningfulness and the legitimization of that action – or lack of it – depends on how the situation is framed.

We utilize frame analysis as a concept and a method of analyzing our data, which consist of six focus group interviews with specialist health care professionals (n=30) on the topic of encountering domestic violence. The focus groups comprised nurses, doctors, social workers, and psychologists working in a general hospital. The interview questions concerned the ways in which participants perceived their own role, and their possibilities for action as professionals when encountering problems related to domestic violence, and their attitudes toward domestic violence and people seeking help for this problem.

Findings

Frames Justifying the Lack of Intervention in Domestic Violence

First, we introduce the frames that are used to justify lack of intervention in domestic violence. We have named these frames medical, practical, individualistic, and psychological.

Medical frame. From the standpoint of the medical frame, the problem hampering intervention in domestic violence and accepting responsibility for dealing with it is the understanding of violence as a strictly medical problem. This frame is based on a medical definition: it focuses on recognizing the patient's somatic

symptoms, diagnosing them, and deciding on the proper treatment. In addition, medical framing raises the issue of the symptom homogeneity, which prevents recognition of the diverse characteristics of the effects of violence. In the medical frame domestic violence is seen as a social problem, and thus as belonging to the domain of social work or to the domain of psychology or individual psychopathology.

Practical frame. The practical frame refers to dealing with questions of domestic violence from the standpoint of concrete practices. Professionals justify their lack of intervention in violence by reference to the inadequacy of existing working practices. In particular, gaps in the social and health care service structures and differences in municipalities' practices, as well as the lack of permanent models of action were brought up in the discussions. In addition, confusion over the division of responsibilities, lack of information and dysfunctional cooperation between different authorities were mentioned as reasons for not intervening in violence.

Individualistic frame. In the individualistic frame, domestic violence is defined as an individual problem, which cannot therefore be defined as a health issue. For example, social effects and effects on health were interpreted as personal characteristics of the target of violence. The professionals explained that they were frustrated and disappointed with the repeated and continuous problems caused by the domestic violence experienced by their patients, as it made them feel that intervention in violence was a futile effort. From the perspective of the individualistic frame and its reliance on individuals' ability to function and their freedom of choice, it was difficult to understand that people living in a violent relationship found it very difficult to withdraw from it, or to understand what kind of assistance such withdrawal would require.

Psychological frame. The psychological frame provides grounds both for intervening in violence and for not doing so. In the psychological frame, violence is considered a problem linked to many other psychological problems as well as to traumatization of the patient, and thus offers an opportunity to understand the patients' situation from a more holistic point of view. Although the psychological frame in a significant way opens up possibilities for encountering domestic violence, the professionals had ambivalent feelings about experiences of domestic violence that emerge during the treatment. They considered that experiences of violence should be a target of treatment, and as such, they should be curable. Nevertheless, some were concerned about the potential consequences of treatment, fearing that treating experiences that were considered traumatizing would do more harm than good. Although the psychological frame differs from the other frames presented above, in the sense that it enables understanding violence as a physically and mentally wounding phenomenon and draws attention to the significance of the effects of violence and considers these effects an ethically relevant target of treatment, it nevertheless easily ignores domestic violence due to its fear of "opening up old wounds".

Frames that Support Intervention in Domestic Violence

When we analyzed the focus group discussions, we noticed that as the discussion progressed, the participants began to look for grounds and justification for intervention in domestic violence in their own work. In our data, we found three frames that support intervening in domestic violence: these are labeled the health promotion, the justified intervention, and the process launching frames.

Health and well-being promotion frame. As a frame supporting intervention in domestic violence, the health and well-being promotion frame requires an understanding of the effects of violence on people's health and well-being. This approach questions the notion expressed in the medical frame, according to which intervention in violence requires that the issue is perceived as a medical problem. Instead, the health and well-being promotion frame considers dealing with the effects of violence as an "equally important aspect of work compared to any other task that aims at the overall well-being of the patients." The health and well-being promotion frame also questions the individualistic and psychological frames: issues that have an impact on the patients' health and well-being are not private questions or "opening up old wounds," but are something that all health care professionals should be prepared to deal with.

Justified intervention frame. The justified intervention frame presents reasons for intervening in domestic violence. What ultimately emerged in the focus group discussions was the need for laws, regulations, and shared routine questions. Practices for asking about domestic violence and intervention guidelines that could be agreed on and shared at the institutional level might justify and thus help intervention in cases of domestic violence. The most evident justifications of this kind include child protection laws and regulations that oblige people to take action. Whereas the practical frame focuses on the difficulties of intervention in domestic violence, and the psychological frame focuses on the fear of traumatizing patients, the justified intervention frame offers different possibilities for making intervention in violence an easier task. At best, intervention in domestic violence would be considered a natural part of everyday work, and would not be seen as adding to the burden of already overloaded specialist health care personnel.

Process launching frame. By the process launching frame we mean an understanding that supports intervention in domestic violence; more specifically, an understanding of (a) the effects of violence on the lives, well-being, and the ability to function of the targets of violence and (b) the role of the professionals who encounter victims of violence as the authorities who launch the intervention process. This frame questions the notion of individual responsibility that is typical of the individualistic frame and the exclusion of the effects

of violence that is typical of the medical frame. It also questions the lack of time, typical of the practical frame and fear of traumatizing processes, typical of the psychological frame. Instead, this frame includes an understanding of the challenges posed by changes and the difficulties of launching the process. Instead of requiring immediate results, the process launching frame underlines the idea that caring, and sowing the seeds of change, giving the victim a nudge in the direction of seeking help and thus triggering a process that questions domestic violence are significant gestures and important as such in encounters with violence.

Conclusion

The results indicate that there might be some seeds of change in spite of the initial reluctance or even strong opposition towards domestic violence intervention. The initially negative attitudes toward domestic violence interventions and pessimistic views of one's possibilities for intervention may be questioned and changed to become more positive.

In addition, the research findings suggest that it is possible to develop well-functioning practices for identifying persons who have experienced domestic violence, for deciding appropriate actions to take when encountering violence, and for breaking the vicious circle of violence. Developing well-functioning practices for interventions in domestic violence requires (a) understanding the consequences of violence, (b) becoming conscious of attitudes, beliefs and framings that act as barriers to violence interventions, and (c) recognizing the challenges and possibilities of violence intervention in regard to the professional practices of health care organizations.

To conclude, the results imply a need for a deeper understanding of the importance of launching a process that questions non-intervention in domestic violence and changes the meanings and interpretations linked to situations of violence, thereby enabling change in personal attitudes and the reform of professional and organizational practices. Such understanding would help social and health care professionals to outline their agency, and their role as members of their organization and community, and as members of a larger chain of service providers working collaboratively against domestic violence.

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Learning objectives

Participants will...

1. have an understanding of the conceptions and attitudes justifying the lack of domestic violence interventions in the health care sector.
2. identify how the barriers of domestic violence intervention, examined as frames of thinking and acting, might transform in a more positive and fruitful direction.

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Acts of indirect aggression as tactics of hierarchy negotiation mediated by personality in registered nurses

Poster

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Perspective: Research

Background and context

In 2008 the Joint Commission for the Accreditation of Hospital Organizations (JCAHO) released a sentinel event alert titled Behaviors that Undermine a Culture of Safety. In the alert, behaviors defined as intimidating and disruptive included not only overt behavior but also covert behavior. Citing several studies in the alert, JCAHO remarked that safe, high-quality patient care is linked to the communication styles and team interactions of healthcare personnel. These covert behaviors are encompassed under the category of indirect aggression. As a category of behaviors, indirect aggression is defined as a form in which the instigator manipulates others, or by other means, makes use of the social structure in order to inflict harm. To date, this has been found to be more typical in females' interactions with other females as noted by studies of adult and adolescent human females. Nursing remains a 92% female profession in which teamwork and communication are vital to patient care. This study was conducted to determine the extent to which female registered nurses are aggressors and targets of acts of indirect aggression by their peers in their practice. The study also examined hierarchy negotiation related to these acts and personality trait correlates.

Method

Exploratory, descriptive, non-experimental, web-based.

Setting: Online, United States, UTMB IRB approval obtained.

Participants/Subjects: 29'091 registered nurses in the United States who spoke English were sent email invitations explaining the study purpose, approximate length of time for study, and a link to the online survey. Participation constituted consent.

Methods: Demographic questions and three reliable and valid psychosocial instruments were adapted to an online survey format. Email invitations were sent to 29'091 registered nurses in the United States. 213 female registered nurses of various ages and backgrounds completed the entire set of questions.

Findings

Significant findings from this study suggest that higher levels of education, age, years as a nurse, and environment are at least moderately, and often highly, correlated with acts of indirect aggression and tactics of hierarchy negotiation between registered nurses. Findings also show significant correlations across several categories of nurses in aggressing through guilt induction behaviors using the tactic of deceptive self-promotion. The personality traits agreeableness, openness and conscientiousness are significant predictors for most acts of indirect aggression and tactics of hierarchy negotiation.

Implications

Results from the study can be used to define and identify acts of indirect aggression to aid in nursing education as well as to inform policies and procedures to effectively acknowledge and address occurrences. Additionally, it should be beneficial to discuss this issue with nursing students in schools and newly hired nurses in new-hire orientations and training. Defining what indirect aggression is and how it is expressed could lead to self-awareness and perhaps fewer instances of these types of interactions.

Learning objectives

Participants will...

1. be able to discuss indirect aggression and it's relationship to registered nurses teamwork, patient care, and physical and psychological well-being.
2. be able to discuss research findings related to registered nurses experience with peer indirect aggression, hierarchy negotiation, and personality traits.
3. be able to discuss implications and future research plans.

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A challenge for 14'000 employees and physicians: Prevent violence and promote civility and respect

Workshop

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Perspective: Organisational

Keywords: Harassment, workplace, problem-solving, employees, physicians, policy

In 2002, the Quebec government added new sections to its legislation respecting labour standards [1], which specifically targeted psychological harassment in the workplace. For its purposes, *“Psychological harassment” was defined as any vexatious behaviour in the form of repeated and hostile or unwanted conduct, verbal comments, actions or gestures, that affects an employee’s dignity or psychological or physical integrity and that result in a harmful work environment for the employee. A single serious incidence of such behaviour that has a lasting harmful effect on an employee may also constitute psychological harassment. (Article 81.18).*

The Quebec government listed the employers’ responsibilities as: The employer is required to provide his employees with an environment that is free from psychological harassment. However, this is an obligation of means and not of results. In other words, the employer cannot guarantee that there will never be any psychological harassment in his enterprise, but he must:

- prevent any psychological harassment situation through reasonable means
- act to put a stop to any psychological harassment as soon as he is informed of it, by applying the appropriate measures, including the necessary sanctions (Commission des normes du travail, 2002, <http://www.ent.gouv.qc.ca/en/in-case-of-psychological-harassment-at-work/index.html>).

Each organisation had 2 years to establish and implement means to prevent and eliminate violence and harassment in the workplace. Therefore, the MUHC had to mobilize resources to address these expectations. In 2004, the MUHC implemented a policy and procedures on prevention and elimination of violence at work. In 2009, a Committee was created to review the prevention and elimination of violence at the MUHC. This new committee was composed of all of the different stakeholders in the organization including various representatives of the unions and levels of management. Its mandate was to review not only the policy on prevention and elimination of violence in the workplace, but also the procedure for problem resolution, incivility and conflicts.

The Committee realised that the programme of prevention and management of violence and harassment that had been put in place at the MUHC did not totally fulfill its purpose. It needed to be reviewed and updated for the following reasons:

1. It was impossible to draw a clear picture of the experience of violence and harassment in the workplace for the 14,000 employees and doctors.
2. It was difficult to determine the number of people who reported or filed a complaint about a violent event or harassment situation and obtaining complaint data was nearly unfeasible.
3. The level of satisfaction of people having reported a violent or harassment situation was rather low. Union representatives noted that their members did not know who to turn to when they experience a violent situation or harassment. Bad situations tended to become worse with time. A conflict that was ignored or badly managed could degenerate into violence.

Experts wrote on the necessity of acting quickly to defuse and de-escalate problematic situations [2]. In fact violent situations have many consequences on the physical and psychological health of victims and witnesses at an organisational level, on workplace stability, on the functioning and motivation of teams, on workplace efficiency, etc. However perceptions of the extent of the phenomenon varied within the Committee. Some believed that violence and harassment at the MUHC was minimal and when it occurred it was well managed. For others the problem was important and not well managed.

In order to identify the problems associated with the existing programme and better evaluate the steps required for an employee to complain about a violent incident, the committee decided to do a “process mapping” exercise of the existing practices regarding complaints of violence or harassment. The mapping demonstrated gaps at the level of the initial complaint, the report or filing and management of problematic situations. The process to follow in order to report or file an incident of a violent situation was neither clear, nor coherent and it was hard to know how a case was concluded.

It became clear that it was essential to centralise all initial calls and complaints in order to obtain a better and a more realistic picture of the problem at the MUHC and to develop a more coherent and preventive approach to violence and harassment in the workplace. After looking at what was done elsewhere in terms of prevention and

management of violence and harassment at work, after discussions and reflection the members of the committee reached the conclusion that a new system had to be created to manage the reporting of violence and filing of complaints to promote respect and civility throughout the organisation. In 2012, a consensus was reached by the committee to create a position of Commissioner for a respectful and non violent workplace.

The MUHC set up a selection process and agreed on the requirements of the position. These requirements include:

- Master's degree in a discipline deemed relevant;
- Ten years of relevant experience;
- Any other combination of education and experience deemed equivalent could be considered
- Excellent communication skills both oral and written;
- Excellent conflict resolution skills including mediation;
- Excellent self-control, listening ability and proven empathy;
- Excellent judgment;
- Knowledge of the legal environment applicable to the field;
- Knowledge of the health and social services network an asset.
- Bilingualism (French and English) – oral and written.

The Commissioner for a respectful and non violent workplace started her work January 14, 2013 on the following objectives:

1) Publicize the mandate and the role of the Commissioner within the various services, departments and directorates.

As a first step the Commissioner had to integrate into the MUHC community; meet people and explain her role and mandate. It was essential to meet members of the main management committees, senior management, all directors and the major unions. She was aware of the importance of developing a relationship of trust with her partners to foster the will and the involvement of each member of this academic health care community. It was essential to inform people that the status granted to the Commissioner was the following:

The Commissioner answers to the Director General [CEO] and not to the Human Resources Directorate [HR]. This was established in order to ensure a certain level of neutrality, independence and autonomy towards management and employees. The MUHC chose the ombudsman model, which had been used successfully with patients, rather than an adjudicative or disciplinary model. The Commissioner has no authority or disciplinary power towards anyone within the MUHC. All levels of the members of the community could consult her, solicit her support in a difficult situation, seek her advice or inform her in a confidential manner of any conflict or violent event in a secure and safe manner. When the Commissioner conducted an investigation in a case of violence or harassment in the workplace, then her report was to be given to Human Resources Directorate who will decide on sanctions or measure to implement to prevent recurrence of the situation when appropriate.

A high level of discretion and confidentiality are essential in the role and function of the Commissioner. Confidentiality permits a greater degree of confidence on the part of any individual against whom a complaint is made. Information gathered during consultation meetings, conflict resolution, lodging of complaint or reporting of violent incidents is kept in confidential files under her sole authority. This information does not form part of the official HR employee file. For instance during an investigation each party signs a confidentiality agreement.

Unionised employees who use the services of the Commissioner keep their rights and recourses under the collective agreement. Thus a unionised employee may lodge a harassment complaint as well as a grievance. It is believed that if the employee is satisfied with the management of the complaint by the Commissioner the grievance may be abandoned.

2) Review and update the policy for the prevention and elimination of violence in the workplace.

As a second step, the Commissioner, with the Committee, must review the policy in order to update it and revitalise it. This policy will become the Respect and Civility policy of the MUHC. Between 2002 and 2010 organisations had generally created policies to denounce violence. Since January 2010, the purpose and the substance of the new policies on violence and harassment in the workplace are more and more geared towards respect and civility. The first approach was to focus on understanding and denunciation. With time the policies evolved and the emphasis is now on prevention and recognition of the importance of acting quickly and coherently.

Jarvis and Pronovost (2014) have argued that after 10 years of observing harassment, defining it, receiving and investigating such complaints it is now time to emphasize prevention [3]. The new approach of the MUHC is more collaborative and constructive; it favours the importance of respect and civility in the workplace and less emphasis on violence. The Committee hypothesises that when values such as respect and civility are important and integrated in an organisation there could be fewer incidences of violence and harassment.

The policy on respect and civility favours empowerment in inciting people resolve tensions quickly. This policy promotes resolution of situations before they degenerate into violent situations. It requires the involvement of managers in resolving conflicts. It requires the collaboration of unions in terms of prevention and management of problematic situations.

The policy explains clearly the process of complaint management related to psychological violence or harassment and the roles of everyone. It details the steps to take, the person to contact and the place where to lodge a complaint. It defines the rights and responsibilities of everyone with regards to this policy. It underlines the importance of prevention at the level of violence and harassment in the workplace. Civility and respect are now on a pedestal.

Cantin (2014) underlines the importance of applying the policy to cases of incivility [3]. With this vision the slogan of the MUHC prevention of violence programme has been simplified to: **AVEC RESPECT! WITH RESPECT!**

Every year a new subtheme will be added to the slogan with regards to the reality and professional context of the moment. For instance the first year will be: «I am moving, I am integrating, I am harmonising **WITH RESPECT!**»

In fact four of the six MUHC hospitals will be moving to a new site in April 2015 and the other two will be undergoing major renovations and reorganisations. Some of the units will be closed or folded into others. Therefore employees are going through a transition period which generates anxiety, stress, fatigue and uncertainty. This fosters tensions, conflicts and violence within the teams.

3) Establish a process of problem solving

The third step for the Committee was recognising the importance of putting in place an approach of problem solving leading to “good behaviour agreements” between employees. The process of problem solving is voluntary and aims to find solutions rather than culprits, when there is a violent or problematic situation. This process can only function if both parties agree and results in such an agreement. Each time an employee wants to lodge a complaint of violence or harassment towards a colleague, a manager or a doctor the Commissioner determines with the employee the possibility of problem solving. In the same way the MUHC health care ombudsman who also receives complaints against doctors from employees [4] and the Commissioner work together to allow employees who experience a problem with a doctor, pharmacist or dentist to participate in a problem solving process with the doctor in question. The complaint goes to the Ombudsman and if the employee and doctor agree to the process then the Commissioner will manage the complaint. In all cases if the problem solving process is unsuccessful then a formal harassment complaint can be lodged and will be investigated.

Education and tools for managers

At the same time the Committee recognises the importance of education and tools to help busy managers better understand the problems of violence in the workplace and to better intervene in a preventive and curative manner. Educational sessions and coaching meetings are offered to the managers. Immediate superiors and supervisors also have a role to play in recognising the importance of acting when tensions are high or when there is a conflict between two employees. They must also have the tools to act. Workshops, meetings, conferences are organised by the Commissioner to inform, support and equip the managers in their role with regards to the policy.

Working with the unions

In many cases the unions will refer their members who experience a violent situation to the Commissioner. The purpose of these referrals is to allow the conflict to be resolved in a manner other than through a grievance yet without losing the right to grieve. Additionally since conflicts often occur between members of a same union there are advantages to managing a situation in a conflict solving process.

Preliminary results of the implementation of this new approach

For nearly two years the Commissioner has been in place and fulfilling the functions described above. More years of the new process must occur before reaching a formal conclusion but the programme appears successful. In 2013 and until July, 2014, 137 complaints were received. 8% of those complaints were managed as formal harassment complaints while the others were successfully managed through consulting, advising and problem solving. Here follows some of the commentary of clients of this service:

Some Labour relations advisors noted a diminution of harassment grievances; union representatives say they are less often called in once they suggest the services of the Commissioner. They add that their members say positive things about the approach and the results of their experience with the Commissioner.

Conclusion

These preliminary results are encouraging and may indicate that the new approach which favours prevention, answers the needs of employees and managers with regards to conflicts and violence in the workplace. As noted above, 2015 will be a year of moving for the MUHC; this means major organisational challenges such as harmonisation of practices, adaptation and integration of new technologies, development of new protocols, and digitization of charts, adaptation to a new workplace and to new teams. In this context, employees are experiencing many situations which produce tensions, pressure and stress. This affects the work climate.

Although the new programme appears promising, we expect some readjustment will be required as well as the development of a statistical model for reporting the nature of complaints and other calls to the office of

the Commissioner as well as their resolution. This will assist with being able to have the information that will facilitate the revision of information packages, workshops, adequate protocols to foster the understanding and involvement of the members of the MUHC community towards respect and civility. It will also eventually assist us with benchmarking with other like organizations.

Literature and footnotes

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2. Rivest R. L. et al, Prévention des conflits et du harcèlement psychologique au travail : adopter une approche gagnante! , in Le harcèlement psychologique au travail 2004-2014 : De la prévention à la résolution, Éditions Yvon Blais, 2014 p.113.
3. Cantin, I. Le temps est-il venu de bonifier votre politique relative au harcèlement psychologique in Le harcèlement psychologique au travail 2004-2014 : De la prévention à la résolution, Éditions Yvon Blais, 2014 p. 90 : « Plusieurs plaintes de harcèlement psychologique concernent des cas d'incivilités ponctuelles qui ne rencontrent pas toujours les conditions requises dans la définition du harcèlement psychologique. Certains employeurs ont jugé pertinent, surtout dans un souci de prévention, de stipuler que les indélicatesses, les manques de courtoisie et paroles inappropriées envers autrui constituent de l'incivilité, de réitérer que le respect est primordial au maintien d'un environnement sain et harmonieux et, éventuellement, de prévoir des mécanismes adaptés pour traiter de telles situations de manière à éviter l'escalade. »
4. Jarvis D., Pronovost S., La prévention du harcèlement : trois stratégies pour agir à la source, in Le harcèlement psychologique au travail 2004-2014 : De la prévention à la résolution, Éditions Yvon Blais, 2014 p.51 : « Après une décennie, un constat s'impose : on s'est davantage attardé à l'observation du phénomène qu'à l'amélioration des milieux où il s'exerce. Mais cela est tout à fait normal. Il fallait d'abord savoir ce qu'était le harcèlement psychologique et si ce phénomène existait vraiment lorsqu'un employé alléguait en être victime. Cela a donc conduit à l'adoption de politiques institutionnelles, au dépôt de plaintes officielles, et dans un grand nombre de cas, à la conduite d'enquêtes et d'auditions judiciaires. Maintenant que nous avons fait nos classes, ne serait-il pas temps de se placer en mode prévention pour tendre vers l'amélioration? »

Learning objectives

Participants will...

1. appreciate that policy making for the prevention of violence and promotion of civility and respect in a challenging workplace.
2. appreciate that the implementation of the policy for prevention of violence and promotion of a respectful and civil environment at work through: problem solving, coaching and innovative agreements of civil and respectful behaviour.

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Building our house together: Implementing an indigenous framework of wellness to achieve safety and security

Workshop

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Perspective: Practice

Keywords: Organizational Culture, Safety, Security, Indigenous

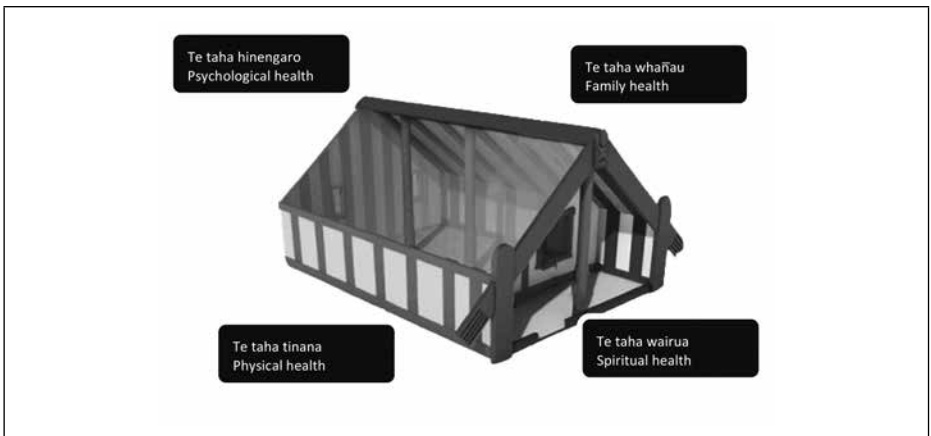
It was in 1974 that I first became employed in the Human Services profession. I fear that all I have done in the ensuing years is to assist in the creation of a supported employment program for human service professionals. When I think about the state of human services, the drive for independence by service users and the ways in which we “treat” mental illness, intellectual disabilities, substance abuse concerns, I fear that we are not really getting to the issues that will include rather than exclude people into the societies in which we all live, learn, work, and play.

In a forward to a document on a unified approach to mental health services, Rob Grieg wrote (Royal College of Psychiatrists, 2007):

- The real challenge to abilities and capacities is to those responsible for planning, commissioning, managing and providing services for people with such complex needs.
- It has been our historic failure to do that successfully that has resulted in people being excluded from mainstream society and segregated into inappropriate services.
- The acceptance of that ownership by ourselves rather than attributing the outcome to the individual’s behaviour is an important step towards achieving better outcomes for all people.”

In our western approach to understanding and treating mental health concerns, across a wide spectrum of diagnostic categories, we have brought our technological prowess to bear and have developed a myriad of treatment approaches that have had little impact in a global sense. While rates of treatment success in mental health services are between 45% and 80% (NAMI, 2011), the rates of mental illness are increasing in the United States (NIMH, 2014). The names of the clients may change, but the overall issues we face as a system are increasing and not decreasing over the course of time.

The approach of the Maori culture in New Zealand to wellness is one that has the potential to provide a framework that can provide safety to individuals and to family groupings that can provide more support, integrate more people into society, and increase safety for all people. Known as Te Whare Tapa Wha, or in English, the Four Walls of the House (Durie 1982, New Zealand Department of Health 2014).



Creating a trauma informed service system or culture is like building a house. The framework for this chapter comes from New Zealand, specifically the Maori people. The concept known as “Te Whare Tapa Wha” compares Maori health to the four walls of a house, with the central theme being that all four walls are equally necessary to ensure good health and wellbeing.

In the Maori approach, psychological health is not just cognitive, it also includes our emotions and represents a balance between our thoughts and feelings. In western cultures, we tend to separate rational and emotional thought processes, but for many cultures the two are so intertwined it is impossible to separate them. In order to prevent trauma, and if necessary provide a structure for the healing of trauma, feelings and thoughts must be integrated or re-integrated.

Family health is more than what western culture sees as “family” – in almost all cultures throughout the world, family extends both outwards to cousins and backwards to grandparents and great-grandparents. The multi-generational transmission of abuse and its effects was the subject of a presentation by Dr. Maria Yellow Horse Brave Heart (Heart, 2005) in which she said talked about the transmission of pain through abuse from one generation to the next. Other authors (Vogel, 1994, Goodman & West-Olatunji 2008, Willis 2009, Schwab, 2010) have also recognized the power of trauma in its passage and subsequent effects from one generation to the next. In order to build a strong house, we need to understand and protect against the trauma in our family histories.

Physical health is affected by trauma (Anda, 2007). Rising rates of obesity, alcoholism, and diabetes are associated with trauma. Increasing emotional, psychological, and physical safety also increases the physical health of people. (Stewart-Brown 1998, Coughlin Della Silva 2006). By creating physical, emotional, and psychological safety we will be able to improve the physical health of people.

Every house needs a foundation as well as a roof. The foundations of the house we will be building come from an activity Dr. Julius Lundy developed (Lundy, 2000) in which people are asked to name five characteristics of human relationships that are most important to them. The five most often listed characteristics of healthy relationships in this activity are:

- Respect – honoring people for who they are, without judgment.
- Fidelity – doing our very best to remain true to a person, idea, or process
- Forgiveness – not letting the past direct our present or future behavior
- Honesty – transparency with others in word and deed
- Justice – equality in getting needs met.

A house with a solid foundation, strong walls, and a protective roof will be one that provides the emotional, psychological, and physical safety with can prevent trauma and provide healing if necessary. Within this house resilience can be developed and strengthened, and people can envision and work towards a new future.

It is in this house that we can integrate western and indigenous approaches to mental health and overall wellbeing. In the wall of psychological health, for instance, we can add our knowledge of the neurobiological impact of trauma, how the brain works, and specific neurosensory interventions that can provide not only relief by a rewiring of the brain in a “bottom up” fashion that uses a neurosequential model of therapeutics (Perry, 2014) which has been shown to be effective in studies.



The model of healing proposed by Dr. Maria Yellow Horse Brave Heart (Heart, 2007) provides a context for both individual and cultural approaches to overcoming traumatic events. Confronting the trauma and embracing our history, whether as an individual or culture, does not mean embracing the act but rather acknowledging its presence. In doing so, we start the journey through the traumatic event to the other side.

Understanding the trauma through knowledge and wisdom means that we bring our western science and our indigenous wisdom together. We use knowledge and science in order to make choices to overcome the effects of trauma. It is in using knowledge to bring about forgiveness, restoration and healing that it becomes wisdom and can be of benefit to all. It is here, in this step, that we can apply the “tools of the trade” in mental health and behavior change sciences. There is a science to the work we do, and there is an “art” of healing that exists strongly in indigenous cultures. Bringing them together in this step empowers people, all people and not just indigenous people, to benefit from our combined knowledge and wisdom.

The third step is to release the pain through the gift of relationship. Every person who has written about their own journey of recovery has a story of a hero, a person or sometimes many people who reached out to them in order to protect the person while they were giving up the old ways and learning new ways of relating to themselves and to others. In the book “My Name is Shield Woman” (Lock & Pritchard, 2014), Ruth Scalp Lock recounts her story and names her father as one of her heroes. All of us who work in human services have the potential to be a hero to someone else if we take every opportunity to build people up in all our responses to them, especially when their behavior poses a threat of harm to themselves and/or others.

The final step is to transcend the trauma. One does not “get over” trauma; rather one “gets through it.” The neurobiological effects of trauma are always present in the body, and the emotional scars are always present in the spirit. What we need to do is to embrace this as a part of ourselves, and get through the trauma to the other side, from which we can offer support and assistance to the many people who need help in recovering from their own woundedness.

Conclusion

In many First Nations/Native American cultures, there is a story known by many names, in which a good wolf and a bad wolf are inside every child. (First People US, 2014) One of the wolves is full of anger, envy, sorrow, regret, greed, arrogance, superiority, and it wants to be in charge of the child when he or she grows up. The other wolf, the good wolf, is full of joy, peace, love, hope, kindness, trust, truth, compassion, and faith. It too wants to be in charge of the child when she or he grows up.

Which wolf will win? The one you feed. Every time we respond to people, every time we say a word or make a gesture or give someone a “look” we feed one of these two wolves. As we go about the science of healing, as we structure our plans and our places and our work, we need to do it in ways that build people up and do not tear them down. In doing so we will feed the good wolf and strengthen the ability of people to pass healing on to the next generation while at the same time healing ourselves now.

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Workshop program

The presenter will use case studies from America, Canada, and Australia explain how the model works and will provide outcome data.

Learning objectives

Participants will...

1. be able to describe the 4 walls of the house and Identify factors that weaken each wall.
2. identify factors that strengthen each wall and delineate steps to apply the model in their organization.

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The inpatient violence prevention climate - developing a new measurement scale

Paper

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Perspective: Research

Keywords: Violence prevention, ward atmosphere, pilot study, scale development

Introduction

Violence and aggression by patients are common in inpatient psychiatric hospital settings (Bowers et al., 2011). Between 30 - 76% of psychiatric staff have been assaulted by a patient at least once in their career (Poster & Ryan, 1994; Hatch-Maillette et al., 2007; Campbell et al., 2011). The financial cost of patient assault is significant in terms of subsequent staff illness or injury (Lanza & Milner, 1989; Carmel & Hunter, 1993; Hillbrand et al., 1996), and in terms of the implementation of managerial measures (Flood et al., 2007). Challenging behaviours like violence are a powerful cause of social exclusion, prolong patient's stay in hospital, and delay recovery. Preventing inpatient violence and aggression is therefore an important aim and holds the potential for economic gains, improved staff wellbeing and patient recovery.

From a public health perspective violence prevention comprises three tiers (Paterson et al., 2004). Primary prevention of violence is the actions that are taken to stop violence in advance of its occurrence. Secondary violence prevention is the actions that are taken to prevent imminent violence. Tertiary prevention comprises the interventions that occur during and following an episode of violence to reduce its impact and minimise the harm to the individuals involved (Paterson et al., 2004). Additionally, care staff, patients and service providers engage in a wide range of primary and secondary violence prevention activities including education and training, planned activities, self-regulation, communication, de-escalation, and environmental management (Paterson et al., 2004; Haimowitz et al., 2006). However, these issues are less well researched than tertiary measures such as seclusion, restraint, and emergency medication. The interplay between the physical environment and the patterns of behaviours and interactions between people in a setting, and how they are perceived, has been described variously as the 'ward atmosphere', the 'social climate' and the 'therapeutic milieu' (Duxbury et al., 2006).

A number of measurement scales have been developed to investigate social climate in psychiatric inpatient settings including the Ward Atmosphere Scale (WAS) (Moos & Houts, 1968), and the Essen Climate Evaluation Scale (EssenCES) (Schalast et al., 2008). Both scales purport to measure aspects of the social climate, but neither is aimed specifically at measuring the violence prevention element of the social climate. There are many aspects of the ward environment, and of the behaviours and interactions of staff and patients that are, at least, perceived to be related to violence prevention (Hallett et al., in press). Therefore we may speculate that the violence prevention climate is a specific and measurable aspect of the ward climate which, if amenable to change, could be subject to interventions aimed at making improvements. However, only one study, to date, has attempted to measure a 'violence prevention' related construct. Bjorkdahl et al. (2012) devised a measurement, the E13, to test the ability of an educational intervention to change the violence prevention climate in 41 units in Sweden. While the resulting tool appeared to measure a single underlying construct there were limitations. For example, the E13 had no initial review or pilot testing and was not validated against tools measuring related constructs. Therefore, further work is needed to measure violence prevention climate.

Aim

The primary aim of this study was to develop a new scale to measure the violence prevention climate in inpatient mental health settings, the Northampton Violence and Aggression Prevention Scale (NoVAPS). The aims of the pilot testing presented in this paper were to ensure that all scale items were comprehensible and acceptable to participants; that it was feasible for them to complete the scale; to establish face and content validity of the scale items; to establish whether there were any redundant items; to undertake test-retest reliability measurement to ascertain temporal stability; and to establish internal consistency of the scale.

Methods

Setting

Development of the new scale was conducted across two hospital sites of St Andrew's, a UK Charitable provider of specialist inpatient mental health care, mostly at levels of low and medium security. Eligible participants for the pilot were members of staff working in, or patients currently resident in one of three mental health, adult wards.

Procedure

Ethical approval was obtained from the Nottingham 1 NHS Research Ethics Committee and the University of Northampton research ethics committee. Governance approval was obtained from St Andrew's. The NoVAPS was developed by following steps typically taken when constructing scales of this type (Streiner, 2008).

Item pool generation

A systematic literature review was conducted to investigate patient and staff perceptions of the prevention of inpatient violence and aggression (Hallett et al., in press). The search yielded 37 empirical papers for inclusion in the review. Twenty papers described studies of the perceptions of psychiatric care staff, five of patients, and twelve of both care staff and patients. First, a number of studies investigated patients' and care staffs' self-reported preventive measures, i.e., in what ways do they personally act to prevent aggression. Second, and more commonly, participants were asked to make suggestions about what preventive measures would be effective. Finally, a number of studies used a form of measurement scale to investigate attitudes towards preventive measures, or towards a related phenomenon that included some aspect of violence prevention. Thematic analysis of the studies identified three high-level themes: patient-related factors, care staff-related factors, and organisational/environmental factors. Items were developed reflecting examples within each of these themes.

In addition, key informant interviews were conducted with knowledgeable staff members (two prevention and management of aggression and violence trainers, one ward manager of a female secure mental health ward and one deputy ward manager of a male secure mental health ward). Two focus groups with patients were held, the first with three female patients and the second with four male patients, both within a secure mental health hospital. The interviews were recorded then transcribed, and notes from the focus groups were made during the sessions, and items were developed from these.

Statement development and review

Positively and negatively worded statements were developed from the item pool to generate a 53-item scale. Agreement/disagreement with statements was measured using a 5-point Likert Scale (strongly agree to strongly disagree).

Expert review

The 53-item scale was sent for review to experts in the fields of nursing, research and psychology. Following review and subsequent discussions, nine items were removed because they were ambiguous or unclear, and ten items were added to ensure that pertinent areas were covered by the scale leaving a final 54-item scale.

Pilot of scale

A researcher attended each ward and staff members were given a copy of the draft scale to self-complete whilst patients completed them with the researcher. Consent was implied by completion of the scales by staff, and written consent was obtained from patients following a full explanation of the aims and purpose of the study. Patients' clinical teams advised on whether each participant had capacity to consent to the study, and this was monitored by the researcher during the consenting process and subsequent interview. All participants were asked to comment on the included statements, particularly to note any that were confusing or difficult to rate.

Reliability and validity testing

Participants also completed the EssenCES (a scale of ward atmosphere) and the Attitudes to Containment Measures Questionnaire (ACMQ) to measure concurrent and divergent validity. Participants completed the NoVAPS a second time, 7-14 days after the first iteration, to assess test-retest reliability.

Analysis

Item reduction

Items that performed poorly were eliminated, as their retention would reduce the reliability of the final scale. Items were eliminated using the following criteria: (1) items deemed difficult or confusing to rate by participants, via a written evaluation form and verbal feedback; (2) items showing poor or slight test-retest reliability (linear weighted Kappa coefficient <0.20) (Landis & Koch, 1977), see Table 1; (3) redundant items measured by item-item correlation (Spearman's rho >0.70) (Streiner, 2008).

Table 1. Benchmark scale (from Landis & Koch, 1977)

Kappa Statistic	Strength of Agreement
<0.0	Poor
0.0 to 0.20	Slight
0.21 to 0.40	Fair
0.41 to 0.60	Moderate
0.61 to 0.80	Substantial
0.81 to 1.00	Almost perfect

Internal consistency

Internal consistency was measured using the Cronbach's alpha coefficient. Very high internal consistency (>0.90) suggests that some items are redundant (McDowell, 2006), and for attitude scales an alpha of 0.80 is considered optimal (Gliem & Gliem, 2003).

Results

Response rate

Fifty-eight staff were invited to participate, and all but four completed a questionnaire, (response rate 93%). Of the twenty-five patients invited to participate, fifteen declined (response rate 44%); the overall response rate was 77%.

Acceptability of statements

After all staff participants had completed the scale, two questions were removed as participants struggled to understand them. Patients were subsequently given a 52-item scale to complete. Six further questions were difficult for patients to answer, and these were also removed at this stage.

Test-retest reliability

In total, 36 staff and 5 patients completed the scale a second time, 7-14 days after the first iteration. Linear weighted Kappa was calculated for all statements; one statement showed slight agreement, 14 fair, 34 moderate and 3 substantial. The statement that showed slight agreement was one that patients reported as difficult to answer and was removed.

Item-item correlation

One statement showed high correlation (>0.70 , $p<0.01$) with two other statements and this was removed as the correlation suggests redundancy.

Internal consistency

The final scale with ambiguous, redundant, and non-reliable items removed comprised 44 items. Cronbach's alpha for this 44-item scale was .886.

Discussion

The primary aim of this study was the development and initial validation of a scale to measure the violence prevention climate in a secure inpatient hospital setting. Content validity was important in the development of items for the scale, with the content being grounded in the views of patients and staff, in conjunction with a systematic review of the literature. The scale was reviewed prior to testing by a range of experts, and pilot testing of the scale with both patients and staff serves to establish the content and face validity of the scale. Psychometric evaluation of the scale showed moderate to substantial test-retest reliability for the majority of items.

The high value for Cronbach's alpha indicates internal consistency suggesting that the scale may measure an underlying construct; however, it does not mean that the scale is unidimensional. To determine the dimensionality of the scale, principal component analysis (PCA) will be used following a roll-out of the scale for further testing. This type of analysis requires a much larger sample (Kline, 2000). The refined 44-item scale will, therefore, be used with a larger sample of participants, to include both patients and staff from a range of settings. Rasch analysis will be used to validate the factor structure as determined by PCA.

To aid in delineating the construct boundaries, thus knowing more precisely what the scale does and does not measure, convergent and discriminant validity against existing measures will be tested. Pilot participants also completed two other scales, the Essen Climate Evaluation Scale (EssenCES) (Schalast et al., 2008) and the Attitudes to Containment Measures Questionnaire (ACMQ) (Bowers et al., 2004). Following PCA, convergent validity of the scale will be tested against the relevant parts of these.

Further testing of the scale will be conducted to measure its relationships with: patient variables, to include diagnosis, time since admission to hospital and medication adherence; staff variables, including gender, job role and experience; and ward variables, including ward type, level of security, and frequency and type of aggressive incidents.

Development of this scale, and its use in subsequent research will build on what is currently known about violence prevention and should enable improvements to be made with the aim of reducing violence and aggressive incidents in inpatient settings.

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Learning objectives

Participants will...

1. have an understanding of the concept of a 'violence prevention climate';
2. identify the factors that make up the violence prevention climate.

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Proactive promotion of nurses' resilience to occupational stress injuries in remote workplaces

Paper

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Perspective: Practice

Background

The Occupational and Critical Incident Stress Management (OCISM) program is a partnership within Health Canada, between First Nations and Inuit Health Branch and Specialized Health Services Directorate. Services are provided to nurses working in First Nations communities across Canada, including in 2 hospitals, 222 health centres, and 78 remote and isolated nursing stations.

Recognizing nurses are at high risk for work-related trauma, the program was developed in response to a retrospective study where significant violence resulted in symptoms of Post Traumatic Stress Disorder in 33% of the nurses, with high staffing turnover (1992). The initial pilot project evaluation identified that 24% of nurses would have quit had they not received services following critical incidents. With a 7:1 return on investment, the program was implemented nationally (1993). Formal external evaluations have guided and reaffirmed OCISM as best practice for supporting nurses working in isolated posts.

While originally based on the International Critical Incident Stress Foundation model for critical incident stress management, OCISM is a modified, comprehensive approach to prevention and proactive response to workplace incidents, tailor-made for nurses working in remote locations. The evidence-based service is provided by peer nurses, who coordinate mental health interventions. OCISM collaborates with management and union stakeholders about emerging issues. Based on their proactive contact with field nurses, OCISM identified escalating verbal and physical violence which is consistent with international trends.

OCISM services include (a) education and training for nurses, management and a network of mental health professionals; (b) direct client services, involving proactive contact with nurses involved in workplace incidents; (c) administration, including resource development, implementation, and evaluation; reporting and consultation with management about statistics, trends and urgent issues, while ensuring confidentiality of nurses' personal information. OCISM provides education about Occupational Stress Injuries (OSI) and resiliency promotion during nurses' orientation. More than 1000 nurses have received Nursing Safety and Awareness training, with a focus on violence awareness and prevention.

Recognizing that nurses are less likely to initiate access to mental health services, OCISM has been integrated into the established incident reporting system to allow proactive contacting of nurses involved in practice-related events that may be traumatizing. Administrative reports that are routinely submitted by nurses to their managers are copied to OCISM, who follow up with each nurse involved. Services provided include assessment, defusing, individual debriefing, or referral to alternate counseling, and follow-up.

Since the establishment of the program, OCISM data and intelligence gathering has provided evidence about the relationship between violence and critical incidents. This has supported organizational policy and practice changes, including elimination of single-nurse stations, zero tolerance violence policies, implementation of security staff, flexible work schedules, and safety training.

A critical incident is defined as any practice related situation faced by nurses that cause them to experience unusually strong emotional reactions, with the potential to interfere with their ability to function immediately or later.

The annual number of critical incidents has decreased over time, despite documented escalation of violence. From the 2940 requests for service received in 2012/2013, there were 30 critical incidents. While 40% of critical incidents identified related to violence toward nurses, all of the 66 nurses involved remained or returned to work after intervention. Organizational support, including OCISM services, has contributed to the retention of nurses.

Expanded services for prevention of occupational stress injuries (OSI)

In 2009, the long-standing OCISM services, providing early intervention and case management for critical incidents, responded to requests from their National Advisory Committee. The committee, with union and management representatives, was seeking expanded support services to deal with the severe impact of the first wave of the H1N1 Influenza Pandemic.

Nurses are highly dedicated professionals who are the primary health care providers in nursing stations. They prioritized high patient care needs over their own most basic needs, with minimal breaks for meals or sleep for extended periods. Despite every effort by management to provide resources to meet escalating demands, exhausted nurses assessed by OCISM presented with symptoms of potential cumulative stress, vicarious traumatization, compassion fatigue or burn out.

In consultation with OCISM mental health professionals with extensive expertise in occupational stress and trauma, OCISM developed expanded support services to promote resiliency. Services focused on prevention, early identification, and referral for OSI, maximizing use of OCISM's established relationships and communication networks with nurses.

The goals of the pilot project stemmed from recommendations by the Public Health Agency of Canada (PHAC) in providing psychosocial support for health sector workers: protect and promote psychosocial well-being and resilience of nurses working in isolated First Nations communities; mitigate, prevent or treat mental/behavioural health issues arising in response to pandemic or recovery process; ultimately augment capacity to respond effectively over time through the retention of nurses (PHAC, 2009).

Proposed services were adapted from evidence-based best practices applied to the needs of 107 nurses working in isolated areas highly impacted by the pandemic.

1. Peer Assistance Line Support (PALS)

Objective: To provide peer social support, as a form of mentoring, mitigating professional isolation, and lack of consistent peer in remote and transient workplaces.

The telephone peer support network was an expansion and adaptation of a buddy system. Peer with similar experience (PALS) provided a listening ear as an alternative to venting with personal supports who aren't locally available, or who would risk vicarious traumatization, with potential breach of confidentiality. PALS provided an earlier option to EAP, as the majority of nurses seeking help will first look for social, practical support rather than mental health intervention. PALS helped nurses monitor their stress levels, offered help in coping, and referred as needed.

2. Support Promote Assess Resilience Coping Skills (SPARCS)

Objective: To provide post-rotation assessment for early identification, intervention, referral and follow-up of trauma-related mental health effects on nurses exposed to intense workplace stress. Nurses rotate into and out of isolated communities. While in the community they are disconnected from family and other support networks. When they return to their homes, they are disconnected from collegial support networks.

Post-rotation follow-up for nurses exiting the worksite at the end their rotation was broadly based on the concepts of decompression after deployment. The goal was to mitigate, prevent, or refer mental / behavioural issues arising in response to traumatic events or the recovery process. Proactive telephone contact with nurses provided support from a strengths-based approach. Services included education about OSI identification and prevention, self-care, preparation for reintegration home, and for return to work. SPARCS is consistent with recommendations to develop plans, including rapid assessment of psychosocial needs, and mapping of resources and vulnerabilities (PHAC, 2009). OCISM's assessment and referrals provided psychosocial care and referral for treatment of mental health problems.

3. Psychological First Aid Training

Objective: To provide expanded training for nurses to support their peer colleagues. The goal was to provide knowledge and skills to assist peers involved in situations of extreme workplace stress. Training offered tools to stabilize their functioning, mitigate distress, and prevent dysfunctional coping, with timely return to adaptive function. The focus was on normal psychological responses and support networks.

4. Resiliency Coaching

Objective: To provide short-term telephone coaching to nurse leaders and managers to support adaptation to workplace stress and the capacity to respond to adverse impacts. OCISM mental health professionals provided telephone coaching with a participant handbook and tailored resources to enhance existing skills, resources, and creativity. Resiliency coaching was consistent with the best-practice recommendations of supporting nurses' adaptation to stress and their capacity to respond to adverse impacts. Through a sense of empowerment, responsibility, and an action orientation, nurses were supported to restore their sense of confidence, competence, efficacy, and trust (PHAC, 2009).

Evaluation of the pilot project

The two services accessed and evaluated during the 2009-2010 pilot project included PALS and SPARCS.

Evaluation Survey

A pre-intervention survey was developed to measure nurses' stress levels and resilience, using validated psychological questionnaires (Current Level of Stress; Response to Stressful Experiences; Resilience Scale). It was distributed to 107 nurses working in nursing stations at the launch of the services, with a 30% response rate.

The post-pilot project survey was distributed four months later, with a 28% response rate. The post-intervention survey repeated the three quantitative scales, with additional qualitative questions about services accessed.

Quantitative

Review of the psychological questionnaires demonstrated significant positive changes from pre- to post-intervention surveys. The Current Stress Levels results were positively lower for the post-evaluation group. The Response to Stressful Experience scale showed upward movement. The overall scale results were significantly improved for all participants and more for those who used PALS. There was improvement noted in subscales for meaning-making and self-efficacy, indicating that those who used the services learned to better deal with stressful events, even in the very short time span. On the Resilience Scale, there was a modest but significant upward shift. The improvements were very noticeable in those who used both the PALS and SPARCS, indicating that they were effective in improving resilience in this sample.

Qualitative

Subjective evaluation comments from the nurses reported improvements in all areas: health habits (88%), work performance (88%), work relationships (77%), sense of well-being (88%), stress levels diminished (95%).

- PALS:** Three PALS provided support to 59 nurses (55%). Fifteen of those submitted evaluations, with 100% stating they would use the service again and would recommend it to their peers. Further assessment confirmed that the PALS demonstrated five characteristics that fostered productive and positive relationships including: social support; experiential knowledge; trust in their honesty, integrity, and reliability; confidentiality; and easy access.
- SPARCS:** Three OCISM Assistant Coordinators, who are peer nurses, provided SPARCS telephone support to 67 nurses (63%) who provided their contact information to be called at home after their rotations. Of the 15 who submitted evaluations, thirteen stated they would use the service again (all full-time nurses provided positive feedback with continued access requested); 14 would also recommend it to their peer. OCISM has made adaptations to the service in response to feedback, including the development of a workbook with OSI educational resources and self-assessment tools. An unexpected outcome of the 4-month SPARCS post-rotation follow-up was the identification of 4 delayed critical incident stress reactions, of which three involved nurses-in-charge. While they had been contacted at the time of the event, their reactions weren't identified until after their scheduled departure from the community. It appeared that their operational responsibilities to their nurses and community clients superseded their own self-care. Consultation with OCISM Clinical Director, Dr. Greg Passey, confirmed that such late onset of symptoms does occur post-deployment, when employees are finally away from work, no longer task oriented, with the opportunity to think and feel. Though critical incident stress identification was not the target of SPARCS, these nurses were able to access needed intervention.
- Psychological First Aid Training:** During the pandemic, broad scale delivery of Psychological First Aid Training to all nurses was not feasible. The high workload prevented nurses from leaving their worksite to access preventive training. A validation session was provided during that time, with two initial training sessions in 2012. Session evaluations were positive, including recommendations from all participants in the validation session that the training be incorporated into the basic skills provided to all nurses during their initial orientation. Further adaptations are in process with plans for further rollout.
- Resiliency Coaching:** This was not provided to all the nurses during the four-month pilot project. Upon review of the SPARCS post-rotation follow-up, the delayed critical incident stress reactions highlighted the extreme stress experienced by nurse leaders. In response, preventive resiliency coaching has since been offered to nursing leaders and managers. Of 22 nurses accessing services, 32% were interviewed. Over 85% stated it helped them address issues, find solutions, and develop further coping strategies. All nurses recommended resiliency coaching to their peer.

Evaluation summary

Review of the pilot project survey by an external evaluator reiterated the positive findings.

“Another test which is often indicative of the value placed on a service by professionals is their willingness to refer colleagues to it. This is a critical feature in determining the reputation and acceptance of a service, particularly in such a close-knit professional community as these nurses. The response was overwhelmingly positive for all the service lines. This is a strong indicator of the degree of acceptance and level of need for such support services. This is a very robust evaluation conducted with both qualitative and quantitative measures with a representative sample. The results clearly indicate that the interventions created not only cognitive changes but also positive behavioural outcomes among those who used the services” (Corneil, 2010).

Conclusion

The described OSI prevention supports expanded on the existing OCISM services for critical incident stress. Evaluation of the piloted services confirmed promising practices in promoting resilience of nurses working in isolated and remote worksites.

While historically and typically nurses tend to avoid accessing services for any psychosocial intervention, overall there appears to be a consistent cultural shift in many worksites: most nurses are receptive and appreciative of OCISM services, and continue to highly recommend it to their peer.

Throughout the provision of services and evaluations, nurses readily identified that they felt supported by Health Canada because of programs available to them. Together with First Nations and Inuit Health Branch, OCISM continues to provide preventive and responsive supports, with ongoing evaluation and adaptation to the needs of nurses.

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Acknowledgement

The collaborative efforts of the Health Canada’s OCISM team with First Nations and Inuit Health Branch national, regional and front line staff has resulted in dynamic resources for nurses. Their commitment has promoted nurses’ health, safety and resiliency, enabling their continued provision of quality care to First Nations communities across Canada. OCISM also acknowledges with great appreciation the consultations with Dr. Wayne Corneil and Dr. Greg Passey.

Learning objectives

Participants will...

1. learn that presenting peer support initiatives help promote resilience of nurses in remote and isolated posts.
2. learn that presenting proactive interventions help reduce occupational stress injuries for nurses.

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Impact of upper limb position in prone restraint as a factor in restraint related death

Paper

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Perspective: Research

Background and context

Physical restraint remains an unpalatable but accepted emergency response to acute behavioural disturbance or instrumental violence in many health and social care settings for people with mental ill health as well as those individual with intellectual disabilities who present significant behavioural challenges. However, there have been growing concerns that the use of restraint may be misused or abused and therefore needs to be reduced. In particular, the number of deaths occurring during and/or in close proximity to physical restraint and which have largely been attributed to positional asphyxia, remains the focus of the debate with prone restraint a key factor. Within the U.K. new national guidance has recently been issued and the minister for health and social care has given a two year commitment to eradicate forced prone restraint in all health and social care services. The presentation will draw on the scientific published evidence to highlight the multi-factorial risks that contribute to sudden or proximal restraint related deaths and will summarise an investigation into the physiological impact of three recognised prone-restraint positions, where one position (the Supported Prone Position - SPP) was designed for emergency use to reduce the physiological impact of such interventions in situations where prone restraint cannot be avoided.

Methodology

Twenty-five adults participated in the study. Forced vital capacity (FVC), expiratory volume in one second (FEV1), heart rate (HR) and oxygen saturations (SpO2) were taken three times in an upright seated position (baseline) and in each prone position following exercise at 80% of participants HR maximum to physiologically simulate an aggressive and violent struggle.

Findings

The data demonstrates that the supported prone position (SPP); which was designed to reduce the extent of pressure on the anterior chest wall, offers a safer position in those situations where individuals are restrained in an emergency and where prone restraint is unavoidable.

Implications

Whilst staff training programmes which include the use of restrictive physical interventions should emphasise preventative, non-physical approaches contextualised within a framework of positive behaviour support and person-centered approaches which avoid or minimise the use of restraint, it is important to recognise that in some situations involving acute behavioural disturbance or instrumental violence, staff are sometimes left with no choice but to use emergency physical restraint to limit an individual's ability to harm themselves or others. Where staff are required to use such approaches, it is important that the methods of restraint taught and used do not unnecessarily place the individual at risk of harm and do not contribute the restraint-related death.

Learning objectives

Participants will...

1. have a clear understanding of the multi-factorial risks implicated in restraint-related death.
2. understand that all prone positions do not have the same negative physiological impact on the individual being restrained.
3. understand that the negative physiological impact of prone restraint can be reduced using a specific supported prone position.

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BCNU Resilience Workshop: An innovative group intervention for cumulative trauma in nurses

Poster

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Focus: Guidance

Background

Nursing is a highly demanding profession with many physical and psychological hazards. Many nurses are routinely exposed to primary and secondary trauma, threat, violence, and unfixable human suffering. Nurses are more likely to be physically assaulted on the job than police officers, with less training to handle violence, and fewer protections. The incidence of disability related to psychiatric illness is significant among nurses. While the BC Nurses' Union is working to create healthy healthcare workplaces that are both physically and emotionally safe and healthy, the union also sought to provide more immediate assistance to members who have been deeply traumatized at work through sponsorship of this innovative pilot project.

This unique intensive group process was originally developed for the RCMP in an effort to help police officers cope with the cumulative stresses of police work. Since that time Resilience Workshops have been run for Traffic Collision Analysts, Forensic Identification Investigators, Homicide Investigators, Child Exploitation Investigators, Dispatchers, Corrections officers and military veterans. This project represents the first time this process has been used within healthcare, targeting nurses working in highly volatile and violent work environments. A small group participated at an offsite venue, working together intensively over 3 days facilitated by two psychologists. The workshop included psycho-education on trauma, compassion fatigue, resilience and healthy coping and involved a semi-structured group process for participants to speak about key events in their lives, and about traumatic or stressful events in their work.

Methodology

Participants were screened by the lead psychologist prior to the workshop for risk factors that would suggest participation would put the individual at risk of harm. Anonymous written feedback was solicited from all participants at the completion of the workshop and the lead psychologist contacted all participants by telephone following the workshop to debrief. The Impact of Events Scale (revised) was administered to all participants pre/post workshop. Participants will continue to be followed at 6 months to assess emotional resilience and work status.

Findings

Preliminary feedback was extremely positive with participants stating the workshop was very helpful in terms of both professional and peer support, feeling less alone and isolated in their work distress, providing a better understanding of how their work affects them and how they can become more resilient. Participants did state the workshop was intense and talking about their lives and work traumas was challenging and emotionally draining. The Impact of Events Scale administered to participants showed decreases in each of the Avoidance, Intrusion, and Hyperarousal scales.

Implications

This process shows promise for helping nurses better proactively cope with the stress and trauma they are exposed to on the job. Less intensive psycho-education for nurses at high risk for work-related trauma who are not yet experiencing significant psychological distress may also be useful.

Learning objectives

Participants will...

1. be able to describe how group intervention provides nurses with tools to better proactively cope with immediate and cumulative stress and trauma in the workplace.
2. appreciate the potential of psycho-education for nurses at high risk for work-related trauma.

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Reducing aggression among chronic psychiatric inpatients through nutritional supplementation

Poster

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Focus: Research

Background

Aggressive incidents occur frequently among long-term psychiatric inpatients (n=11000 in the Netherlands). These incidents include verbal aggression, physical aggression towards persons, physical aggression towards objects, and self-harm and suicide attempts. Aggression has serious consequences as incidents may be traumatic and cause stress in caregivers and patients as well as giving rise to various types of costs.

Although effectiveness in the general population is questionable, several studies in specific populations have demonstrated anti-aggressive effects of vitamins, minerals and essential omega-3 fatty acids (n-3 FA). In four randomized controlled trials (RCTs), daily administration of multivitamins and n-3 FA (eicosapentaenoic acid and docosahexaenoic acid) reduced the number of (violent and nonviolent) offences, antisocial behaviour, and agitation in juvenile delinquents, frequently disciplined schoolchildren, and in young adult prisoners. Finally, a pilot study with 12 treatment resistant schizophrenia patients demonstrated reduced agitation (measured by prescribed anxiolytics) and psychopathology and increased functioning upon n-3FA supplementation.

We propose to conduct an RCT to test the effectiveness and cost-effectiveness of multivitamin-, mineral- and n-3 FA supplementation versus placebo to reduce aggressive incidents in chronic psychiatric inpatients. We hypothesize that supplementation reduces aggression and thereby costs of care while increasing quality of life.

Method, findings and implications

The study is designed as a double-blind, randomized, placebo-controlled multicenter trial. We aim to include a total of 200 patients who have been hospitalized for ≥ 1 year in one of 10 involved institutions for long-term psychiatric care. Patients who are randomized to the intervention will receive daily supplementation of vitamins (B1, B2, B3, B5, B6, B11, B12, C, D, E, Beta Carotene), minerals (Calcium, Iodine, Copper, Magnesium, Selenium, Iron, Zinc, Potassium, Chrome, Manganese) and n-3 FA (EPA, DHA), in the form of Orthica Soft Multi and Orthica Fish EPA Forte supplements; controls will receive placebo.

The main outcome measure in this study will be the number and severity of aggressive incidents. Secondary outcomes are costs of time spent on incidents by staff, additional costs related to aggression incidents, nutritional status, aggression scales, and quality of life.

Learning objectives

Participants will...

1. learn about the potential aggression reducing effects of a nutritional intervention.
2. learn about the cost effectiveness of a nutritional intervention in the reduction of aggression.

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Chapter 7 - Examples of collaborative working toward aggression and violence free environments

Violence risk reduction for teen and adult males

Workshop

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Perspective: Practice

Keywords: Violence prevention, mass murder, psychotic, autistic, criminal behavior, mental illness, criminal justice, violence reduction, violence risk factors

Background

Preventing future events of violence is an important forensic task. Violence prediction tools have been widely used in Canada, the UK and the Netherlands, but not the US. To a greater or lesser extent, risk tools are based on the idea that violent acts may be the “result of a highly complex interaction of biological, psychological and sociological factors (Ashley, et. al. 2014).

The HCR-20 is a structured clinical judgment tool. Risk factors for violence identified by the HCR-20 include:

- History of: violence, anti-social behavior, relationship difficulties, employment difficulties, substance abuse, Major mental illness, personality disorder, traumatic experiences, violent attitudes, non-compliance with treatment or supervision;
- Clinical issues: Lack of insight, violent ideation, and instability
- Risk Management: living situation, support systems, services, stress, and coping.

Risk profiles have been difficult if not impossible to create because this complex array of risk factors may have an infinite number of combinations (FBI, 2005). What the researchers of violence risk appear to agree upon is the number of risk factors is elevated for those that are at risk for violence while the exact combinations of risk factors may be different for each offender. Additionally, in order to delineate the risk factors of violence, it is necessary to determine if there is more than one profile. A large number of recent mass murders appear to have been committed by males with severe mental illness, psychosis, or autism and no significant history of prior violent acting out behaviors. This group appears, upon cursory examination, to be different in some ways from the group of violent offenders with histories of chronic criminal behavior and violence (Douglas, 2013).

Risk Reduction Plans based on using interventions to decrease the known risk factors for violence may also be a very effective method to reduce future violence for those at risk for such behaviors.

This study was undertaken to determine if the mentally ill mass murder group is significantly different from the chronically violent anti-social group and a non-violent group. Group 1 tends to have a long criminal history beginning in adolescence and a life-long trajectory of violence (Moffitt, 2001). This group label is “Chronic Violent Offenders.” Group 2, the autistic, or psychotic group appear to be narcissistic and paranoid but without a history of chronic violence (Allely et. al., 2014). This group, often experiences life-long trajectory of social inadequacy rather than violence in which a “flash point” occurs when a problem exceeds the person’s ability to cope and injures his ego. The individual erupts with extreme violence, attempting to kill or injure multiple victims in a public place. Those in this group have histories of emotional outbursts, but not histories of violence against people. The mentally ill or autistic group erupt with a single act of multi-victim murder or attempted murder following an event that the person in question considers to be devastating beyond recovery. The label for group 2 is “Socially Detached Violent Offenders.”

Measures

Traditional measures of risk for violence for adult males, such as the HCR-20 (Douglas, 2013), have been focused primarily on the chronically violent offenders.

A newly developed checklist (AVRRT) was used to collect data aimed more specifically at the mentally ill (or autistic) offender rather than the chronically violent and criminal offender. While there is overlap of characteristics between the two groups there are also distinct differences. The AVRRT was created by the author, Dr. Kathryn Seifert. It has 20 items associated with those that have committed mass or serial murder. Items include: social awkwardness, mental illness or autism, co-occurring substance abuse, paranoia, lack of support, delusions, not in treatment, violent communications, and school or job difficulties. Items are scored on a 0 to 3 scale by severity (0 = not present, 1 = little or mild; 2 = moderate or somewhat; 3 = severe or completely true).

Publicly available information on mass and serial murderers was collected on those that have committed multi-victim murders. Data was also collected by using the AVRRT on teens and men with histories of violence, but not murder, and those with no history of violence. Consents were signed by all participants except public figures where only public data was used. The scores on the AVRRT and characteristics of the three groups were compared.

Sample

After eliminating 12 cases with insufficient data, the sample consisted of 31 male teens and men between the ages of 15 and 40. They were divided into 3 groups: Mass murderers (n = 15, 48%), those with violent behaviors, but not murder (n = 8; 26%), those with no histories of violence (n = 8; 26%). Non-violent individuals in the sample had a mean score of 10 (SD = 4) on the AVRRT (ranging from 2 - 16). Violent individuals without a history of murder had a mean score of 38 (SD = 8) (the range was 26 - 47). Mass murderers had an average score of 44 (SD = 6) (ranging from 33 - 51).

In the sample there were 21 (68%) Caucasians, 3 (10%) African Americans, 2 (6%) Eastern Europeans, 2 (6%) Asians, and 1 (3%) Hispanic. Two had unknown ethnicity (6%). Fourteen (45%) had been diagnosed as psychotic or Autistic. Twenty (49%) were socially awkward. Twenty Three (74%) had some interpersonal difficulties.

Methods

A list of common characteristics of group 2, Socially Detached Violent Offenders, was compiled from structured data collection from public information on mass murderers without a history of chronic criminality and violence. The AVRRT was developed using this collection of common characteristics of mass murderers from the literature and data collection. A scale from 0 to 3 was used to indicate severity of the item to achieve a final score of items present weighted by severity. Data was also collected on closed files of a mental health clinic. All clients had signed permission to be included in a study of violence when they enrolled in the clinic. Data was entered into Excel and analyzed. All names in the study were given an ID # so that identities were protected. Only Dr. Seifert has access to the names and data on a computer that is password secure.

Results

There is overlap in scores between the two violent groups, but not the combined violent groups with the on-violent group. The AVRRT appears to distinguish well between violent and non-violent individuals but not between violent individuals and mass murderers. When the aggressive and mass murder groups were combined, there was good definition of groups.

	Violent	Non-Violent	All
Mean	42	10	34
SD	8	4	16
Range	26-51	2-16	2-51

Correlation of score with the 2 groups was $r = .90$. Probability that the two groups are the same $F = ns$.

Characteristics of the Groups and Literature Review Reference

- Psychotic or Autistic. (Allely, 2014) In this sample 80% of the murderers in this sample were psychotic or severely autistic, 25% of the aggressive group and none of the no-aggressive group
- Problems with intimate relationships, such as girl friends or lack of girlfriend (In this sample 93% of murderers, 100% of the aggressive group and 12% of the non-aggressive group)
- Weak coping skills, such as problem solving, self-soothing, anger management, self-regulation. (FBI, 2005) (In this sample 93% of Murderers, 100% of the Aggressive Group, and none of the non-aggressive group)

- Limited family, professional, or friend support (In this sample murderers 93%, aggressive group had 88%, and the non-aggressive group had 12%).
- Narcissism (FBI, 2005) (In this sample murderers had 93%, Aggressive men had 100%, and the non-aggressive group had 12%)
- Co-occurring mental illness and substance abuse (Seifert, 2012) In this sample 6 (40%) murderers, 5 (62%) those that had been aggressive, and none of those that did not exhibit aggression

Conclusions

The data on risk factors is consistent with prior research. While on a small sample, it appeared to confirm that when compared to those that had not exhibited aggression, a greater percentage of those that had used aggression in any form had the following characteristics: Problems with intimate relationships, poor life coping skills, limited support, narcissism, co-occurring mental illness and substance abuse, needed treatment, but were not in treatment, problems at work or school, violent communications, and a recent severe life stressor that was damaging of the ego.

A greater percentage of the mass murderers (80%) were psychotic or autistic than the general aggression group (25%) or the non-aggressive group (0), and were paranoid (60%) compared to the aggressive (25%) and the non-aggressive group (0). Two thirds of the mass murderers were delusional, while none of the other two groups exhibited delusions.

While the mass murder group appears to have some of the same characteristics in common with the general aggression group such as poor coping skills and substance abuse and mental illness co-occurring and limited support, it also appears to be distinguishable by being psychotic or autistic, paranoid and delusional.

A combination of poor coping, lack of support and not being in treatment is a prominent factor for all aggressive clients regardless of frequency or severity. Therefore, a growing body of research in this area could be used by advocates and providers to strengthen access to a particular type of care in the community, such as peer support networks and walk-in and crisis clinics.

Discussion

One of the goals of this research was to demonstrate that among those that are mentally ill or autistic, the measurement for risk of dangerousness encompasses a specific list of risk factors that is not necessarily the same list that providers use to measure mental health problems. Measurements of both mental illness and dangerousness are necessary so that treatment plans cover both areas of need. Therefore, if we strengthen coping skills and supports for the mentally ill that are at risk for violent acting out in the community, we can prevent future acts of violence by those vulnerable to that method of coping by including those items in the treatment plan.

In the *Developmental Origins of Aggression* Edited by Tremblay et. al. (2005) it is stated that aggression past the age of 5 as a means to cope indicates that a child has not been taught alternative coping strategies. This research supports the idea that males in late adolescence and adulthood that use violence as a means to an end may not have developed or failed to use or have forgotten other coping strategies. By guiding clinicians to provide skill building as an intervention strategy, it could help clients reduce their use of violence as their main or only coping strategy. Further, research can strengthen the list of risk factors and risk reduction techniques for teens and young men that are mentally ill or autistic and at risk for aggression. Training Mental Health, Juvenile Justice, Criminal Justice, Schools, and associated agencies about identification of risk and violence risk reduction techniques needs further research and wide dissemination of the results.

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Learning objectives

Participants will...

1. be able to describe risk factors for a group of teens and men that commit public mass murder.
2. be able to describe violence risk reduction techniques and to add risk reduction techniques to their workplace.

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Workplace bullying: The internal threat in health care

Workshop

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Perspective: Education and Training

Keywords: Workplace bullying, aggression, psychological abuse, revenge, internal threat, conflict

Introduction

Despite organizational zero tolerance policies and conflict resolution programs workplace bullying continues to occur. This problem has negatively impacted the employee, the organization, and society because there are health ramifications for the target, loss of revenue for the organization, and an added burden on social welfare programs for society. This research study was an attempt to learn more about the relationships of workplace bullying, aggressive thoughts, the impact on patient care, employee morale and satisfaction, and the employee's perception of the organization after an encounter with bullying. Additionally, this study aims to understand the success or failure of conflict resolution styles attempted to resolve the bullying episodes of each of the participants.

Methods

Participants were selected using criterion sampling based on their knowledge and experiences with workplace bullying. This qualitative research study used a phenomenological approach to focus on the lived experiences of the research participants. Semi-structured interview questions were used to collect data from participants. Carefully formulated interview questions allowed the interviewer to focus on the subjective introspection of the participant and capture the essence of each participant's experience with workplace bullying.

A horizontalization process to review the data was used; the data was bracketed to identify import aspects of each of the participant's experience. Then data was categorized using a quantitative coding system that reduced the data into themes, patterns, and relationships. To establish validity of the data it was triangulated, to examine any personal biases about workplace bullying, and to provide rich thick descriptions of the patterns, themes, and description identified. A member check process was applied for accuracy and clarification.

Results

This study was conducted in the U.S. in a large hospital with over 5,000 employees. Participants were selected from various departments and eight different campuses. Participants self-identified as targets of workplace bullying.

During Phase I of the study N=275 employees took part in the selection process by completing a 14 page booklet to see if they met inclusion criteria for Phase II of the study. After careful review of each of the booklets N=60 employees were selected for Phase II. One participant selected for Phase II of the study withdrew within two weeks of completing Phase I due to continued bullying she had to be institutionalized for mental health reasons and self-terminated from the organization. Two additional females withdrew from Phase II out of fear that their bully manager would find out they were participating in the study and retaliate against them. Two males withdrew from the study out of fear of being retaliated against. One male withdrew because he said "the questions tugged at him" and he found it very difficult to go to Phase II. During Phase I of the study one female who would have been a good candidate for Phase II became overly emotional and distraught while completing the booklet.

A counselor had to be called to assist in calming her down; this was a two hour process. This individual later revealed she had been institutionalized because of the bullying. One female had inquired about participating in Phase I of the study but was discouraged from doing so because she was suicidal at the time. She was referred to counseling. A female employee declined to participate in the study but provided an email detailing her experience with workplace bullying while at the organization.

The major study findings

Workplace bullying does negatively impact patient care, workplace bullying share similar characteristics to other forms of violence, both males and females exposed to workplace bullying presented with severe psychological injuries (anxiety, depression, emotional and sleep disturbances, and suicidal ideations), also these individual were on doctor prescribed medications for anxiety, depression, and other health issues related to the bullying, other chose to self-medicate with drugs and alcohol, standard conflict resolution processes are inadequate to address workplace bullying, workers who experience workplace bullying become disengaged

form the organization, employees who experienced workplace bullying entertained thoughts of revenge against their bully, co-workers they believed participated in the bullying experience, and organizational leadership, females had just as many violent thoughts as males, on average bullied employees spent at least 72.2% of their day focused on the bullying and not on patient care, and 48% of employees in the study admitted to having nightmares and violent dreams about their bully(s) (Tables 1&3). Employees participating in the study used negative descriptive terms to describe their work environments (Table 2).

Table 1: For acts of revenge participants had multiple ways of carrying out violence against their bully. Some felt shootings were not “personal enough” and they wanted their revenge to be personal.

Thoughts of revenge	78%
Experienced depression	56%
Experienced anxiety	56%
Experienced stress	69%
Suffered from increased headaches	59%
Suicidal ideations	19%
Self- medicated (Alcohol consumption/drugs)	20%
Doctor prescribed medication (depression/anxiety)	35%
Nightmares/violent dreams	48%
Focused on the bullying during work hours	72.2%
Average number of sick days used	1,480
Frequent gastric upset	50%

Table 2: Descriptive terms used to describe work environments

Abusive	Authoritative	Bad culture
Cancerous	Corrupt	Different
Hostile	Manipulative	Nightmare
No communication	Not normal	Poorly managed
stressful	Tense	Toxic
Unhealthy	Unpleasant	Unpredictable

Table 3: Descriptive Quotes for Violence

“If you are backed into a corner you come out fighting.”
“I wanted to hurt someone.”
“I wanted to stomp a mud hole in her ass.”
“Make him so his own mother wouldn’t recognize him.”
“Shoot them!” ALL of them.”
“Following them home and shooting them there.”
“Making them feel what I feel.”
“I wanted to bring a gun to work to shoot them”
“Disregard the law I didn’t have anything to lose at that point.”
“At one time I was really at a bad point; so I was really thinking about doing something.”
“I had many many dreams about how to best handle the situation beat them or shoot them. I always ended up shooting them”.

Conclusion

Workplace bullying can be described as a toxin in an organization. One that contaminates the environment and makes it difficult for all employees to properly function. It is a phenomenon that greatly impacts the employee, patient care and the perception of an organization. Employees suffer a multitude of physical and psychological injuries because of abusive work environments. Because workplace bullying is one of those issues that organizational leaders fail to properly address employees are left to deal with this issue alone. When left to find

their own solutions to this problem an employee may react the only way he/she feels will get the greatest impact and that may very well be violence.

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Learning objectives

Participants will...

- identify how workplace bullying threatens the safety, security, and wellbeing of employees and the health care facility.
- Identify workplace bullying as a form of violence and its impact on patient care.

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Predictors of trivialization of violence in the workplace: Why boys don't cry

Paper

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Perspective: Research

Background and context

Caregivers and law enforcers tend to trivialize violence in the workplace (Akerström, 2002; Dick, 2010). Whether violence is perceived as being “part of the job” or muted by the worker in order to avoid being labeled as “incompetent”, trivialization of violence leads to under-reporting (Dragon, 2006). Consequently, this affects the capacity of organizations to appropriately address work-related threats.

Before assessing the consequences of trivializing violence, we must understand what factors lead to this tendency. This study focuses on individual and organizational predictors of trivialization of violence in two workplaces: caregiving and law enforcement. The comparison between these two work environments will lead to a better understanding of the influence of the nature of the job on perceptions of violence. Moreover, these predictors will be assessed according to the sex of the worker.

Methodology

The findings are based on data from a survey conducted among a convenience sample of 1141 workers (697 women) from two distinctive work environments: caregivers and law enforcers. Individual (sex, age, exposure to violence) and contextual factors (violence prevention training, support from colleagues and supervisors, ‘zero tolerance’ management policy and safe physical environment) were used to predict normalizing violence and tabooing violence in the workplace. Analyses were also conducted separately for women and men.

Findings

Overall, men were more likely than women to think that violence in the workplace is obviously “part of the job”, regardless of the nature of the job (Odds Ratio = 0.736; $p \leq 0.05$). Law enforcers were more likely to refrain from complaining about violence in the workplace than caregivers (Odds Ratio = 1.584; $p \leq 0.01$). This result was especially significant in the women model, where the odds of tabooing violence doubled for law enforcers. Organizational factors were all negative predictors of tabooing violence in the workplace. Our logistic regression models also showed that normalization and tabooing of violence were associated with being witness of several acts of violence, not necessarily being the direct victim of them. This may suggest a “habituation phenomenon”.

Implications

To decrease or prevent trivialization of violence in the workplace, organizations must consider the “professional identity” prone by the job, the sex of the workers, and the level of exposure to violence, while accentuating the presence of management policies as well as support from colleagues and employers.

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Learning objectives

Participants will...

1. realize that a decreasing or preventing the trivialization of violence in the workplace, organizations must consider the “professional identity” prone by the job, the sex of the workers, and the level of exposure to violence
2. appreciate the importance of accentuating the presence of management policies as well as support from colleagues and employers.

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Investigating the working practices of professionals protecting vulnerable adults: A Scottish Perspective

Workshop

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Perspective: Research

Keywords: Interagency working; Interprofessional Education; Vulnerable Adults; Multi-agency; Police; Health and Social Care

Introduction

Supporting and protecting vulnerable adult members of society is of signal importance for the public protection work of the Scottish Police Service. Recent reviews of current practice have highlighted a number of challenges associated with effective inter-agency working with vulnerable adults. Vulnerable adults include those with learning difficulties; mental illness; substance and alcohol misuse and those with issues of protection e.g. domestic violence and child protection and disability due to illness.

In line with the national priorities of the Scottish Government the aim of this interdisciplinary collaborative study is to facilitate effective interagency practice of police and health and social care professionals through research and knowledge exchange using Interprofessional Education (IPE) as the vehicle. Public protection represents a key challenge faced by Police Scotland and was one of the 12 priority areas identified in the Scottish Policing Assessment 2011-15 (ACPOS)¹. Particular emphasis was given to the protection of vulnerable members of our society, i.e., “those individuals or groups who have a greater probability of, than the population as a whole of being harmed and experiencing an impaired quality of life because of social, environmental, health, or economic conditions or policies”².

In making provision for the purposes of protecting adults from harm, the Adult Support and Protection (Scotland) Act 2007 has resulted in the establishment of 29 Adult Protection Committees (APCs). Membership includes those agencies with a “statutory responsibility for safeguarding adults” with all local authorities across Scotland represented. Core APC members predominantly comprise police officers and health and social care workers. However, whilst all APCs acknowledge the importance of multi-agency working as a means of ensuring the effective implementation of the 2007 Act, evidence derived from a recent qualitative analysis of their biennial reports highlighted a number of challenges associated with effective multi-agency working and the associated protocols.³ These include: difficulties encountered by some practitioners in the development of their professional judgement in Adult Support and Protection (ASP) work; a lack of common understanding of definitions and thresholds; a limited understanding of ASP; and the absence of a “culture of co-operation”. Such difficulties inevitably restrict open communication and the sharing of information (particularly in respect of sensitive personal data due to variation in perceptions of ethical practice). Furthermore, recent research that explored how practitioners support and protect adults at risk of harm in the light of the 2007 Act reported that a lack of collaboration among partners prolongs investigations and delays the provision of help to those people in need.⁴

A National Adult Protection Coordinator (NAPC) post was created in consultation with APC Convenors and the Scottish Government. Located within the University of Stirling (School of Applied Social Sciences) it forms part of the “HUB”, which has developed around Child Protection activity since 2009. To date many of the issues that the NAPC has identified from discussions and meetings around Scotland, as well as research findings, endorse the extent to which an effective multi-agency approach is required in the increasingly topical domain of ASP.⁵

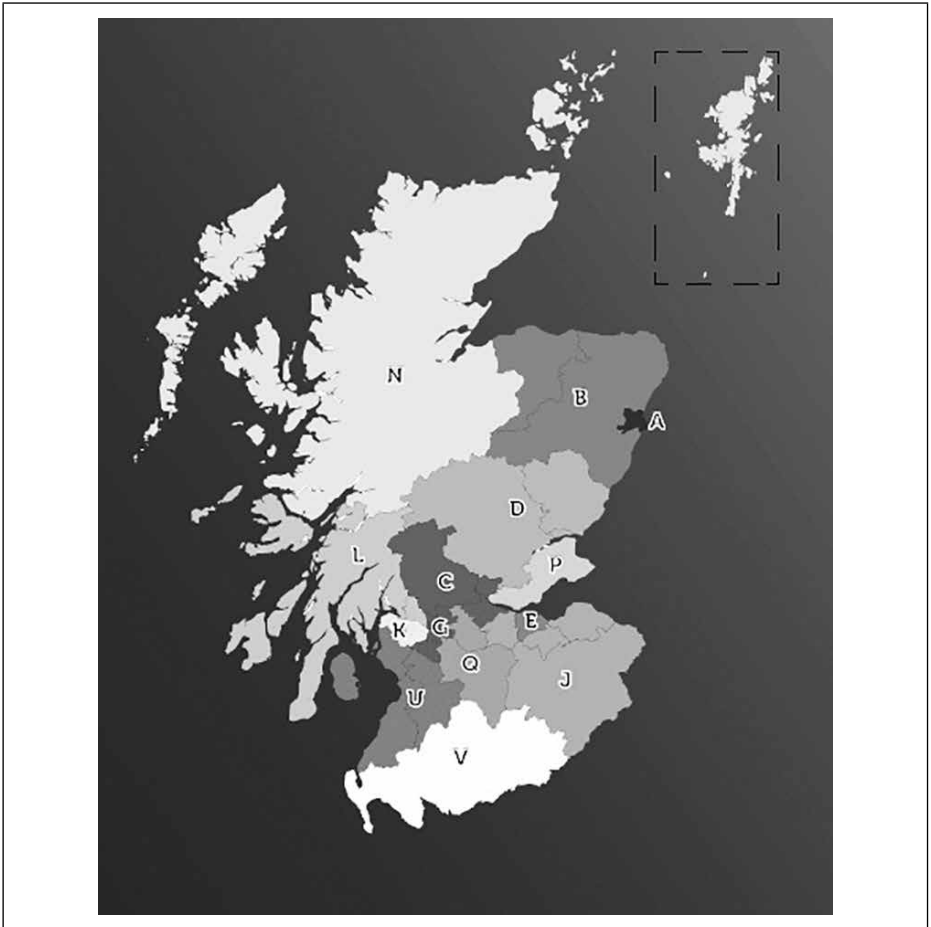
Whilst there has been a particular emphasis on the need to develop multi-agency capacity, as has been the case with other aspects of ASP work, the extent of training has varied considerably across Scotland. Education, training and development have mainly been undertaken in accordance with the Scottish Government Implementation Group Training Sub-Group (2007) framework. Consequently, training comprises a sliding scale of modules such that Level One involves basic-awareness training and is required by all staff involved in ASP. Currently, police training in relation to Public Protection is centred on understanding the 2007 Act legislation, police responsibilities within the 2007 Act and expectations if a crime has taken place involving a vulnerable adult. However, there is little police and interagency education in relation to building relationships in practice and enhancing the understanding of interdisciplinary roles and constraints despite recognition by the APCs of the value of multi-agency collaboration in the design, delivery and review of training and their concerted effort to use consistent methods, particularly across statutory bodies required to undergo ASP training. However, currently, unmet training needs are most prevalent for the basic level one awareness-raising training among

partner agencies including the NHS. The barriers to meeting such needs, however, pertain to the number of staff requiring training, the regularity with which it needs to be updated, and the associated cost. Given the requirement for further training activity, authors of the 2012 report examining the implementation and delivery of the 2007 Act across Scotland conclude that "...it is difficult to assess how APCs will prioritise limited resources when training needs analyses are not supported by the evaluation of outcomes of training already provided" (p.14).³ Thus, there is an urgent need for a more in-depth analysis of training requirements in order to determine priorities and enhance effectiveness of interagency practice.

In line with the commitment of ACPOS and the Scottish Government⁵ our project builds on previous research and analysis. It is founded on an interdisciplinary collaboration comprising Robert Gordon University (RGU; Faculty of Health & Social Care; Institute for Health & Wellbeing Research), the University of Aberdeen (UoA) and Police Scotland. A steering group of key stakeholder experts guided the project team. The aim of the project was to evaluate interagency ASP practice of police and health and social care professionals, viz, IPE, information sharing and partnership working in Scotland.

Figure 1 highlights the scope of the project in terms of geographical locations, police command areas, local authorities and health boards.

Figure 1 Inter-Agency Organisations: Police; Health; Social Care and Focus Group Locations



Focus Groups	Division	Local Authority	Health Boards
	NORTH Command		
Police Only Health Only Social Care only Mixed- Police, health and Social Care	A Aberdeen	Aberdeen	NHS Grampian
	B Aberdeenshire & Moray	Aberdeenshire & Moray	NHS Grampian
	D Tayside	Angus, Dundee City, Perth & Kinross	NHS Tayside
	N Highlands and Islands	Eileanan Siar, Highland, Orkney, Shetland	NHS Orkney; NHS Shetland; NHS Western Isles; NHS Highland
	EAST Command		
Police Only Health and Social Care Mixed- Police, Health and Social Care	C Forth Valley	Clackmannanshire, Falkirk, Stirling	NHS Forth Valley
	E Edinburgh	Edinburgh	NHS Lothian
	J The Lothians and Scottish Borders	East Lothian, Midlothian, West Lothian, Scottish Borders	NHS Lothian; NHS Borders
	P Fife	Fife	NHS Fife
	WEST Command		
Police Only Health and Social Care Mixed- Police, health and Social Care	G Greater Glasgow	Glasgow, East Dunbartonshire, East Renfrewshire	NHS Greater Glasgow and Clyde
	U Ayrshire	East Ayrshire, North Ayrshire, South Ayrshire	NHS Ayrshire and Arran
	Q Lanarkshire	North Lanarkshire, South Lanarkshire	NHS Lanarkshire
	L Argyll & West Dunbarton	Argyll & Bute, West Dunbartonshire	NHS Greater Glasgow and Clyde
	K Renfrewshire & Inverclyde	Renfrewshire, Inverclyde	NHS Greater Glasgow and Clyde
	V Dumfries & Galloway	Dumfries & Galloway	NHS Dumfries and Galloway

Method

The project has two inter-related phases.

Phase 1: To identify: (i) existing gaps in the implementation of effective interagency practice by reviewing the “state of play” in interagency collaboration between the police and health and social care professionals; (ii) education and training needs in relation to key ASP issues, and (iii) information sharing.

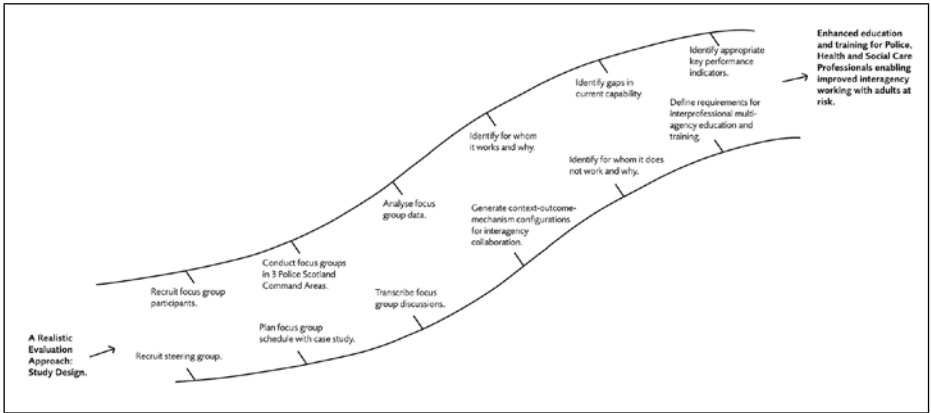
Phase 2: To: (i) identify interprofessional and interagency training resources with key performance indicators to enable subsequent evaluation and monitoring of practice for all professionals involved in adult support and protection.

The Realistic Evaluation Approach⁶ will be used to generate Context-Mechanism-Outcome Configurations of interagency collaboration between the police and health and social care professionals in order to identify: (i) for whom it works; (ii) in what way, and (iii) why it works (and if not, why not?). The advantages of this approach are as follows. First, in anticipation that those factors which constrain and enable interagency collaboration and practice will be subject to ongoing change, the evaluation itself will seek to take account of this mutating context and frame outputs appropriately and contextually. Second, this methodological approach will promote active forms of engagement with those in strategic positions thereby creating a potential action-orientated feedback loop early in the project. This will help to: (i) identify gaps in current capability; (ii) assess the appropriateness of current methods; (iii) define requirements for the development of the IPE training resources, and (iv) identify appropriate KPIs.

Data Collection

The research was conducted in the three command areas of Police Scotland. For each APC-related sample, focus groups were conducted comprising core members (i.e., police and health and social care professionals). Participants were recruited by means of purposive sampling. The composition of each group varied to benefit from experiences and characteristics shared by participants. For each APC-related sample, there was one mixed focus group comprising police and health and social care professionals. The rationale for this approach is to maximise the opportunity to solicit views and take into consideration the hierarchical nature of the target populations. Each focus group lasted 1-2 hours and comprised 6-14 participants. Sessions were audio-recorded and transcribed verbatim to identify key thematic domains to inform the development of the IPE training resources and the identification of KPIs. Ethical approval was granted by the University’s research ethics sub-committee.

Figure 2 Study Design using a Realistic Evaluation Approach



Data Analysis

13 focus groups, involving 101 participants, were conducted and the transcribing of the audio recordings and data analysis is completed. This has yielded 26 hours of data and 800 pages of text. Framework analysis was used to identify categories, themes and sub-themes. Transcripts were randomly allocated to members of the project team for analysis and checking. Two members of the team synthesised all the analysis and collated the themes.

Nine key themes were identified from the thirteen focus groups.

They are: Information sharing; Relationships; people and processes; lessons from child protection; environment; implementation of the act; regional variations and training; rights of the service users.

- 'Information sharing' included discussions on the development of a vulnerable persons' database which would be available to all involved in protection issues. Participants identified existing issues with information sharing across the different professions often exacerbated by the need to protect confidentiality. There were differences between the professions regarding this finding with police and social work demonstrating frustration at healthcare professionals' reluctance to share vital information.
- 'Relationships' highlighted the 'team working' that results when organisations are co-located and relationships are established resulting in greater collaborative working practices and the development of trust for information sharing.
- 'People and processes' identified both positive and negative influences for working practices. If protocols and processes were 'unfit for purpose' then this was a demotivating factor for collaborative working. In contrast where processes were working well and professionals felt included, the system motivated collaborative working.
- 'Lessons from child protection' related to the established and effective practices of information sharing and case conference processes that already exist for child protection cases, and that there were no longer any confidentiality and information sharing issues.
- 'Environment' related to the lack of places of safety for vulnerable adults to recover from an acute episode. The closure of safe environments such as National Health Service hospital wards has led to individuals being inappropriately 'locked up' in police cells.
- Implementation of The Adult Support and Protection Act (2007) stipulates local authority social work departments' responsibilities for coordinating the inter-agency working practices. However participants felt that this Act has not fully met the needs of the vulnerable adults and has required some challenging decision making by professionals to provide appropriate support.
- Regional variations were obvious throughout the focus groups. It appeared that remote and rural areas had developed more cohesive team arrangements and practised cross boundary working. Urban locations tended to report fragmented team working and a lack of understanding regarding people and processes and lack of information sharing.
- The rights of the individual were also highlighted. It was interesting to note the difference in opinion amongst the professionals. The debates centred around the rights of the individual to adopt a 'risky' lifestyle choice and the need for professionals to 'protect and support'.

Conclusion

This project concludes in September 2014. It will have provided a comprehensive evaluation of adult support and protection practices that inform education practices to prepare tomorrow's workforce of police and health and social care professionals to effectively support and protect vulnerable members of society.

This project has illuminated the challenges of current interagency collaboration and practices between police and health and social care professionals in order to identify opportunities to develop collaborative interagency training, engender trust, and equip police officers and health and social care professionals to confidently challenge inconsistencies.

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Learning objectives

Participants will...

1. have knowledge of the Scottish perspectives on interprofessional working in adult protection.
2. be able to consider the implications for their own contexts and develop shared collaborative solutions.

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Psychosocial determinants of violence in India

Paper

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Perspective: Research

Background and context

Violence is a part of human history but growing violence is a disturbing feature of today's times. Moreover, violence is closely related with aggression which is also documented as a part of human evolution. Growing violence is not only a major issue in India but has come to be major global issue which is reaching to epidemic proportions to the extent that today, almost all of us are touched directly or indirectly by violent acts. Violence is now seen as a multifaceted social problem with each facet requiring a separate approach. Studies reveal that the nature and manifestations of violence have changed in the recent past. Evidently every violent act is a result of an array of some complex psychosocial forces coming together. Identification of such aspects is helpful in devising effective intervention programs. Hence, in the context of the above background, violence as a part of the human behaviour repertoire needs to be studied both intensively and extensively.

Methodology

This paper is qualitative in nature and is derived from a thorough literature review from the archival sources of research and attempts to conceptualize and evaluate the dynamics of violent behaviour and highlights the various psychosocial determinants of violence in India. The findings of the paper are based on an in-depth analysis of few case studies of violence reported in India among selected populations namely; women, people with mental illness and drug abuse population.

Findings

The present paper elucidates the dynamics of violent behaviour in a multidisciplinary perspective Based on a few Indian case studies; it establishes the link of violence with urbanization, migration, role of family, mental illness and ethanol and drug abuse. Studying the determinants of violence, it concludes that violence is intimately intertwined with a variety of major social and psychological problems and whenever there appears a rupture in the fibre of social fabric, violence manifests itself. Violence has been found that some aspects of the physical and social environment provoke aggression and facilitate violence. Research done on the antecedents of aggressive behaviour in institutional settings like mental health sector provides some significant insights. Contrary to popular belief, people with severe mental illnesses are more likely to be victims, rather than perpetrators of violent crime. The general image of a mentally ill patient as essentially dangerous and violent is because the stereotypical representation of mental illness by the mass media which is often unfounded. Furthermore, increasing ethanol dependence and drug abuse has also been linked with escalating incidences of violence in India.

Implications

Factors contributing to violence are varied and necessitate a multi-disciplinary approach. The interaction of individual with society in determining aggressive or productive behaviour is a very potent area of study for researchers today. Identification of such aspects of violence as indicated in the present paper could prove to be helpful indicators for policy makers and health providers in devising both prevention and intervention programs in future.

Learning objectives

Participants will

1. realize that violence is a growing global issue and is a resultant of a complex interaction of multiple factors.
2. Be able to identify that the identification of such factors could prove to be helpful tools for policy makers and health providers in devising both prevention and intervention programs.

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Take care of your colleague and yourself – a visual e-learning program

Paper

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Perspective: Education and Training

Background

In 2011 the Capital Region of Denmark implemented a survey of the working environment for all employees. The results from Mental Health Services, which is a part of the Capital Region of Denmark, showed different areas within the psychological working environment that the organization had to focus on. One of these focus points was risk of violence and threats. The results showed that incidents with violence and threats were many with the risk of implications such as stress and anxiety for employees. The survey also showed that employees in general experienced much support from their colleagues in situations with violence and threats and that this support was crucial in the process of recovering. The Mental Health Services decided to support and qualify the help between colleagues in all phases of an escalated situation. This resulted in the e-learning program Take care of your colleague and yourself with the presumption that the program in time can cause fewer incidents involving violence and threats. The program is developed by a reference group consisting of members with both practical and research knowledge in the area of conflicts and follow-up in cooperation with an external consulting firm. The program is available on the Mental Health Services' intranet which is accessible for all employees.

Introduction

Take care of your colleague and yourself is an e-learning program for employees in the Mental Health Service in the Capital Region of Denmark where physical/verbal aggression and violence and threats are a potential risk when going to work. The purpose of the program is to inspire and improve employees to be even better to prevent and follow-up on conflicts, aggression and threats of violence in cooperation with their colleagues. The program contains: A short movie trailer - "a teaser" describing the main focus of the program. Statements from experts in conflicts, stress and follow-up on escalated situations, who give their perspectives regarding best practice before, during and after escalated situations.

Three dilemma stories are told by employees working in different psychiatric wards. Each story represent a "non-perfect" situation where the employee did not act in accordance with best practice but acted on their instinctive individual response pattern. Best practice interview with 4 staff members working in psychiatric wards. They give their best suggestions and ideas for further inspiration. The program is relevant for all hospitals around the world, both somatic and psychiatric wanting to improve and qualify the physical and mental environment for their employees. The program initiates a structured dialogue between all members of the staff disregarding level of education and seniority.

Methodology

The reference group was chosen representing various levels of competencies and experts with both practical and research knowledge in the area of conflicts and follow-up. An external consulting firm, Great Dane Communication was hired to produce and edit the films using the specialized knowledge retrieved from the reference group.

Findings

In relation to the program's implementation in the organization key stakeholders as the local coordinators of health and safety and prevention instructors have been essential. They will continue ensure the required knowledge of the program, its relevance and in which contexts it can be used.

For the past year Mental Health Services has used the e-learning program for education and training of employees in different courses such as courses in violence prevention and deescalating communication.

It has also been presented in various management layers with great success. The response has been very positive. Some of the users of the program have reported that "finally the Mental Health Services made a program that reflects the reality and gives us a foundation and tools to articulate challenges with preventing, handling and following up on escalated situations".

In 2014 The Capital Region of Denmark implemented the same survey as in 2011 of the working environment for all employees. The results from Mental Health Services showed that the risk of violence and threats was still the greatest challenge in relation to the work environment; however aspects in relation to handling the challenges in general have improved since 2011. E.g. more employees have experienced collegial support in situations with violence and threats, more employees think that they have the requisite knowledge about conflict management and more employees state that their leader makes an effort preventing the risk of violence and threats. During the autumn 2014, there will be implemented an evaluation of the e-learning program focusing on the users and their immediate experiences and results.

Learning objectives

Participants will...

1. learn that the program is to inspire and improve employees to be even better to prevent and follow-up on conflicts, aggression and threats of violence in cooperation with their colleagues.
2. appreciate that guidelines at work may help preventing and following up on escalated situations.

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A collaborative approach to developing a workplace violence intervention

Paper

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Perspective: Research

Background and context

Several interventions have been proposed or initiated to prevent the onset of workplace violence in healthcare settings by patients and visitors; however, violent events in the workplace still occur and can lead to negative psychological outcomes for victimized workers. One strategy to increase the effectiveness of future violence prevention programs is to collaboratively develop a prevention intervention with employees at risk for workplace violence victimization.

Methodology

A participatory action research design was used with an interprofessional board of stakeholders vested in preventing workplace violence. The board was convened to design an ideal intervention. The ten board members consisted of a paramedic, registrar, physician, social worker, captain in law enforcement, two violence researchers, and three emergency nurses. Board members conducted individual analyses of the strengths, weaknesses, opportunities, and threats (SWOT) to implementation of a violence prevention program. Individual analyses were followed by small group discussions and a large group debriefing. Next, board members individually generated lists of primary, secondary, and tertiary violence prevention strategies. Small group discussions and a large group debriefing followed. The principal investigator organized a comprehensive list of 82 primary, 18 secondary, and 27 tertiary prevention strategies developed by board members. Strategies were organized by level of prevention and the Community Prevention Through Environmental Design framework. The comprehensive list of proposed strategies was provided to board members. Board members then separately rated each strategy on a 0-10 scale for its priority and feasibility for implementation as a component of a violence prevention program. Board members were given the opportunity to document relevant SWOT information for each strategy. A mean was calculated for each prevention strategy's priority and feasibility.

Findings

Strategies with a mean priority score greater than 8.0 and mean feasibility score greater than 7.0 were deemed useful for a future workplace violence intervention. Twenty-five of the 127 strategies met these criteria. Some strategies, such as having a security presence around-the-clock and having a personal alarm system to call for help, require a higher infusion of financial resources and organizational commitment as compared to strategies like peer support. The Workplace Violence Community Advisory Board was an effective mechanism to collaboratively design a workplace violence prevention program with researchers and practitioners.

Implications

Participatory action research still is needed with healthcare administrators and other invested employees to examine their willingness to adopt and commitment to enact the recommended violence prevention strategies.

Learning objectives

Participants will...

1. be able to state the strengths, weaknesses, opportunities, and threats (SWOT) for the implementation of a workplace violence prevention program.
2. have ideas on how to create a workplace violence prevention program for healthcare settings.

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Organizational partnering to prevent violence in a large Montréal teaching hospital

Paper

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Perspective: Organisational

Keywords: Civility, respect, prevention, process mapping, staff ombudsman/commissioner

Introduction and background

The McGill University Health Centre (MUHC) is an academic healthcare centre in Montreal, Québec. It provides tertiary and quaternary care across six sites, representing nearly 14,000 employees. In 2004, the MUHC implemented a policy for the “Prevention and Elimination of Violence at Work”, initiated training on preventing violence for management personnel and hired a part-time conflict resolution counselor reporting to the Human Resources department. There was an emphasis on “Zero Tolerance” to violence in the workplace. However, by 2009, there were clear indications that these initiatives to prevent violence and harassment in the workplace were inadequate. Accreditation standards were not being met. Workplace safety should be at the forefront of health care (Accreditation Canada, 2009), and this was not the case in our healthcare center.

Members of the nurses’ union, the nursing directorate and patient ombudsman office lobbied relentlessly to create an interdepartmental committee to address serious issues related to workplace safety and security. Building trust and collaboration in the group led to successful solutions towards the development of a civil and respectful work environment. This presentation will discuss the extensive, strategic work accomplished by this interdepartmental committee

(MUHC Non-Violence Committee) to prevent violence and promote civility and respect in the workplace.

Methods: The MUHC Non-Violence Committee united diverse members, representing our three staff unions, human resources, clinical disciplines (nursing, medical, allied health), security services, legal services, patient ombudsman and medical examiner office. The mandate of the committee was to evaluate the implementation of the MUHC “Prevention and Elimination of Violence at Work” program and related initiatives (complaint resolution process, training sessions etc.) and to make recommendations for improvement. Our healthcare centre is very complex, with six different cultures on six different sites. The departments the committee members were representing were transversal across the sites. The guiding principle for our work in progress was that at the MUHC there would be a systematic, equitable process for managing violence for all members of our community. The work evolved strategically and could be described as involving three phases. The specific work and outcomes in terms of understanding the complexity of the issues will be described for each phase.

The **first phase** of this interdepartmental committee’s work entailed a detailed assessment of the present situation in all the departments that were represented on the committee. In general, the committee members expressed concern regarding the impact of violence on patient and family care (quality of care), as well as impact on staff members across the institution (health problems, stress). Workplace violence is a serious and disturbing issue that affects staff and service providers across the health care continuum (Coutts, 2010). The committee members agreed that we needed to implement a culture of thinking where violence at work cannot be part of the job (Accreditation Canada, 2009).

In this early phase, the institution’s legal and labour obligations were also reviewed. There was dialogue about our national and provincial laws (the Act respecting Health and Social Services, the Charter of Human Rights and Freedoms, the Health and Safety Legislation, the Quebec Civil Code, the Regulation for Management Personnel and the Act respecting Labour Standards). Most importantly, with the three unions present, the obligations and standards as stated in the labour collective agreements were discussed. The nurses’ union, the Professional Union of Nurses and Cardiorespiratory services (SPSICR) was particularly concerned about meeting their mandate of preventing violence, harassment and discrimination at work. This was outlined in their internal bylaw as well as guidelines and the politics developed by their Federation (FIIQ, 2000, FIIQ 2002, FIIQ 2010). They were well aware that a nurse is more likely to be assaulted on the job than a police officer (Canadian Federation of Nurses’ Union, 2007).

The effects of workplace violence on staff are numerous and can range from decreased commitment and productivity to higher rates of injury and illness (Coutts, 2010). Economic impacts of violent incidents, including human resource quality indicators (absenteeism, staff turnover) were identified. Statistics presented by our Human Resources department showed that there were 100 complaints annually, and that there were 70% complaints from women and 30% from men (same as MUHC staffing proportion by gender). Sixty-five

percent of complaints were for verbal abuse, while 35% for physical abuse. Most reported physical abuse was from patients to health care staff, in particular from psychiatric and geriatric patients. The alleged abusers were from 50% women and 50% men. The group reviewed these annual statistics with a critical lens. Most of the committee members agreed that the number of complaints were underestimated, as complaints were not necessarily reported to Human Resources, but also to the patient ombudsman, to the legal department, and to the individual unions. Also, the Human Resources statistics appeared to be an underestimation of complaints towards supervisors, colleagues and medical staff.

There were multiple issues resulting in few complaints directed to Human Resources. A high percentage of staff were not aware that there was a policy against violence and a complaint form to be completed, nor where and how to access documents. A number of staff who made complaints described the experience as very negative, due to a perception of lack of support and poor follow up. The time for a response to the complaint and any form of resolution was deemed extremely long. It is extremely important for a rapid intake of a complaint for harassment or violence in the workplace (FIHQ, 2002). Therefore complaints ended up in arbitration, with no room for conflict resolution or mediation. One important issue was that the resolution of incidents with the physicians used a different process. This process was mostly due to legal obligation, which caused conflict and dissatisfaction on both sides. Having a physician leader on the committee was a very positive step towards a more standardized approach to violence in our healthcare center.

The **second phase** of the interdepartmental committee's work was to establish clear objectives for improvement and to create a MUHC Non-Violence Action Plan. The main objectives were:

1. to create a systematic and equitable process for all sites and clinical and non-clinical members of the MUHC community,
2. to create a culture of respect that does not allow violence in the workplace,
3. to increase credibility and belief in our system of response to complaints,
4. to track and trend incidents accurately; and use data towards increasing respect and prevention of harassment/ violence.

The committee members discussed an Action Plan highlighting 5 components (**Process, Structures, Tools, Education and Evaluation**) that were essential to improve the response to violence in our health care center. Evidence-based literature regarding violence in the workplace guided us in organizational strategies for implementing a culture of respect and civility: best practices, risk assessment and knowledge translation, leadership and quality performance measurement.

We studied guidelines for best practices that provided clear and courageous recommendations for realistic actions that could be taken at the individual/team, organizational and system levels (RNAO, Best Practice Guidelines, 2009). On the individual level and team level, we discussed how everyone on our staff: employees, physicians, volunteers and students, were responsible for their own behavior and for collaborating with team members to foster respect and civility in their workplaces. (RNAO, Best Practice Guidelines, 2009). As well, our organization had the responsibility to provide a clear **process** that was equitable for all, with psychological support and timely follow up (RNAO, Best Practice Guidelines, 2009).

A clear organizational policy towards workplace violence is a necessary antecedent for a prevention program to be maximally effective (Wang, Hayes & O'Brien-Pallas, 2008).

We had a healthy debate about our MUHC "Prevention and Elimination of Violence at Work" program, which was part of the **structure** that needed to be in place throughout our large healthcare center. "Zero Tolerance" was strongly emphasized, reinforced with posters and other documentation throughout our healthcare center. "Zero Tolerance" was a policy campaign addressing violence against health care workers from care recipients, advocated by many governmental bodies and health care organizations in Canada. However we realized that it had had negative effects in our workplace. There was difficulty fully implementing the "Zero Tolerance" approach as it implied an attitude of punishment toward any aggressive behavior, thereby negatively impacting aggression management (Wang, Hayes & O'Brien-Pallas, 2008)

Therefore we agreed that we needed a new policy.

Having the appropriate **tools** was also a critical component of a new approach. Part of the process to make a complaint was to create an easy, comprehensive way for the victim to make a complaint (written form, verbal report, online) Secondly, implementing a workplace violence risk assessment tool was extremely important. This required: determining whether or not a risk exists, assessing the safety and security of work environment, and assessing the current training/ **education** of staff regarding the identification and management of risk indicators (McIntyre, S. 2010).

One last but important component of our action plan was **evaluation** of the all initiatives related to prevention of violence. This involved: the review of outcomes, the measurement of quality indicators and the promotion of research opportunities in our academic healthcare center, for this was a very important workplace issue (Crew Project, 2008).

In the **third phase** of the interdepartmental committee work, there was consensus that the component of the action plan that needed most urgent attention was the **process** of reporting/filing a complaint for harassment or

violence at work. However members of the group were not totally in agreement about the current process and the ways to improve it. Therefore a subgroup of the interdepartmental committee, with the addition of a few frontline staff, embarked on a very important initiative: a **Process Mapping** exercise. Process mapping is an easy-to-visualize representation of a process that allows people to analyze and agree on the most efficient routes for improving a process (Savory & Olson, 2001). The first step in creating this process map was to develop an understanding of the goal or purpose for the improvement effort, which was to reduce frustration and anger regarding the response and follow up to a complaint for harassment/violence (Savory & Olson, 2001; Taylor, 2010).

This “LEAN” exercise allowed the group to map out and study the current process as well as the desired process. The individuals in the group had a vested interest, knowledge and involvement with the process (Savory & Olson, 2001). Process maps were created for complaints reported from: 1) employee to employee; 2) employee to manager; 3) manager to employee; 4) employee to physician; 5) physician to physician; and 6) employee to patient/family member.

For the **current process**, the remarkable barriers or “bottlenecks” identified in the process mapping were an eye opener for the sub-group of the committee. A major barrier was that managers were not responding to complaints due to lack of understanding or knowledge. Therefore this resulted in poor support and follow up with the employee, and total lack of satisfaction with the process. Also, the process mapping identified that the “alleged aggressor” was often not aware of the complaint made against him or her. It also identified that there was little mediation and that the situation escalated mostly to arbitration for unionized employees and little action when a physician was involved, which rendered the victim depressed and angry.

For the **desired process**, the mapping allowed the group to identify a strong need for: improved time response to the complaints, improved perception of neutrality in the resolution complaint process, improved equity in the treatment and resolution of the incidents, increased use of mediation process and enhanced psychological support throughout the process, for both individuals and teams.

Results

This process mapping exercise was most useful for validating and supporting all the concerns that had been raised, as well as adding credibility to the components of our Action Plan. Most salient was the need for a new resource person to help coordinate and facilitate the implementation of a new process, new policy, tools, data management etc. A proposal was made to senior management to create a new position for a staff Ombudsman or Commissioner. The person needed to be independent and reporting directly to our CEO. The person needed to be able to receive all complaints in a confidential manner, as per all laws and regulations. With continuing support from a committee that was to be determined, this individual would be a leader in sensitizing and teaching staff, including physicians, to prevent harassment and violence in the work environment.

In January 2013, our first staff Ombudsman/Commissioner for the development of a civil, respectful and non-violent workplace was hired. A new MUHC committee is also in place to support this new role. In almost two years there has been astonishing recognition of this role and continuing progress in creating a safe and healthy environment. A new MUHC respect and civility policy is ready to be implemented. The slogan is no longer “Zero Tolerance. The new slogan is “With Respect!” Other accomplishments include a clearer process for staff complaints, as well as greater use of mediation and conflict resolution. There has also been greater support and education to individual staff and managers, as well successful team activities towards a culture of civility and respect.

Conclusions

In our large teaching hospital with 14,000 employees, an interdepartmental committee of members who were concerned about harassment and violence in the workplace were successful in meeting their goals by establishing trust and collaboration. Sharing and identifying issues, studying labour laws, and reviewing evidence-based literature allowed the members to formulate an Action Plan. A process mapping exercise allowed the group to visualize and validate the current process for reporting/filing complaints and find solutions for improvement. All this led to the creation of a staff Ombudsman/Commissioner role for the development of a respectful, civil and non-violent workplace.

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Acknowledgements

A sincere thank you to Dr. Andrea M. Laizner, MUHC Nursing Practice Consultant-Research, Assistant Professor (part-time) at the McGill University Ingram School of Nursing

Learning objectives

Participants will...

1. have a basic understanding of how "process mapping" can be used to identify barriers and facilitators to improve response time to complaints of violent behavior.
2. learn how the role of an employee ombudsman can help increase use of conflict resolution and coaching activities for civil /respectful behavior in the workplace.

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Understanding aggression from patient and provider perspectives

Paper

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Perspective: Research

Background and context

Aggression prevention in the psychiatric inpatient department is a well-recognized challenge for hospital clinicians and administration. Its successful execution can contribute greatly to an environment that is physically and psychologically safer for both staff and inpatients, but effective prevention necessitates an understanding of the reasons for aggression. Prior research into the reasons for aggression has focused on staff perspectives or administrative data, but often neglected the insights of aggressive inpatients themselves. This exploratory study contributes to the field by investigating the perspectives of (a) psychiatric inpatients with documented incidents of verbal or physical aggression, and (b) mental health clinicians.

Methodology

To allow inpatients and staff sufficient scope to articulate their experiences, qualitative methods were employed. Semi-structured interviews were completed with fourteen inpatients and ten clinicians, when saturation was reached with each sample. Data were systematically examined through inductive thematic analysis, with quality of analysis upheld by both independent coding of a subset of transcripts and a review of the codes.

This exploratory study critically integrates varied factors contributing to aggression, offering a cohesive portrait for consideration. Five major themes are identified as causally connected to aggression amongst psychiatric inpatients: (a) Major life stressors, (b) Physical confinement and related departmental policies, (c) The experience of illness, (d) Insufficient opportunities to be active participants in health services, and (e) Poor interpersonal connections with staff. Overlaps and discordances between factors identified by inpatients and staff, respectively, elucidate the limitations of sampling only one group.

Implications

The current study presents implications for future research on aggression amongst psychiatric inpatients. The authors of this exploratory study encourage interested researchers to further investigate the presented findings' applicability to varied psychiatric inpatient settings, and suggest additional opportunities for enquiry. As well, given the dearth of aggression-focused research explicitly including the perspectives of psychiatric service users, the authors will discuss both the substantial value and necessary considerations when including psychiatric inpatients as research participants.

Acknowledgements

This study received financial support from the Psychiatric Associates of St. Michael's Hospital, as well as the Ontario Ministry of Health and Long-Term Care through the Applied Health Research Questions Fund and the Innovations Fund. Funding agencies were not involved in any research activities.

Learning objectives

Participants will...

1. cultivate greater insight on personal and organizational factors contributing to aggression by psychiatric inpatients.
2. Consider prospects for aggression research in mental health service settings.

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Effective lobbying and collective bargaining strategies to address workplace violence in Manitoba

Paper

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Perspective: Organisational

Violence has many forms and repercussions, making finding a solution a complex undertaking. Frequently, the perpetrators of violent behaviour are a patient's family members and patients who have mental health issues and behavioural problems. Given the nature of the nursing profession, nurses internalize violence as part of the job, while management may not address the issue in the interest of protecting an institution's reputation. The mix of personal and structural factors in underreporting of incidents, make violence in workplaces a challenge for everyone working in the health sector.

The impact of violence has serious repercussions for both nurses and patients. Research shows the likelihood of PTSD, chronic pain, depression and acute stress disorder is much higher amongst nurses who experience workplace violence. On the other hand, patients on wards where nurses experience a threat of violence are more likely to experience medication errors (Duffield et al. 2007, p. 113). The threat of violence, not to mention having experienced violence creates additional stress and anxiety on the job, which inevitably impacts patient care. Workplace violence is an issue that affects the entire healthcare system, not just a single individual.

Addressing violence, an all too common reality for frontline nurses is a challenging task, but it's one that the Manitoba Nurses Union (MNU) undertook with measureable success. The results of the union's many efforts achieved tangible changes that have set a precedent across the country and protect all healthcare workers in Manitoba. This paper outlines the impetus for the lobbying campaign to curb workplace violence in Manitoba. The first part of the paper gives an overview of factors that shaped a multifaceted lobbying campaign, and the strategy that was employed by MNU. Section two follows with an overview of lobbying successes and an outlook into work that remains to be done.

Section 1

Addressing violence is challenging due to the fact that incidents are often unreported. The perpetrators of violence are overwhelmingly patients with behavioural or mental health problems, and from time to time patient's families. Given the complexity of a patient's condition, nurses are unlikely to report violence, and most have come to expect a certain degree of violence as part of their jobs. On the other hand, management may not take claims seriously due to a patient's condition, and therefore do not support nurses coming forward with claims. The result is that management does not take necessary steps to prevent future incidents. This cycle fosters an environment in which violence is ignored, and one in which nurses do not have access to necessary tools to cope with their experiences with violent acts.

Although MNU was always thorough in enforcing the highest measure of safety for members, when two violent incidents became high profile cases in Manitoba, it was clear that there were gaps in enforcement of violence free policies that left members vulnerable. It was also a signal that workplace violence had become an issue that required attention that was beyond the scope of collective agreements and workplaces- the workplace health and safety framework was obviously flawed.

Prior to launching a lobbying campaign, it was critical to substantiate stories coming in from locals and worksites, so a research firm was commissioned to conduct independent research. Research provided an opportunity for the union to locate hotspots and devise effective solutions.

The membership survey was a qualitative and quantitative study, composed of phone interviews with structured questions and a qualitative component that involved focus groups that were held in different regions of the province. Focus groups were particularly useful as they provided an opportunity for nurses to discuss detailed personal accounts of their experiences, adding depth to statistical information generated by structured questionnaires.

The objective of the study was to determine the frequency of workplace violence and the level of support from management in dealing with workplace violence. Another goal was to determine if workplaces were equipped with adequate tools to deal with violence.

Research results were synthesized into a comprehensive report with a set of clearly defined recommendations that were used to lobby the provincial government. Simultaneously, the union was actively engaged in educating members, as well as raising public awareness of workplace violence against nurses.

Research Findings

The results confirmed that workplace violence, abuse, and harassment were persistent issues that were becoming worse. In fact, more than half of MNU's members had been physically assaulted. Violence was a problem irrespective of facility type and unit.

The situation was particularly dire in Emergency Departments, Long Term Care (LTC) facilities and in-patient psychiatric units. Over 30% of those working in these facilities reported being physically assaulted weekly. 93% of emergency department nurses reported experiencing verbal abuse, 80% experienced intimidating gestures and more than 40% are intimidated with a weapon on a regular basis.

Below is a graph comparing the frequency of violence in high risk departments to all others. Nurses across departments experience violence on a weekly basis, with 37% of in-patient psych unit nurses experiencing violence weekly, followed by nurses working in long term care facilities and emergency departments. While physical violence is easily detected, the percentages of non-physical incidents may not be identified as abuse and therefore, may be under reported.

Figure 1

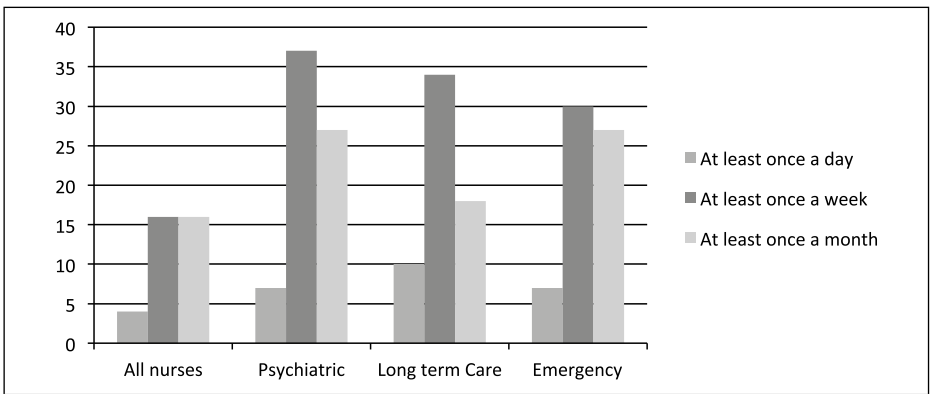
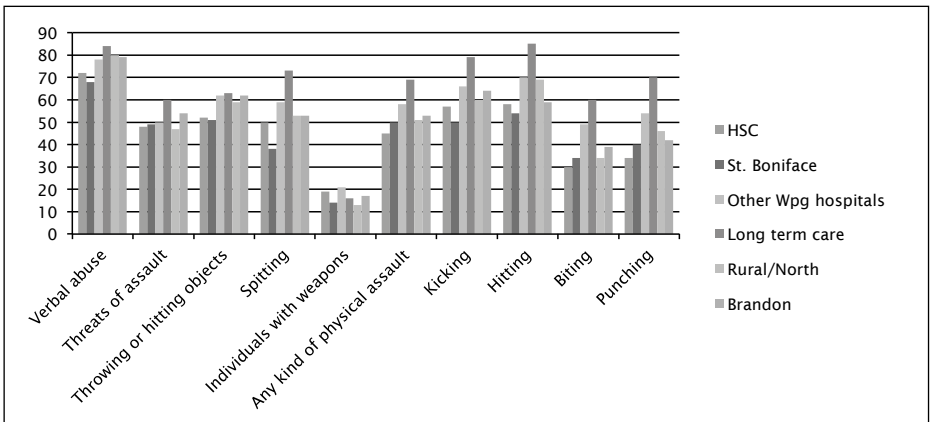


Figure 2 represents the frequency of specific violent incidents. Research showed that the most common violent incidents experienced by nurses in Manitoba, and especially those in LTC facilities were hitting, verbal abuse, kicking, spitting, and punching, as well as all forms of physical assaults.

Figure 2



Comprehensive Report

Based on the survey, MNU synthesized a report with a series of recommendations that were presented to the Minister of Health. The first recommendation urged for provision of security support in healthcare facilities, as it's the most immediate and straightforward intervention to protect nurses against violence.

Ensuring adequate security involved three specific recommendations. The first recommendation was that security personnel be specially trained for the role of providing security in healthcare settings and that they be added in high risk areas of hospitals. MNU also made two specific proposals for improvements in the physical layout of units. It was recommended that units be designed in such a way to maximise visibility and access in the event of a violent incident. As part of the physical layout, it was recommended that panic buttons for summoning assistance be included in the design of units.

The second recommendation laid out a process for tracking and monitoring. The information gathered from this process, may be used in allocating resources and training. Furthermore, this information would enable facilities to develop effective safety measures and best practices that could be shared with others. Having effective security measures that are regulated by collective agreements is essential, however, without the legal obligation to implement the highest level of security, enforcement would be inconsistent. With this in mind, MNU lobbied the government to amend legislation, which involved two separate amendments.

The first of these amendments obligated employers to notify nurses of a patient's history of violence. For instance, only nurses coming into direct contact and treating an individual would be notified of a patient's history. Knowledge of a patient's history of violence ensures one takes necessary precautions to approach the patient in a safe manner, but it also enables a nurse to provide the highest level of care for the patient. Secondly, MNU proposed that a legal onus be placed on all healthcare facilities to prepare a violence prevention strategy that clearly outlines a procedure for summoning immediate assistance in the event of a violent incident. The prevention strategy also includes mandatory reporting and investigating.

Lobbying and Public Awareness

Claims of workplace violence that MNU had been making were substantiated by research, giving the union irrefutable evidence to present to the government. In September of 2010, MNU started a series of consultations with the Minister of Health, high ranking government representatives, and policy makers. Ongoing meetings facilitated an open dialogue and kept the issue current. Given the urgency of the situation, the government was pressured to commit to working with the union and to finding solutions.

In the meantime, MNU undertook an education campaign, disseminating information to members and the public about violence across the province, which also helped maintain pressure on the government. Every media opportunity was used to highlight the prevalence of violence against nurses in Manitoba. Information was communicated through social media and through the union's official publication. MNU was adamant about raising member's awareness of the issue, stressing that incidents that take place on a daily basis are not isolated, and are by no means an acceptable part of the job.

Section II - Successes

The union's numerous efforts came to fruition when in May of 2011, Manitoba became the first province in Canada to reform its health and safety legislation. The Provincial Violence Prevention Policy was the first of its kind and still stands as the strongest piece of health and safety legislation in Canada. In particular, a Nursing Safety and Security Fund was established, the goal of which is to improve nurses' safety and security in workplaces. Additionally, strengthened violence free policies now obligate all healthcare facilities in Manitoba to do the following: have a violence prevention policy and strategy in place, a procedure for summoning immediate assistance, a procedure for flagging potentially violent patients, and a system for reporting and reviewing incidents.

Additional progress was made during the 2011 round of collective bargaining. The union negotiated a clause in the collective agreement that obligates employers to commit to ensuring safe workplaces. The clause is broad in its scope, meaning that no individual, entering the work environment, is exempt from the policy. The clause applies in all situations that include employees, patients, visitors and employer representatives. Another important tool that was a result of bargaining is the respect and personal safety sign.

All facilities are now mandated to prominently display this violence and abuse free signage, clearly stating that no forms of violence or abuse would be tolerated and failure to comply could result in the refusal of service, being asked to leave or contacting of law enforcement.

Ongoing efforts

Having reached its goals, the union's dedication to achieving violence free workplaces did not wane. The president of MNU currently co-chairs an advisory committee on staff safety and security in health facilities. The mandate of the committee is to ensure there is a permanent process for reviewing workplace security issues in

healthcare and to monitor the implementation of violence prevention programs. The committee also monitors incident investigation, tracking and follow-up and identifies new initiatives to strengthen safety and security for all health workers. MNU also engaged in an education campaign regarding legislative changes, and member's rights under the Workplace Safety and Health Act. Information was shared via emails, magazine articles, social media and more.

Resources were allocated for the creation of a 24 hour health and safety hotline for immediate reporting of incidents of violence, abuse and harassment. In addition to this, a new position was created for a health and safety officer whose duties are solely dedicated to health and safety issues. The officer is tasked with looking into reports of violent incidents, educating members about their rights and responsibilities and holding employers accountable when it comes to upholding health and safety legislation.

Conclusion

Regulatory changes were an important and significant victory for MNU's members and healthcare workers across Manitoba. However, the work is far from over, and given MNU's efforts, the current government continues to be committed to working with the union to ensure safety. It is not just the evidence that was presented to the provincial government, but the nursing shortages that exert additional pressure on the government to ensure nurses are working in safe conditions. Numerous studies, including internal polling, show that nurses reporting the lowest levels of satisfaction with their jobs were found in facilities reporting the highest levels of violence and abuse against nurses. In some cases violence can influence a nurse's decision to leave their job, or worse – leave the nursing profession. In light of expected retirements, population booms, increasing acuity of patients and overall, increased demand for nurses, it is paramount that working conditions are such that nurses can work safely. As a union, MNU is determined to first and foremost educate members and change their perceptions of violence in the workplace, namely that it is not a part of the job, nor that it should be tolerated. Member engagement and awareness continue to guide MNU's fight to make workplaces safer for nurses and their patients.

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Learning objectives

Participants will...

1. understand challenges in affecting legislative reform from a union stand point
2. be able to elucidate effective lobbying strategies used by MNU for changes in Workplace Safety and Health legislation and bargaining strategies.

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Redressing a dangerous confluence in Nova Scotia's long-term care sector

Paper

Paul Curry, Janet Hazelton
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Perspective: Policy

Background and context

Workload issues are particularly severe in long-term care (LTC), an often undervalued segment of the health care system where resources are scarce and nurses are regularly expected to oversee the care of a large number of residents at once. Nova Scotia has the highest proportion of seniors in the country and the acuity and complexity of LTC residents continue to rise. Concurrently, nurses in LTC report alarming rates of injury and abuse. According to Nova Scotia's Workers' Compensation Board, workers in LTC homes experience more violence at work than any other sector, including security guards.

Bearing this in mind, the Nova Scotia Nurses' Union believed it was necessary to conduct research, closely investigate the situation of front-line nurses, and devise a plan to institute effective change in LTC staffing and safety regulations.

Methodology

This project began with research, including a literature review of staffing standards and workplace violence, particularly in the LTC sector, a review of past initiatives and an examination of the current state of LTC in the province. Next, the union conducted a blind survey of nearly 200 front line nurses working in Nova Scotia LTC facilities, followed by four regional focus groups including the participation of roughly 30 nurses overall. This work serves as a basis for current efforts designed to influence staffing and safety standards in Nova Scotia's LTC sector.

Findings

According to best available evidence, LTC residents should receive a minimum number of nursing hours per resident day, including a fixed amount from licensed nursing staff. The literature also establishes a clear relationship between staffing levels and the level of violence experienced by residents and staff in LTC facilities. Experiments with staffing standards in the US, moreover, reveal the benefits of appropriate staffing levels.

The survey of front-line nurses revealed a challenging work environment often fraught with the threat of violence and injury. In focus groups, nurses spoke about being bullied, about sustaining injuries and about the heartache of not having the time to provide appropriate care for residents.

Implications

The research portion of this project provides a platform for the current policy and lobbying portion. The Union has brought its research to the government which has promised to revise the legislation governing LTC in the province. The Union is partnering with other labour organizations and patient advocacy groups in order to promote its message. This effort will centre on five key recommendations following from the research: the implementation of evidence-based staffing standards; increasing public transparency around staffing and patient indicators; including staffing levels in LTC home licensing reports; including reporting on aggression, bullying and violence in licensing reports; and convening a provincial task force on violence and bullying in the LTC sector, with the participation of the appropriate stakeholders, and with the authority to institute new measures to protect the safety of residents and health workers alike.

Learning objectives

Participants will...

1. understand the situation of long-term care nurses, including their workload and the violence and aggression they suffer.
2. understand that improvements can be made with the appropriate stakeholders on board and the political will to effect positive change.

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Safety and security: Which comes first?

Workshop

Bob Bowen

The Mandt System, Inc., Richardson, USA

Perspective: Education and Training

Background and context

Around the world, there is recognition that health care workers are at a greater risk of harm than workers in other sectors (Janocha & Smith 2010, Farrell & Cubit 2005). Safety and Security are key concerns in many health care settings, especially hospitals and forensic psychiatric settings.

Methodology

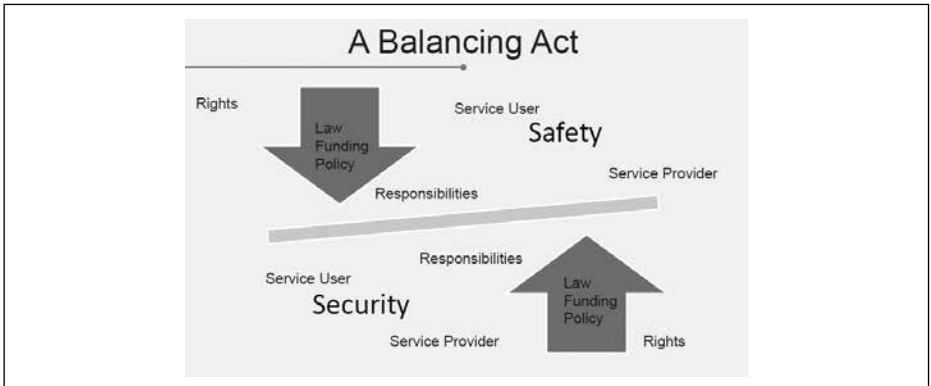
This presentation will review how hospitals and forensic psychiatric treatment centers have, within their organizations, identified and prioritized safety and security. When staff have safety, they can give safety to patients and residents. When staff have security, they can give security to patients and residents. In order to achieve this goal, the words 'safety' and 'security' must be identified by service users (patients, residents, clients) and service providers (clinical staff, security staff, administrative staff). When there is agreement on what safety and security mean from these three groups, a matrix can be designed to identify commonalities and set goals on how to achieve safety and security for all the stakeholders in an organization. Without common definitions of these terms, the disparity between stakeholders will continue to result in heightened risks to all people. The 'No-Mans Land' (Cameron, 2008) between stakeholders is where harm and injury occur. The ability to crossover the no-mans land and collaborate with all stakeholders will result in safety and security for all.

Discussion

This presentation will review how hospitals and forensic psychiatric treatment centers have, within their organizations, identified and prioritized safety and security. When staff have safety, they can give safety to patients and residents. When staff have security, they can give security to patients and residents. In order to achieve this goal, the words 'safety' and 'security' must be identified by service users (patients, residents, clients) and service providers (clinical staff, security staff, administrative staff).

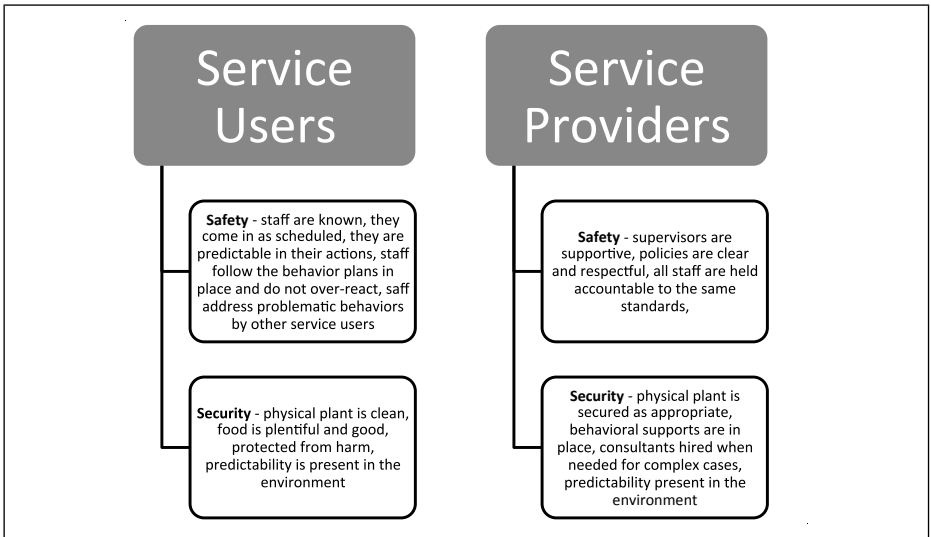
When there is agreement on what safety and security mean from these three groups, a matrix can be designed to identify commonalities and set goals on how to achieve safety and security for all the stakeholders in an organization. Without common definitions of these terms, the disparity between stakeholders will continue to result in heightened risks to all people. The 'No-Mans Land' (Cameron, 2008) between stakeholders is where harm and injury occur. The ability to crossover the no-mans land and collaborate with all stakeholders will result in safety and security for all, and will require a continuous balancing act, especially on the part of the administrative and supervisory staff of the organization.

When workplace violence occurs, if it is between staff in horizontal violence, it will have an effect on the perceived safety and security of the individuals served in the organization. What is termed the "Stanton-Schwartz Effect" demonstrates the impact of unresolved conflict on patients in psychiatric hospitals. (Stanton & Schwarz 1954) Likewise, patient to patient conflict will also have an effect on staff (Rashkis & Wallace 1959).



When staff must intervene in situations of conflict involving individuals served, whether or not the intervention is physical, there is a level of coercion present in the interaction. (Bowen et al, 2011) This has implications for all stakeholders within the organization, as the rights of service users and service providers are at times at odds with each other. This is the concept known as the “No-Man’s Land” (Cameron, 2008) and provides both opportunity and risk for all parties. In an exercise done at Treasure Coast Forensic Treatment Center in Indiantown, Florida, this concept was explored by participants. What they discovered was that when staff felt they were safe and secure, they were better equipped to provide safety and security for individuals served. Central to a successful movement out of the No Man’s Land is the ability to resolve conflict by building bridges between the stakeholders in the organization.

For decades health care professionals have focused on the issue of staff safety. Despite all of the attention, conferences, articles and initiatives, the risk to the safety of staff in health care in America has increased in the past 10 years. (Janocha & Smith, 2010) By identifying what the words “safety” and “security” meant from the perspectives of individuals served and service providers, we can more easily understand the relationships between these 2 words as they are applied to two different groups of individuals. In answering the question posed in the title of this paper: safety and security – which comes first, the consensus among participants in several workshops was that staff safety, and then staff security came first. If staff did not feel safe and secure, participants from all levels of the organization agreed that they would not be able to pass safety and security on to the individuals served by the organization. Instead of a “client first” approach, a “staff first” approach is called for. The safety protocols on airplanes, if the oxygen masks deploy, is for people to put on their mask first, and then help others.



This approach is at odds, in some regards, with the “conventional wisdom” and many regulatory and accrediting bodies. “Patients come first” is the mantra of many hospitals. In their book “Patients Come Second” (Spiegelman & Berret, 2013) argue that for staff to give world class care in hospitals, they must have world class support from administrators. It is doctors and nurses and technicians and therapists and clerks and hundreds of others direct contact roles that provide patients with the treatment, care, and healing central to any hospital setting. If staff do not come first, patients will come second or even last.

Implications

Implications for practice, research, policy & procedure, and training: At a practice level, there is a tendency to live and work in our own silos. (Privitera et al, 2015) Translating how each discipline conceptualizes safety and security can provide common ground upon which we can move forward. This common ground can now be codified in policy and procedure within each organization and consistency in practice will follow. Training staff in this approach will be critical to ensure fidelity to the model at an operational level. Further research into the outcomes will be needed to establish the ability to replicate the model broadly.

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Workshop program

Description of how participants will be actively involved 50% of the time: Participants will, individually, complete definitions of safety and security. They will then work together in small groups to define safety and security across traditional disciplinary boundaries. Each participant will be able to take the outcomes of the transdisciplinary approach to services back to their organization.

Learning objectives

Participants will...

1. be able to define safety and security from their own perspective and from a broader organizational perspective.
2. have ideas on how to integrate the models in a format usable in their organization.

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The Clinical Practice Assessment Tool (CPAT): Assessing a tool to prevent client-on-staff violence in mental health facilities

Paper

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Perspective: Research

Keywords: client-on-staff violence, patient-on-staff violence, workplace violence, mental health care

Background

Workplace violence is a critical and growing health and safety issue for health care workers worldwide (Duxbury, 2002; Johnson & Hauser, 2001; Shields & Wilkins, 2009; Spencer et al., 2010). Health care professionals are at the highest risk for workplace violence, even when compared to other service providers such as police officers, prison guards, bank personnel or transport workers (Kingma, 2001). In 2008, Ontario, Canada's Workplace Safety and Insurance Board (WSIB) allowed 2,100 lost-time claims for workplace violence-related injuries, an increase of 40% between 1996 and 2005 [Ontario Public Service Employees Union (OPSEU), 2011]. Workplace violence is such an immediate and widespread concern that international agencies, International Labour Office (ILO), the International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI) collaborated to develop framework guidelines for addressing workplace violence in the health care sector (ILO/ICN/WHO/PSI, 2002). In mental health care, violence against staff is increasing (Almvik et al. 2000; Decaire et al., 2006; Privitera et al., 2005). In 2011, it was reported that violence accounted for 37% of lost-time injuries in Ontario, Canada's psychiatric hospitals (WSIB, 2012). Among nurses, psychiatric nurses report the highest rates of violent events (Islam et al. 2003; Peek-Asa et al., 1997).

Consequences

The effects of client-on-staff violence are widespread and costly. Staff reactions to violence are numerous with physical, emotional and psychological ramifications. With "minor" violent events, victims often report residual emotional effects such as fear, anger, humiliation, anxiety and depression (Celik et al., 2007; Gates et al., 2011; Lanza, 1992; Robinson et al., 2003; Shields & Wilkins, 2009; Stadnyk, 2008). Some victims suffer from post-traumatic stress disorder (PTSD), which can manifest as severe depression and anxiety, fatigue, startle response, flashbacks, sleep disturbances and nightmares, reactions common among victims of street crime and terrorism (Erdoş & Hughes, 2001; OPSEU, 2011; Shields & Wilkins, 2009). A victim's clinical practice may suffer, decreasing client safety and quality care delivery. Nurses who have been assaulted have reported an array of outcomes affecting their practice, including changes in their relationships with co-workers, difficulty returning to work, and decreased job performance (Celik et al., 2007; Lanza, 1992). Organizations are affected by client-on-staff violence as well. Organizations incur direct (e.g., lost-time claims, liability and litigation, absenteeism, staff turnover and associated costs with recruitment) and indirect costs (e.g., decreased productivity and poor organizational image; Shields & Wilkins, 2009; WorkCover NSW Injury Prevention, 2001).

Managing Workplace Violence

Many approaches to managing or reducing client-on-staff violence are reactionary and controlling. These approaches neglect the important role of the clinical environment. Currently, a scientifically credible tool to assess the clinical environment does not exist. To address this knowledge gap, the Public Services Health & Safety Association (PSHSA) and Ontario Shores Centre for Mental Health Sciences (Ontario Shores) developed the Clinical Practice Assessment Tool.

The Clinical Practice Assessment Tool (CPAT)

The PSHSA in collaboration with Ontario Shores developed a unique set of tools for clinical frontline caregivers and clinical managers. The CPAT was designed to foster development of a system of care that integrates client and employee safety and reduces workplace violence in the mental health care setting. It provides a snapshot of current violence prevention activities at the unit level and provides respondents the opportunity to reflect on their practice. There are two versions of the CPAT – one for the inpatient frontline caregiver, the other for the inpatient manager. The frontline staff version comprises seven dimensions: (1) leadership commitment, (2) supporting program infrastructure, (3) environmental support for staff safety, (4) staff development, (5) client admission & assessment for violence and aggression risk, (6) client engagement, and (7) client care and communication. The manager version comprises six dimensions: (1) leadership commitment, (2) supporting

program infrastructure, (3) environmental considerations, (4) staff development, (5) client admission and assessment for violence/aggression risk, and (6) security/emergency response.

Objective

The objective of this study is to assess the validity and reliability of the CPAT.

Methods

Original Study Plan

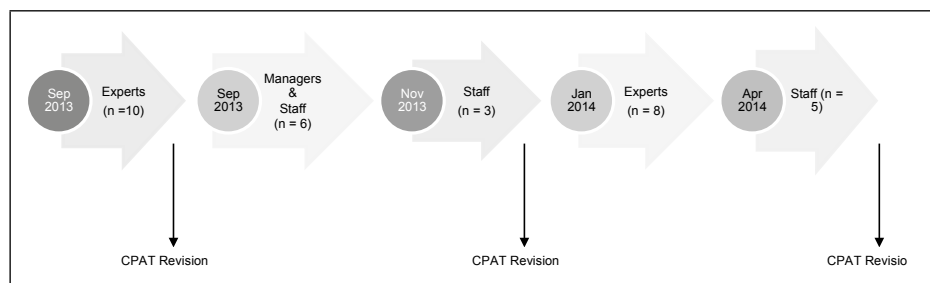
The original study plan was to conduct one focus group with workplace violence experts followed by administering both CPAT versions to over 850 frontline staff and managers at Ontario Shores. Results from the experts' focus group (described below) revealed that the CPAT needed important changes before widespread administration and more complete psychometric testing. Consequently, the study plan was revised.

Revised Study Plan

The new plan was to get consensus from frontline inpatient staff and experts in workplace violence on the caregiver CPAT. We did not continue work with the manager CPAT version due to time restrictions and the importance of first developing a CPAT version relevant to frontline caregivers in mental health.

Results

Over an 8-month period, 5 focus groups were conducted with experts in workplace violence and frontline staff and managers who work at Ontario Shores. With the exception of the first focus group, participants assessed the caregiver CPAT version only. Each focus group was 1.5 – 2 hours in length, audio-taped and field notes taken. See Figure 1 for timeline of focus groups.



Focus Group #1 – Experts (n = 8 to 10)

Before the focus group, eight experts completed a self-report survey about the degree of relevance of each CPAT item along a 4-point scale (1 = not relevant to 4 = very relevant; Lynn 1986). A content validity index (CVI) for each item was calculated. An item's CVI indicates the proportion of experts whose endorsement is required to be content valid beyond the .05 level of significance (DeVon et al., 2007). Findings from CVI analyses indicate that six items from the caregiver CPAT are not relevant to client-on-staff violence.

Key findings from the focus group (n = 10) are as follows: (a) the client care and communication dimension is not relevant; (b) wording of several items imply that staff are to blame for violence incidents involving clients especially in the client engagement and client care and communication dimensions; (c) several items do not relate to client-on-staff violence; (d) wording of several items are ambiguous and double barrelled, and; (e) important elements of violence prevention programs are missing.

The caregiver CPAT was revised by the research team. The revised version was evaluated in focus groups #2 and #3.

Focus Group #2 – Staff and Managers (n = 6)

Participants were a mix of frontline staff and managers. The following issues were raised: (a) several items are not relevant to client-on-staff violence; (b) wording of several items imply that staff are to blame for violent clients; (c) wording of several items are ambiguous, and; (d) items about the effectiveness of organizational resources, education and training are missing.

Focus Group #3 – Staff (n = 3)

Findings from the staff focus groups were similar to those from the experts' focus group. Staff participants had issues with: (a) wording of several items which imply that staff are to blame for violence clients; (b) several items are not relevant to client-on-staff violence; (c) wording of several items are ambiguous, and; (c) items about the effectiveness of organizational resources, education and training are missing.

Based on findings from focus groups #2 and #3, the research team revised the caregiver CPAT. Definitions for each dimension were added and several items were added or revised. The second revision was evaluated in focus groups #4 and #5.

Focus Group #4 – Experts (n = 8)

Experts provided positive feedback about the revised caregiver CPAT and support the tool going forward for further psychometric testing. Additional work is needed before administration. The following recommendations were made: (a) further refine domain definitions; (b) resolve ambiguous item wording, and; (c) remove items not specific to violence.

Focus Group #5 – Staff (n = 5)

Staff think the CPAT is valuable and has the potential to keep staff safe at work but should be further refined. Staff indicated that the client care and communication section is not relevant. They also recommended that items about the following topic be added: (a) inter-professional teamwork; (b) effectiveness of education and training programs; (c) the debriefing process, and; (d) whether or not staff feel safe.

Based on findings from focus group #4 and #5, the CPAT was again revised and is now ready for additional psychometric testing.

Discussion

Workplace violence experts and staff agree that the caregiver CPAT is an important workplace violence assessment tool. Producing a scientifically credible tool to assess conditions of the work environment will assist administrators to make informed environmental changes that prevent client-on-staff violence. The caregiver Clinical Practice Assessment Tool (CPAT) has the potential to be an effective clinical environment assessment tool that can help keep mental health care staff stay safe at work. The revised caregiver CPAT is now ready for additional psychometric testing in a future study.

Conclusion

Client-on-staff violence is a major problem in health care and especially in mental health units and facilities. This violence is affecting those who deliver care both physically and mentally. It also affects the care delivered and the organizational health of the facility or unit. From a health care system perspective, staff exposure to violence makes for an unhealthy and unattractive environment, further exacerbating current and projected shortages of health care professionals (Canadian Nurses Association, 2009). Too many tools supporting violence reduction focus on predicting when a client will become violent and not on the environment in which care is delivered. Producing a set of reliable and valid tools that can be used by health care facilities across Canada where the patient mix is dominated by mental health patients would fill a major need. Furthermore, how care is delivered is a critical dimension of the environment – the CPAT extends those small number of violence prevention tools to include the care delivery process.

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Learning objectives

Participants will...

1. realize that client-on-staff violence in mental healthcare is a significant and growing problem.
2. appreciate that violent episodes occur in response to the client's immediate environment. In more supportive environments, clients are less likely to 'act out'.
3. have knowledge of a valid and reliable tool to assess work environmental factors that prevent client-on-staff violence in mental healthcare facilities.

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Prevalence of bullying/mobbing behaviour among nurses of private and public hospitals in Karachi, Pakistan

Paper

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Perspective: Practice

Background and context

Workplace violence towards nurses is a worldwide problem, with professional nurses at the greater risk of being subjected to workplace violence. While the actual prevalence of workplace violence towards nurses remains unknown, it is expected that a lack of respect towards the nursing profession in the Pakistani society is a significant factor that contributes to workplace violence towards nurses.

Objective

This study aimed to identify the prevalence and characteristics of bullying/mobbing behaviour experienced by nurses, working at the in-patient units and Emergency Departments of two private and two government hospitals in Karachi, Pakistan.

Methodology

The study employed the cross-sectional design and included 458 nurses from 02 private and 02 government hospitals in Karachi, Pakistan. A simple random sampling technique was used to recruit the participants. Data was collected using an instrument that was jointly developed by International Labour Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI).

Findings

The study found 33.8% prevalence of bullying/mobbing behaviour among nurses. The study also reported highest prevalence of bullying/mobbing behaviour among young (19 to 29 years of age) female nurses with less than 5 years of work experience. Nurse participants belonged to the Medical Surgical units, Intensive Care Units, and Emergency and Psychiatric departments. The most common perpetrators of bullying behaviour were nurses in managerial positions.

Implications

The study identified the prevalence of bullying behaviour towards nurses in healthcare settings of Pakistan. The findings of the study may serve as a milestone towards the implementation of “Harassment of Women at Workplace, Act 2010” and may help to achieve the violence free healthcare environment goal set by the World Health Organization, 2003.

Note

This manuscript is the part of the larger study; which was meant to identify prevalence and characteristics of physical violence, verbal abuse, bullying/mobbing behaviour, and sexual violence experienced by nurses working in all the in-patient units and the Emergency Departments of two private and two government healthcare settings in Karachi, Pakistan. This paper will only talk about bullying/mobbing behaviour towards nurses.

Learning objectives

Participants will...

1. Learn of an initiative responding to the “Harassment of Women at Workplace Act” of 2010.
2. Learn of ideas on how to inculcate violence free culture within the healthcare settings.

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Interprofessional dynamics affecting critical decision making as experienced by nurses and physicians

Paper

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Perspective: Practice

Background and context

Effective communication between healthcare professionals during moments of critical decision making is essential to appropriate patient care. Conflicts in communication arise when there is a perception of differing values, beliefs, attitudes, biases, and behaviors that make up a professional culture (Avruch, 2008; Dubinskas, 1992; Weeks, 2004).

Differences in perception may lead to miscommunication, frustration, anger, disruptive behaviors and the most significant complication; medical errors causing negative patient outcomes. To understand the professional cultures of nurses and physicians, research must be done to determine thoughts and feelings from the moment the choice is made to enter that profession until the present. An understanding of the process of socialization into the profession and the interactions between the professions is crucial to understanding the professional culture and its impact on communication and collaboration during moments of critical decision making. This study will interview and explore the interprofessional dynamics of healthcare providers in an effort to explain the causal concepts that contribute to dysfunctional interprofessional dynamics, the contextual phenomenon that emerge from these causal concepts, and the consequences of these phenomena.

Analyzing and understanding the contextual factors that influence the behaviors causing conflict for nurses and physicians through a grounded theory approach could provide theory that can be applied by institutions or structures to adapt and meet the needs of the healthcare provider and organization. By doing so, programs can be developed to decrease healthcare violence and promote mutual understanding, foster mutual respect, decrease professional ethnocentrism, improve collaboration and establish trusting relationships by improving the awareness of cultural differences.

Methodology

This is a qualitative study designed to explore the interprofessional dynamics of nurses and physicians at moments of critical decision making. The purpose of this grounded theory will be to transform social processes of education and the professional practice of healthcare.

Using Constructivist Grounded Theory, the study employs semi-structured phone and/or face to face interviews. The data analysis is based on verbatim transcriptions of semi-structured, in-depth interviews of key participants as well as extant text. Data collection will be simultaneous to analysis of data utilizing methodology by Charmaz (2006). Initial coding will be line by line and will utilize gerunds. Emerging categories will be placed in theoretical categories to assist in interpretation of meaning. New data will be continually compared to previously obtained data. This iterative coding process will allow for analytical interpretation of the data.

Findings

The findings currently undergoing data analysis will be presented in detail.

Implications

Implications of these findings could serve to promote proactive delivery of communication and conflict interventions during education into the professional roles. It may also promote improvements in the organizational structure of healthcare by avoiding promotion of these dysfunctional profess.

Learning objectives

Participants will...

1. understand the inter-professional dynamics of professional cultures and their effects on communication through an understanding of the process of socialization and education of the professions.
2. begin to develop a process to transform disruptive behavior, reduce the conflict, and decrease the adverse effects that impact both the professional and the patient.

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Dealing with violence at the Airport Medical Center: A unique challenge

Paper

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Perspective: Practice

Keywords: Nurses, violence, airport, aggression.

Introduction

Violence in health care facilities is a common problem, especially for nurses who are considered the front liners facing patients in their facilities. The incidence of patient violence and aggression in health care is reportedly increasing. Healthcare workers interact closely with their clients, often under difficult circumstances. The actual frequency of the occurrence of workplace violence may be under reported and this occurrence is a new challenge at the airport medical center in Dubai. Clients may act aggressively due to medical condition or the medication they are taking. They may also have a history of violent behavior, or feel frustrated and angry as a result of their circumstances. Dealing with violence is a challenge for healthcare providers and a unique encounter at the airport medical centers. This Paper aims to discuss verbal, physical and emotional challenges faced by Staff –dealing with violent, drug abused patients, deportees and various other cases at the Dubai Airports Medical Centers in Dubai, United Arab Emirates (UAE).

Background

Working in a rapid growing environment such as Dubai airports, puts the health care providers that work in Dubai Airports Medical Centre face a very big challenge in terms of triaging, treating and dealing with violence. The incidence of aggression and violence by mental patients and deportees out of the country is on the rise and issues about the management of this problem are growing with the core leadership sharing concerns about staff safety and security. Incidents don't always occur at the worksite; in the case of airports the abusive behavior and its consequences may start up on the air. Dealing with people under the influence of drugs or alcohol could be challenging if healthcare workers are not prepared and not aware of how to handle these kinds of situations before they happen. The airport medical center emergency care department is in particular the most volatile and vulnerable settings for patients with aggressive behavior and violence. Dramatic life-and-death cases, abusive patients, mentally ill, drugged patients, Rape victims, Criminals, Handcuffed patients; Deportees with Police come straight through the front door at the airport medical center. The natural stress and heightened emotions present in Emergency services, combined with high traffic, and different stakeholders like the Dubai police, Dubai corporation for Ambulance services , and Airlines managers involvement creates a challenging and unpredictable environment more prone to violence than any other stable place to work at. The often overlooked problem associated with mental health and substance abuse patients in the Emergency care is the heightened risk of violence, which may lead to grim safety concerns for clinicians, nurses and other patients.

Dubai Airports

Dubai International Airport is an international airport serving Dubai in the United Arab Emirates. It is a major airline hub in the Middle East, and is the main airport of Dubai. Dubai airport has currently three main terminals (terminal 1, 2, 3). The partly underground Terminal 3 serves exclusively for Emirates and has a capacity of over 50 million passengers. Dubai International, the world's second busiest international hub, registered another banner year with annual passenger traffic reaching 66,431,533 in 2013, following a record-breaking December when passenger numbers eclipsed the 6 million mark for the first time. Traffic at the Dubai Airports reached 5,675,246 in February 2014. This number marks Dubai Airports (DA) to be considered the second largest International Airport in the world which is aiming to be the first. The Civil Aviation Authority of Dubai manages the overall safety and security of the airport. Pre-screening takes place in all terminals at the entrance of the airport. In early 2007, Dubai Airport introduced a new type of airport screening device which not only detected weapons, but also could screen the passenger for drugs in the blood. With the new system in place, travelers entering Dubai can be jailed for four years or more if found in possession (including in the bloodstream and the bottom of the shoes) of illegal drugs (even in quantities as small as 0.001 g (3.5×10⁻⁵ oz), including poppy seeds from bagels and prescription and over-the-counter medicines such as Codeine.

Graph: 1- Dubai airport passengers 2010 - 2013



Airport medical Centre

The Delivering of Quality Service, efficacy and customer-focused business processes is fundamental to becoming a global competitor, that is able to respond to any changes, particularly for a business as complex as airport management. The Dubai Airports (DA) continuously strives to set a Brand positive Image and example by ethical and responsible actions that support the community, deliver superior quality customer service, protect the environment and nurture a safe and productive work place. The element that underpins everything that Dubai Airports does is safety and security, and over the past years, DA continued to proactively find ways to improve the safety of passengers, employees and stakeholders. Airport Medical Centre is working directly with Dubai Airports Authority (DAA); it is the health care body in the facilities of airport buildings and it covers services for both passengers and staff of the Dubai airport. The clinics are distributed all over the buildings through concourse A, B, and C within the terminal 3. Airport Medical Center is open around the clock and is dealing with several aggressive cases which put the safety and security of the staff at risk. Cases for instance: Psychiatric patients, Illegal immigrants who are to be deported, Drug dependence, Abused maids who are being deported, Alcoholic and drunken passengers, and criminals are few to mention. Over 50 nurses and 20 physicians take part in providing health services at the airport medical centers. Proper communication is critical due to nature of infrastructure and services. Collaboration among the medical staff with related units such as the control tower, control room and the ambulance services at the airport is vital in providing the best service/care for the passengers, crew and staff. Since the Airport Medical Centre is visited and used with people experiencing extreme life events and emotions, staff perceptions, responses and acclimatization to 'serious' and 'emotive' issues can create a mismatch between patients' emotions and the delivery of practical healthcare.

Violence at the Airport Medical Center:

Dubai airports has a lot of stake holders that play a role in serving the customers (passengers and staff) who use the facility, for instance the airport is operated by Dubai police, Dubai Customs, Dubai Immigration Services, Airlines Officers, Civil Aviation Officers, Dubai Airport Medical Centre and Dubai Corporate for Ambulance Services. So the story begins when one of the front liners such as police or airline attendants faces a situation where the customers exhibits a behavior, such as screaming/yelling at others, harassing staff, or physical aggressive behavior.

The initiation of violence can be either on the air or on the ground. In most cases, violent passengers are drunk and express abusive behavior starting inside the aircraft. Controlling such behaviors in the aircraft seems challenging and at times the passenger needs to be restrained for the safety issues of other passengers. Control tower will be informed until the aircraft lands. They will call the joint control room which will direct an ambulance to be sent to the location for help. Most of the times those kinds of patients require more assistance and help than the paramedics can offer, so the patient will be taken to the clinic for further assessment and treatment. Depends of the level of aggression nurses and doctors will be at risk dealing with an abusive behavior of a restraint and drunk passenger. Nevertheless, emotional challenges are always part of the scenario. There has been cases that the staff have been abused physically by either psychiatric patients or drunk passengers. Staffs are expected to deal with a lot of stress and care for very difficult individuals.

There can be conflict between the desire to care and the desire to be protected especially when difficult and emotionally overwhelming cases comes and female staffs are on duty. Sometimes female deportees, Rape victims are being bought handcuffed by police. They create unexceptional behavior scenes, or tear away their clothes leaving the people attending them in turmoil too. Different people handle, fear and stress differently. At times distressed and disturbed patients make a lot of noise and this can be alarming and cause anxiety in other patients sharing the same space.

Main challenges and future plans

A difference of setting and ambience at the Airports makes it a unique challenge for staff in dealing with violence. It is important that policy makers consider the inimitable environment of airport medical center while establishing any policies in place. One of the main challenges that staff are experiencing in dealing with violent cases is lack of education/training and experience in dealing with such individuals. Dubai airport medical center has created a lot of policies that deals with other stake holders and to draw the lines where each stake holder should take responsibilities in such incidents along with each affected by.

Proper identification of psychiatric patients from the concerned parties is the first step to proper management and initiating policies and procedures. Another aspect to avoid the violence issue in regards to psychiatric patients is to prepare our health care professionals (nurses, physicians, paramedics) by continuous education about the management of psychiatric patients, more over those nurses should be empowered in decision making, especially in non-pharmacological intervention such as physical restraining and aggression management. Furthermore, the paper emphasizes, discusses the current situation and strategies in place and two case scenarios of violence will be explored.

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Learning objectives

Participants will...

1. realize that violence can happen anywhere and airport medical centers are not an exception.
2. Learn of strategies which help prevent and manage violence in a unique setting.

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The Nevada Experience: Combating lateral violence in the nursing profession

Poster

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Perspective: Practice

Abstract

Lateral violence in nursing is not a new problem, but one that was never talked about openly until a few years ago. Specifically, lateral violence is nurse to nurse directed abuse that includes verbal abuse, passive aggression, and variable degrees of antagonism such as gossiping, innuendo, scape-goating, undermining, and intimidation (Baltimore, 2006). This type of abuse can be collectively defined as dysfunctional behavior from one nurse to while not physically harmful, studies indicate that it can often result in reduced self-esteem, sleep disorders, anxiety, hypertension, impaired personal relationships, disconnectedness, depression, and low morale (Smailes, 2003). Research indicates this type of abuse is found globally in all areas of nursing and affects not only individuals, but the entire health care system (AACN, 2007; Olive, 2005; Smailes. Statistics from the International Council of Nurses (ICN) reveal that worldwide nurses are three times more likely than any other service occupational group to experience violence in the workplace (Del Bel, 2003). 2003).

Nevada is not unique to this world-wide problem and has chosen to combat lateral violence in nursing through the use of education and awareness. It started with a conversation after a presentation on lateral violence at a statewide nursing convention and blossomed from there. Led by the Nevada Nurses' Association and other key players in the State, a task force was formed to look at the issue and how to resolve it. From this task force a Statewide collaboration was formed to include nurse educators, hospital administrators, nursing administrators, nurses, and other key interested parties. The Collaborative implemented a "train the trainers" set educational program on lateral violence and held two trainings to date statewide that key personnel could take back to their institutions to provide training for their own personnel. In addition, the collaborative is looking at software programs that have simulation scenarios on lateral violence education that can also be implemented in different healthcare and educational settings to train not only nurses but student nurses. The Nevada Nurses Association is also educating the greater nursing workforce by supplying a series of articles in their quarterly statewide newspaper that goes out to all Nevada nurses and student nurses. Data is being collected now on the training and it's implication for replication in other states but it's too early to present findings at this time. Through these activities and collaborative efforts, Nevada hopes to change a culture and decrease the incidence of lateral violence in the nursing profession.

Learning objectives

Participants will...

1. learn how to build a collaborative to combat lateral violence in nursing.
2. learn how to use train the trainer education to provide key personnel in their state with the resources needed to combat lateral violence in nursing.

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Violence against health professionals in Palestinian Hospitals: Prevalence, sources, responses and prevention

Paper

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Perspective: Research

Keywords: Violence, Prevalence, Physical and Verbal Violence, Health Professionals

Abstract

Violence in health sector increases and become a serious issues that face health professionals. Quantitative study aimed to investigate the prevalence, source and prevention of violence in Palestinian hospitals, sample includes 120 nurses. Result showed that 30% of nurses experienced physical abuse and 80% of them experienced verbal abuse. Training, security measures and improvement of the environment acknowledged as the main preventative measures for violence.

Background

Workplace violence is the fourth-leading cause of death in the workplace and the leading cause of death among women in the workplace (Monson et al., 2011). Around 2 million workers report being victims of workplace violence each year (OSHA, 2011). In the last decade healthcare workers represented two thirds of nonfatal workplace violence injuries. These workers have a five-times greater risk for requiring time off due to assault (CDC, 2013). The majority of workplace assaults within the healthcare sector occur in nursing since they spend most of the time with patients and their families (Restrepo&Shuford, 2012). The actual number of incidents is probably much higher, since incidents of violence are likely to be underreported, perhaps due in part to the persistent perception within the healthcare industry that assaults are “part of the job. Nothing can guarantee that an employee will not become a victim of workplace violence. However, several steps can help individuals reduce the risk such as Learning how to recognize, avoid, or diffuse potentially violent situations by attending employee personal safety training programs, Alerting supervisors immediately and in writing to any concerns about safety or security and reporting all incidents Workplace violence has become one of the most serious occupational hazards facing personnel working in today’s healthcare environment. Healthcare workers should not be expected to accept violence as “part of the job,” and employers must take appropriate steps to ensure that the chances for violence are minimized. It is necessary for employers to create an environment in which employees are safe, secure, and productive. Systems must be put in place that address violence and promote risk-assessment and prevention (Campbell, 2011).

Problem statement

Violence and physical assault in health care settings are recognized as significant occupational hazards for nursing professionals. Violence in society’s increases .This study intends to investigate the prevalence of violence in health care setting and staff opinions as how such violence might be prevented. To ensure safe working environment in health care setting management must provide security measures and training for health care provider in relation to prevention and responding to violence and aggression. Health worker should understand that violence result from a number of variables, like stress, pain, fear of unknown, extended waiting time to be seen and treated and unpleasant environment.

Significance of study

There is a lack of data in relation to the prevalence of violence in health sector in Palestine, so staff and community awareness will be increased through this research, and this will lead to the development of explicit policies in relation to violence and how to respond to it.

Purpose of the study

The main purpose of the study is to investigate the prevalence of violence in health sector and factors used by staff to prevent such violence.

Method

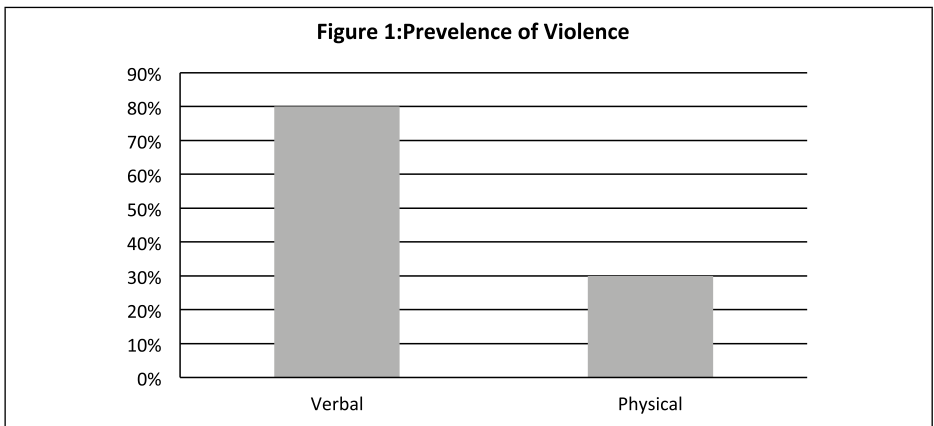
A non-experimental, cross-sectional, descriptive survey was used in this study to identify the prevalence of violence and to identify the preventative measures used to prevent aggression and violence in Palestine.

Sample

A quantitative approach was adopted to investigate the prevalence of violence in health care settings and measures used by staff to prevent such violence. Cross-sectional non-experimental description design was used. Purposive sample of health care provider working in Palestinian hospitals were selected. An instrument developed by the International Council of Nurses (ICN) was used to collect the data. Sample size was 180 nurse and physician.

Results

Due to publication issue the result includes nurses only. The demographic characteristics of respondents showed that 80(66.6%) were male, and 40(33.8%) female. 60(50%) respondents fall within the 20 – 30 age category. 120(66%) are Nurses. Prevalence of physical and verbal abuse presented in figure #1, results showed that 36(30%) of respondents Have been physically attacked while96 (80%) of them have been verbally abused. Moreover, the majority of attacker was the relatives followed by patients, 72(60%) of perpetrator are male and around tow third of them were verbally abused at least more than three times, moreover, 14(13%) of them were verbally abused at least more than ten times in the last year of employment.



The majority of victims took a combination of measures in response to the violence experienced. In case of both physical and verbal violence the majority of victims reported it to senior staff, told the person to stop, told family or friend, took no action, and pretended that the incident never happened. The descriptions of all the existing measures that may minimize violence in the workplace, as reported by all respondents includes security measures, improved surroundings, training ,patient screening and reduced periods of working alone are the most frequent measures taken to deal with violence.

The majority of nurses took a variety of action in response to violent behaviours. The majority of them reported it to the senior staff, told the person to stop, or took no action or pretended that the incident never happened. There was underreporting of incidents, the result showed that 96(80%) of nurses experienced violent behaviour did not reported the incident, as they did not have procedure for reporting, feel it is useless and not important, and there was no encouragement to report work place violence.

Discussion and Conclusion

This study investigated the prevalence of physical and verbal violence in West Bank. The findings shows that 36(30%) of respondents Have been physically attacked while96 (80%) of them have been verbally abused in the last year of employment. This is much higher rate in similar cultural background and geographic zone such as Deep (2003) or that found by Atwaneh et al (2003). However, the rate found by this research falls within the standard range of similar studies. Abu Ali(2012) found that physical attack was 34% and verbal abuse was 74.6% , Rippon (2000) found 30% of hospital staff were abused, Mayer (1999) 41.5% of emergency department nurses, Steinman (2003) 27% of respondents had all been exposed to violence. On the other hand this rate is much lower than the rate reported by Gannon (1998), which reached 85.1% of the sample experiencing physical

abuse. This difference could be related to the fact that Gannon's study was done in dementia wards where the patients were suffering from severe uncontrolled conditions. No gender difference was found in rates of abuse but it was higher across employee grades and years of experience in healthcare. Most of the respondents were working full-time and in shifts. Relatives were the main perpetrators in this study, contrary to other studies where the clients or patients were the main perpetrators.

Consistent with other studies, the rate of reporting of incidents was low such as Zeh et al (2009) and Franz et al (2010) and it was limited at the senior level. The reason for the low reporting level seemed to be related to the ways the incidents handled and low response rate of actions that were taken by the employers themselves. The respondents showed a low degree of satisfaction with the way the incidents were handled.

Respondents believed that training for staff how are at risk for violence is needed in the areas of detection, how to report and how to react to violent behaviour, communication, and stress management. There is a need for the existence of efficient preventative measures that help to prevent or decrease recurrent violent behaviours such as improving the surroundings and the measures that deal with patient issues are the most effective factors in controlling and decreasing the extent of violence. Staff should be qualified and have good communication skills. Respondents showed a low level of awareness of policies and the procedures which deal with the reporting of violence. However, the higher ranks of staff were more aware of these policies and procedures.

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Learning objectives

Participants will...

1. realize that violence in health care center is increasing and it affects the productivity of the employees.
2. appreciate that the issue of violence is a priority of management to ensure the safety of employees.

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Violence in the emergency department...Nothing changes, nobody cares

Workshop

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Perspective: Organisational

Background and context

The issue of violence in the emergency department is not unique to the United States. A literature review and discussions with emergency nursing colleagues in Mexico, Spain, Australia, England, Ireland, The Netherlands and several other countries highlight this is a global issue we all face. This interactive workshop provides an opportunity for a global discussion on the topic of violence in the emergency department.

Methodology

The purpose of this interactive workshop is to review the violence surveillance data from the US and other countries to come to agreement about how expansive the issue is. We will discuss a recently published study examining the “culture of acceptance” that permeates not only the emergency department, but throughout hospital leadership and into the community, all the way to the judicial bench. Resources for addressing the issue in our care environments will be discussed. The richest part of the program will be the discussion among participants. We will share strategies and best practices on how to mitigate violence. Programs to prepare the emergency nurse to recognize escalating situations and keep himself or herself safe will be shared between participants. Discussions around the culture of acceptance will lead to identification of tools and strategies to decrease the incidence of violence in our emergency departments. Global strategies to address the issue of violence will be discussed, including strategies for education, zero tolerance, mitigation, recognition and reporting, and response after an episode of violence in the emergency department.

Findings

Participants will leave the program with new ideas and resources to mitigate violence and keep their nurses safe in the emergency department and throughout the hospital setting.

Learning objectives

Participants will...

1. understand the factors that contribute to a ‘culture of acceptance’ around violence in the ED.
2. be able to discuss strategies that can be implemented for recognition, mitigation, reporting and prevention of episodes of violence.

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Interdisciplinary Experiential Learning: Walking a mile or at least 15 minutes with elder abuse in America

Workshop

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Perspective: Education and Training

Keywords: Elder abuse, healthcare, interdisciplinary, experiential learning

Introduction

There is growing international interest in interprofessional education as a means to more effectively train healthcare workers and ultimately to improve patient care. If interprofessional education and subsequent collaboration are truly to be patient-centered, it is important to identify a foundation, which creates a healthcare professional identity that facilitates collaboration. Most studies—whether dealing with nurses only or with nurses together with other health care workers—have shown that continuing or in-service training can result in significant knowledge increase, increase in reporting of incidence, and most significantly, a decrease in abuse and/or reduction in stress by the healthcare worker caring for elderly (Stiernborg, Zaldivar, and Santiago, 2010). Studies with nursing students also show a similar trend (Fowler, 2008). Among the reasons attributed is the possibility that traditional didactic approaches may not be sufficient to change attitudes among learners (Kelly et al., 1988). It has been suggested that more use should be made of experiential learning methods, such as small-group, interprofessional simulations, and role-playing, if beliefs, values, and attitudes are to be influenced and the increasing trend of elder abuse diminished (Chan, Mok, Po-Ying & Man-Chun, 2009).

Background

Experiential Learning and Interprofessional Education

Experiential learning theory is a holistic model of the learning process and is so named to emphasize the central role that experience through role playing and simulation impacts the learning process (Fowler, 2008). By definition, learning in this way is “the process whereby knowledge is created through the transformation of experience and ...results from the combination of grasping and transforming experience” (Kolb, 1984, p.41). Stemming from the experiential works of Dewey (philosophical pragmatism) (1938), Lewin (social psychology) (1951) and Piaget (cognitive developmental genetic epistemology)(1972), experiential learning blends these perspectives together. The experiential learning model portrays two modes through which people formulate meaningful understanding: concrete experiences and abstract conceptualization as well as two modes of transforming experience: reflective observation and active experimentation. According to Kolb, experiences are grasped through apprehension or comprehension. Apprehension is viewed as participation in the actual experience, whereas comprehension occurs outside the actual experience through abstract conceptualization. For learning to occur, experiences must be transformed through experimentation and reflection to facilitate the process of truly walking a mile in the real life experience which in turn generates a more powerful and sustainable understanding and can effectively influence behavior. The outcomes of experiential learning appear to be diverse ranging from the acquisition of a new skill or personal development through to social consciousness awareness.

Elder Abuse in the American Healthcare Sector

Elder abuse or neglect by a care provider is defined as actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder. This includes failure by a healthcare worker to satisfy the elder’s basic needs or to protect the elder from harm (National Committee for the Prevention of Elder Abuse, 2003). According to the National Center on Elder Abuse Administration on Aging (NCEA) (2014), in 2010 the United States reported the largest number of Americans over the age of 65 in the history of the country, a record 40.3 million people. By the year 2050 over 20% of all Americans will be over the age of 65 and 19 million over the age of 85 (United States Administration on Aging, 2011). It is estimated that one in ten adults over the age of 65 experience abuse. While data from the Adult Protection Services agencies in every state show an increasing trend in the reporting of elder abuse to include abuse by healthcare workers, the prevalence of elder of abuse and neglect is estimated to be exponential (Laumann, Leitsch, & Waite, 2008). As many as 4 million older Americans are victims of physical, psychological or other forms of abuse and neglect according to the Department of Health and Human Services (2014). To complicate this issue, the American Psychological Association (2014) indicates that people with dementia are at greater risk of elder abuse than those without and that approximately 5.1 million American elders over 65 have some kind of dementia. Close to half of all people over 85, the fastest growing segment of our population, have Alzheimer’s disease or another kind of dementia. One 2009 study revealed that close to 50% of people with dementia experience some kind of abuse. A 2010

study found that their caregivers had mistreated 47% of participants with dementia and while the abuser is more likely to be a family member or close personal friend, the incidence of abuse by healthcare workers has increased 15% in the last decade alone (Savundranayagam, Montgomery & Kosloski, 2010).

Although significant legislation and agency regulations have been enacted in recent years to combat inadequate care for elders in the United States and an overwhelming majority of family caregivers provide appropriate care and a supportive environment for their older relatives, the American healthcare system has an inconsistent record of ensuring patient safety with regard to elder abuse (Brennan, Leape, Laird et al. (1991). One of the main factors contributing to this poor record is inadequate interdisciplinary team communication and effective training. Interprofessional education (IPE) refers to occasions when two or more professions learn from and about each other to improve collaboration and the quality of care (Caipé, 1997). Interprofessional collaboration can improve patient outcomes from acute to rehabilitative care (Zwarenstein et al. 2001, McPherson et al. 2001). However, despite the benefits of this approach to health care, it has traditionally not been a clear focus in the education of healthcare professionals (Leipzig et al. 2002).

Research has supported for decades that caregiver stress is a significant risk factor for abuse and neglect and while educational programs designed to inform healthcare workers about abuse, neglect, and the signs of burnout and stress can be easily identified in employee training files, elder abuse and neglect by healthcare workers continues to climb. While experiential learning and simulation has been increasingly used as an effective educational strategy within the healthcare community for the last 20 years, required educational material regarding caregiver strain, abuse, neglect and the conditions of aging have often been presented by education and training departments via presentation board or other popular method such as online training modules with post-test competency certificates. Structural factors within the healthcare education system, such as the complexity of the design for IPE, are often cited as reasons for the failure to engender necessary interprofessional skills; the discipline-specific orientation fosters attitudes that also hinder collaboration (Knox and Simpson, 2004). However, if quality patient care is important, IPE should be in place. Learning about interprofessional work should be viewed as a continuum of learning from prequalification to postgraduate education (McPherson et al. 2001). The growing international interest in IPE is based on a belief that it has the potential to improve patient-centered care, enabling a holistic understanding of patients' needs through better interprofessional communication and collaboration (McPherson et al. 2001).

When the demands of daily care for an older person are thrust onto caregivers who have not experienced such strain, healthcare staff experience intense frustration and anger, which, over time, leads to an increasing range of maladaptive and abusive behaviors (MacNeil, Kosberg, Durkin, Dooley, DeCoster, & Williamson, 2010). In addition, certain societal attitudes may contribute to violence against older people and make it easier for abuse to continue without detection or intervention (Dilworth-Anderson, Williams, and Gibson, 2002). These factors include the devaluation of and lack of respect for older adults and the growing American societal belief that older adults are a burden. Certain cultural values, beliefs and traditions influence caregiver dynamics, intergenerational relationships and ways in which families define their roles and responsibilities and respond to daily challenges. Older individuals who are ethnic minorities, particularly recent immigrants, may face language barriers and financial or emotional dependence that influence their ability or willingness to seek help. "One in six professional healthcare givers report committing psychological abuse and one in ten physical abuse of elderly patients" (Cooper, Selwood, and Livingston, 2008). As reported by Shinan-Altman and Cohen (2009), because attitudes condoning elder abuse influence a healthcare worker's actual behavior, training and supervision programs should be developed to support stress and burnout recognition and to modify these societal attitudes and behavior.

Sample

182 nursing, kinesiology, social work students, and community healthcare workers from a large metropolitan area and a medium four-year primarily residential university in the Midwest engaged in a virtual aging experience allowing participants to feel what it is like to live with common conditions of aging.

Method

A mixed method approach was chosen for evaluation of the interprofessional learning exercise. The data were collected between 2013 and 2014 by group interview and questionnaire. Participants were split into groups of two to don sensory-limiting equipment which include spiked shoe inserts to simulate neuropathy, thick bulky gloves to limit dexterity, goggles which have been altered to simulate cataracts and poor visual acuity, and ear plugs/ auditory distractions such as high pitched sounds to simulate hearing loss and tinnitus. Once impaired, participants quickly discovered the difficulty of following short lists of instructions, which represented normal daily activities of living. Participants were asked to climb stairs, write a three-sentence note, cut paper, pair and fold socks in various light settings, as well as button a sweater all from instructions written in double vision. In addition to experiencing how difficult daily tasks can be, participant partners were provided with instructions of increasing frustration to simulate the increasing mounting frustration of caring for an aging elder. These techniques coupled with interdisciplinary discussion and reflection after the experience led to an understanding of how challenging caring for an older adult can be.

Findings

Being able to dull the senses and allow students to experience first hand the frustrations and often the safety concerns associated with aging taught participants to be more patient with aging adults. In addition, participant themes included a sense of increased understanding because of being able to experience the irreversible and often worsening healthcare concerns of the older adult. Participants also verbalized that the experience gave them a better appreciation for having to actually care for an aging adult-- something very hard to teach in a lecture and something not experienced in controlled clinical settings. There was cultivation in the participants of a deeper understanding of aging and the conditions associated with aging based on openness and a non-judgmental approach, learned from their social work counterparts as well as new perspectives gained from kinesiology professionals on the functional ability, obstacles, and resources needed to help better care for each patient. Reciprocally, social work and kinesiology students learned about the nursing students' daily activities as they observed the natural process of trust and communication in the context of helping patients maintain their dignity while assisting with activities of daily living.

Conclusion and Future Implications

Enhanced understanding of caring in practice is not possible via learning through a uni-professional approach. Participant reflection and dialogue enable their development of understanding not only the deficits experienced by elders and those with dementia but also provided a greater understanding of discipline specific perspective of aging, team-based approach to patient care. Understanding the conditions associated with aging, including the various forms of dementia that often accompany the normal growth and development of older adults is a skill forged from experience that can't entirely be taught in the classroom. While education continues to be the cornerstone of preventing elder abuse, it is the way in which the education is provided in today's technology-based environment that must be further reformed to ensure experiential components are not lost. While media coverage of abuse in nursing homes and healthcare centers has made the public knowledgeable about such treatment there needs to be a concerted effort on the part of healthcare agencies and educational institutions to educate healthcare workers regarding the special needs and risk factors associated with caring for aging adults. For healthcare workers who engage in activities of daily living and provide assistance/ primary care to elderly clients on a routine basis recommendations are being made within the healthcare industry to rotate staff through varying care assignments and environments to decrease conflict, stress, and exposure to high levels of acuity. Interdisciplinary experiential learning is essential for better management of the health and social issues faced by the global aging population. Introducing interdisciplinary experiential aging sessions for all healthcare workers caring for aging adults and the conditions associated with aging such as dementia could enhance their decision-making process through recognition of their values, beliefs, and personal and professional bias and lead to a decrease in healthcare worker abuse and neglect in the United States.

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Learning objectives

Participants will...

1. understand the current evidence regarding healthcare team and care giver elder abuse.
2. be able to define the risks of elder abuse and discuss three risk-reduction strategies.
3. understand through experiential learning the complexities of old age and the impact that these deficits have on performing activities of daily living as they contribute to elder abuse.

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Violence and mental illness: Evidence to inform practice, policy and safety

Paper

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Perspective: Guidance

Keywords: Gun violence, mental illness, public safety

Abstract

The connection between mental illness and violence is not well understood by the general public, policymakers, and at times by health care workers as well. Fear, bias and stigma regarding mental illness are contributing factors that cloud an evidence-based understanding of possible relationships between mental illness and violence. In recent times, the media has perpetuated assumptions regarding a connection between mental illness and violence when reporting horrific individual random acts of violence occurring in public places such as schoolyards and shopping malls. Such media attention has served to bring widespread concerns for public safety to the public policy arena. This presentation will address fact versus fiction regarding the evidence of connections between violence and mental illness drawn from hallmark and current studies in the literature. Use of risk assessment tools coupled with prudent cultural competence for health care personnel to avoid bias and stigma, issues of public policy concern including safety and civil rights, and areas for further study will be presented.

Introduction

Advocating for care and safety on behalf of individuals and vulnerable populations is a familiar one for health care professionals. In its most basic form, advocacy provides a voice to those who cannot speak for themselves, including leadership to overcome barriers to care and safety. Advocacy can also mean addressing bias, misinformation, and myths on important issues. Such is the context for the information in this paper. Is there a connection between mental illness and acts of violence, especially where mass shootings or random acts of gun violence are concerned? What about acts of violence where health care workers such as clinicians become victims? Based on what is known about such connections, what information should be disseminated to patients, families, and communities about the connection between violence and mental illness?

Public Opinion and Public Policy

On June 10, 2014 a school shooting occurred at Reynolds High School in Oregon, USA. This incident prompted a response across social media including FaceBook and Twitter from the Mayors Against Illegal Guns coalition. This organization was founded in 2005 by then mayor New York Mayor Michael Bloomberg, and its purpose is to seek reforms regarding gun control. Public safety issues were again in the media. In the period from December 15, 2012 through February 10, 2014 (14 months) there were 44 school shootings, where 28 (64%) were on K-12 campuses and the remainder on University grounds. While the ages of many of the perpetrators were not known, it was established that in at least 20 incidents these were minors ("Mayors Against Illegal Guns," 2014). In the popular press, an article about the shootings that had taken place at Columbine; Virginia Tech; Tucson, Arizona and Aurora, Colorado indicated that while the weapons had been obtained legally, mental health issues such as paranoia, delusions and depression were "rampant" (Follman, 2012, pg. 1). The appeal for stricter gun laws and more mental health treatment continues to find support in the media and within public opinion. Is this type of coverage informative in terms guiding public policy and addressing public safety?

Given that media coverage of mass shootings often highlight the mental instability or mental health history of the perpetrator, the mythology of a clear connection between violence and mental illness continues (Sabella, 2014). Florida (2011) published data in a popular journal that examined correlations between firearm deaths and selected situational characteristics such as unemployment, mental illness or stress. Florida found a correlation with poverty of $r=.54$, but no correlation to other selected demographic data including that of mental illness. Keating published an informational article in *The Washington Post* (2013) intended to inform the public about homicides. Whites are five times as likely to commit suicide with a gun than be a victim of gun violence, while for every African American who uses a gun to commit suicide, five killings occur due to gun violence, thus bringing the topic of race into the public debate. Shem & Lindstrom (2014) stated that while individualized early intervention upon identification of risk for violent acts would be a welcome strategy, given the complexities of onset of mental illness, access to and obtaining care, as well as diagnostic evidence and predictive strength of risk factors of individuals who have no history of violence, there is little association that can be identified with any certainty.

Contrary to any firm evidence about predictive or preventative factors, the belief among the public at large persists that restricting access to guns or increasing access to mental health treatment are solutions and legislative remedies should be sought. Fisher & Lieberman (2013) argue that while there is evidence of violence in those with serious mental illness (such as schizophrenia, bipolar disorder and depression), only 3% to 5% of violent crimes would be accounted for by this association. Fisher & Lieberman correctly identify that the statistics for suicide among the mentally ill are far higher than that of homicides, and thus advocate for greater access to mental health treatment albeit for much different reasons than the outcry regarding public safety.

Implications for Policy and Safety

A position paper on the gun safety debate from The Bazelon Center for Mental Health Law (2013b) questions whether increased funding for mental health services is a reasonable solution for prevention of gun violence. The Center examined the relationships across states where funding is adequate for mental health services as well as for states that are grossly underfunded and found that there is no evidence that funding has any relationship to murders from handguns. Likewise, dispelling the myth that scarcity of psychiatric beds leads to greater incarceration rates (and therefore diminished access to appropriate care and criminalization of the mentally ill), there is no relationship between incarceration rates and availability of psychiatric beds (Bazelon, 2013a). Binder (1999) raised the issue that the popular and well-established myth of a connection between mental illness and violence perpetuates untoward stigma regarding individuals with mental illness, as well as continuing public pressure for involuntary commitment in relation to public safety. Public comments in the media, blogs, or other forms of advocacy for stricter gun control show that views of the public have not changed over time, although the connection between mental illness as a predictor of violence risk remains unsubstantiated (Harris & Lurigio, 2007). Binder's discussion of policy implications continues among psychiatrists who express similar concerns regarding public fear based on misinformation fed by media sensationalism (Freedman, Ross, Michaels, Applebaum et al., 2007; Fisher & Lieberman, 2013). It would be more reasonable, argues Fisher & Lieberman (2013), to promote gun control restrictions based on factors that do have evidence as risk factors among the public at large such as history of violence or substance abuse.

Notwithstanding that evidence shows no relationship between treatment or hospitalization as a predictor of violence, the civil rights of individuals who may have been diagnosed with a mental illness but who are successful in treatment may be compromised. Clinicians have been shown to overpredict violence in non-White patients and under-predict violence in women (Binder, 1999) so making determinations for involuntary treatment is not a wholly meaningful option on many levels. Fisher & Lieberman (2013) point out that while restricting access to guns may be a prudent public health measure, it is important to note that people with serious mental illnesses represent only about 5% of violent crime. Restrictions for those with mental illness would not address the remaining 95% of perpetrators who have no history of mental illness. Public pressure that focuses on alleged risk factors that are not borne out by research, such as treatment of mental illness (as defined by the public, which may in fact include disorders not classified as illness) to restrict access to firearms may actually deter individuals from seeking professional help rather than disclose a need for help.

What does the Research Say?

Many studies have been done over past decades, each seemingly an improvement on the last in terms of study design such as use of control groups and attempts at eliminating selection bias (Friedman, 2006; Harris & Lurigio, 2007). To date, some broad risk factors have been identified, but none specific enough to serve as predictors of risk of violence for individuals. In aggregate, presence of risk factors has been shown to compound in combination but presence of mental illness alone was not a substantive predictor of violent behavior.

Friedman (2006) notes that many of the studies over the years have focused on rates of violence based on inpatients with mental illness, examining data pre and post hospitalizations or incarcerations. It should be noted that the subjects were specific populations that are not necessarily representative of the population at large. Violence was usually defined as a fight engaging with someone other than one's spouse using a weapon where the incident came to blows (Freedman, 2006). Domestic violence was thus eliminated from the data. Early research (Pollock, 1938 and Cohen & Freeman, 1945, as cited in Harris & Lurigio, 2007) studied individuals after release from state hospitals and found the rate of violence to be less than that of the general population. Likewise, a study by Brill & Malzberg (1912, as cited in Harris & Lurigio, 2007) found that arrests post hospitalization could be predicted by arrests prior to hospitalization, but those who had no arrests prior showed rates post hospitalization that were lower than that of the general population. Binder (1999) found that patients who were hospitalized based on clinical judgment that they were a danger to themselves or others did demonstrate more violent behavior within 72-hours of hospitalization, but after three days of hospitalization these patients were undifferentiated from others with regard to risk. Binder concludes that this leveling is likely due to an effect of treatment rather than the diagnosis itself. Data from the MacArthur Violence Risk Assessment, a study that followed psychiatric patients from 1992 to 1995 to examine prevalence of violence in the community, has served to provide not only a large data set for further research but as a point of comparison for subsequent refinements in research methods. The study found a lifetime prevalence of 16% post-hospitalization for violence among patients with serious mental illness such as schizophrenia, major depression or bipolar disorder.

In a collaborative debate over the MacArthur Violence Risk Assessment Study, recent interpretations reveal that the high prevalence rate may have confounding factors (Torrey, Stanley, Monahan, Steadman and the

MacArthur Study Group (2008); subsequent studies have not found rates as high as in the MacArthur study. The comparison group was also representative of the community where the patients resided, an urban location where crime and poverty were disproportionate when compared to the city as a whole. These statistics from the 1990s should be viewed with caution for several reasons, including that of the subsequent development of antipsychotic medications for control of symptoms.

Information written for the public from the National Institute of Health ("Schizophrenia," 2014) indicates that most people with schizophrenia are not violent and are actually more likely than the general public to commit suicide. However, substance abuse compounds episodes where delusions of persecution are occurring and may lead to violent behavior. The co-occurring issue of substance abuse is mentioned as well by other sources (Binder, 1999; Stuart 2003; Lurigio & Harris, 2009; Torrey et al, 2008) including the observation that such violence is usually targeted towards self or family members rather than random acts aimed at the public at large. Impacts of substance abuse may result individuals becoming less likely to follow a treatment plan, illustrating how other factors may need to be taken into consideration when attempting to draw conclusions about direct associations between mental illness and violent acts.

Stuart (2003) found that a history of bullying or victimization may lead individuals with mental illness to react to provocation with acts of violence, citing a study by Hiday, Swartz, and Swanson (1999). Stuart notes that criminal acts of victimization perpetrated upon the mentally ill in their neighborhoods or at home is higher (8.2%) than in the general population (3.1%). Tools have been developed using an actuarial approach to violence risk appraisal such as the Violence Risk Appraisal Guide, the Historical / Clinical / Risk Management Tool, and the Iterative Classification Tree (ICT) with a data-based computerized component, the Classification of Violence Risk (COVR). In a discussion of these tools, Lurigio & Harris (2009) conclude that there is no single tool that has substantive predictive validity.

What are Salient Predictors or Correlations, if Any?

Link & Stueve (in Harris & Lurigio, 2007) refined the association between violence and mental illness and found that symptoms that involved feelings of personal threat were more likely to lead to violent behavior than diagnosis alone. Sabella (2014) agreed with Stuart (2003) and Lurigio & Harris (2009) that while mental illness has not been shown to be a cause of violence, there are risk factors that might compound risk and are therefore worth noting. According to Sabella, it is important to note any history of mental health issues (such as parental or school referral to counseling or psychiatric assessment) in conjunction with possible risk factors for violence such as being male and under 40 years of age, a history of violence and/or involvement with the juvenile justice system coupled with co-occurring substance use, access to weapons, a belief that thoughts and behaviors are being controlled or that one is being persecuted or threatened, or a diagnosed personality disorder. While many patients may present with some of these factors, it is the co-occurrence that leads to increased risk rather than any one factor taken independently.

Elbogen (2005) also agrees that personality disorders are one of the strongest factors in assessing risk, although he notes that there are detractors in the literature regarding this conclusion. Elbogen further states that although there may be abundant research on what factors or tools should be used to assess risk of violence, there is little research on how or when clinicians have utilized any tools as predictors in practice. Elbogen notes that the clinical usefulness of predictive tools lack empirical evidence in actual practice. In his own research with 135 mental health professionals regarding use of the Psychopathy Checklist (PCL) in public mental health settings, the most often considered factors were history of violence, medication noncompliance, substance abuse and poor anger control rather than tests (e.g.: the PCL) results. Lack of availability rather than disregard for PCL results may account for the reliance on clinical data rather than testing. Another possible explanation is that clinicians may have limited access to historical data needed to complete the PCL (Elbogen). One strong recommendation for community mental health professionals (Elbogen) is that the location of the clinical space, such as the office within a building, should be situated where help can be summoned easily; this is an anecdotal comment but worth heeding.

Recommendations and Areas for Further Research

A consistent definition of violence as well as a consistent definition of mental illness is needed for comparative studies or replication of studies to take place. Ways to identify individuals who have not received treatment for mental illness and who are outside an established mental health system may be problematic but would be extremely helpful in assessing potential risk. Assessment tools for use with adolescents and young adults without history of onset of symptoms is another area deserving of research. Teaching tools to identify changes in behavior of loved ones with mental illness to be used by lay individuals such as family members, neighbors, teachers, school counselors, co-workers and any other interested parties should be developed and disseminated to identify known risk factors. Informing voters on policy issues might be done by professional organizations to separate myth from evidence on pertinent issues.

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Learning objectives

Participants will...

1. become acquainted with study findings from psychiatry, forensics, social sciences and health care literature on violence and mental illness.
2. learn of evidence-based information to further initiatives for policy and safety.

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Integrative whole organisation approaches to workplace violence: The effective alternative to zero tolerance?

Workshop

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Perspective: Education and Training

The rejection of Zero Tolerance based strategies in services supporting people experiencing mental health issues and intellectual disabilities in favour of 'whole organisation approaches' has long been advocated (Paterson & Leadbetter, 1999) but only recently endorsed by a number of authoritative bodies including the British Institute of Learning Disabilities (BILD, 2014) in the UK. However, there is a danger that services in seeking to reject the paradigm of Zero Tolerance whose suggested solutions are uni-dimensional and potentially even harmful (Paterson et al 2008) in favour of whole organisation approaches may underestimate the implications of adopting a perspective whose realisation may require profound cultural and structural changes across the organisation (Paterson, Leadbetter & McKenna, 2008).

It has been known for more than 50 years that there is a relationship between staff behaviour, organisational culture, the frequency of violence towards staff and the use of coercive interventions, such as physical restraints (Stanton & Schwartz, 1954). This relationship may be highly significant with the behaviour and characteristics of service users poorer predictors in some studies of rates of violence to staff and restraint use than key aspects of service cultures including the beliefs of staff.

Violence and coercive intervention, happen not in isolation but rather in the context of interpersonal relationships within the broader context of organizational culture and organizational philosophy. The primary prevention of violence requires, therefore, that attention be paid to agency culture and its effect on workplace climate because violence can only be fully understood and therefore prevented when it is seen as an intrinsic part of agency culture and processes.

Central to the effective delivery of therapeutic care is the development and application of a model that comprehensively and cogently explains the potential impacts of exposure to neglect, abuse and violence upon service users and its implications across their lives. Given the significance of the role played by the organisation the model must however also explain the potentially negative impacts of exposure to violence upon the individual worker, the team and the wider organisation in order that the processes involved can be recognised and overtly managed. These processes are so powerful that a failure to understand them will result in the failure of efforts at service transformation and may lead to the development of the corrupted cultures so often observed in services supporting individuals with challenging behaviour (Paterson et al. 2013).

CALM training services have developed an integrative practice model that synthesises elements of Positive Behaviour Support, Attachment and Trauma and subsumes this model within a public health based approach to violence in order to inform

- Collaborative work with service users
- The training and clinical supervision of direct care staff
- The training and clinical supervision of helping teams
- The development of emotional literacy across for whole organisation.

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Workshop programme

This workshop will introduce the CALM integrative model, discuss its application via a series of case studies and provide structured opportunities for discussion and reflection upon the implications and challenges involved in adopting and sustaining a whole organisation approach in services in general and the CALM model in particular.

Learning objectives

Participants will...

1. understand the role played by framing in how approaches to workplace violence are selected.
2. understand how whole organisation approaches differ from Zero Tolerance based approaches.
3. recognise the central role played by the care model in violence prevention.
4. understand core elements of the CALM model.

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Workplace violence prevention and leadership engagement: The collaboration between a large community hospital and union

Paper

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Perspective: Organisational

Keywords: Leadership, engagement, collaboration

Abstract

The false belief that violence against healthcare workers is the norm leaves thousands of workers at risk each year. In 2012, 31% of lost time due to workplace violence or client aggression occurred in the healthcare sector, representing the highest amount of lost time across all schedule 1-employment sectors in Ontario. Within the healthcare sector, one third of workplace violence injuries occurred in hospitals (WSIB, 2012). Executives have a responsibility to protect their staff, and to develop, implement, and enforce workplace violence prevention (WVP) initiatives in their organizations. These initiatives are driven by the commitment of leaders to create a culture of recognizing, addressing, and preventing violence in the workplace. This article outlines the journey of Toronto East General Hospital as it became a champion of WVP in the healthcare industry. Their collaborative approach involved innovative interventions, strong leadership engagement, and partnerships with staff, unions, and the Joint Health and Safety Committee. Significant improvements in staff engagement, a reduction in the frequency and severity of incidents, and a positive shift in the culture around WVP have all been demonstrated.

Introduction

There is a common misconception within the healthcare industry that violence against healthcare workers is the acceptable norm and should simply be tolerated. This assumption leaves thousands of workers at risk each year. The prevalence of workplace violence in the healthcare sector has remained steady in Ontario. The healthcare industry consistently has the highest amount of lost time due to workplace violence or client aggression across all schedule 1-employment sectors in Ontario, representing 34% of incidents in 2006 (OSACH, 2007) and 31% in 2012 (WSIB, 2012). Within the healthcare sector, more than one third of these injuries took place in hospitals, representing 32% of injuries in 2006 (OSACH, 2007) and 33% in 2012 (WSIB 2012). Surveys collected by the Ontario Nurses' Association (ONA) in 2009 indicate that fifty-four per cent of ONA members say they have experienced physical violence or abuse in the workplace; 85% of members say they have experienced verbal abuse in the workplace, 39% report other forms of violence/abuse, and 19% say they have experienced sexual violence or abuse in the workplace (ONA, 2012).

A multitude of negative impacts are realized as a result of workplace violence, affecting both staff and the organization. At the organizational level, higher staff turnover rates and higher rates of illness, injury, and absenteeism are all experienced as a result of workplace violence. Increased costs are also incurred in the form of short- and long-term disability claims, as well as Workplace Safety and Insurance Board (WSIB) and Employee Assistance Program (EAP) costs. As well, workplace violence has a negative effect on staff commitment and productivity, and an adverse effect on organizational image and reputation. Furthermore, research has shown a clear link between employee safety and patient care outcomes. Studies suggest that employee health and well-being is related to the quality of services provided (Lundstrom, Pugliese, Bartley, Cox & Guither, 2002; Yassi & Hancock, 2005), and that positive work environments enhance patient safety outcomes (Kirwan, Matthews & Scott, 2013).

At Toronto East General Hospital (TEGH), the journey to becoming a leader in workplace violence prevention (WVP) began in 2006, when workplace violence statistics in the organization came to the attention of the senior leadership team. TEGH, a large community teaching hospital serving South-East Toronto, has a unique and challenging patient demographic that includes populations with low incomes and low levels of education, as well as a high number of new Canadians (Murphy et al., 2012). The hospital's catchment area includes neighbourhoods with high occurrences of physical assaults, break-and-enters, drug charges, thefts over \$5,000, and murders, compared to all neighbourhoods across Toronto (Friesen, Rajagopalan & Strashin, 2011). In 2006, the Hospital had 1,136 incidents of code whites, criminal offences, threats, thefts, and disturbances, including incidents involving weapons, police, and the management of aggressive and violent behaviour. In 2007, over 40 weapons were seized by security. A clear need was identified to address the growing threat of violence in the organization. This article outlines TEGH's journey, its partnerships with ONA and the Joint Health and Safety Committee (JHSC), the successes and challenges of its initiatives, and the importance of leadership engagement to bring about cultural change.

Interventions

While most organizations focus on one area of improvement to combat workplace violence, TEGH developed a comprehensive program that addresses a multitude of factors contributing to potential violence across the hospital. Both the commitment and involvement of the senior leadership team, as well as collaboration with ONA and other unions, were key drivers of the organization-wide shift in the culture around workplace violence. By taking the safety of the entire organization into account, TEGH was able to leverage the strengths of different areas of the hospital and ensure that the initiatives it implemented were consistent across the organization.

Strategic Partnerships

For the leadership team at TEGH, tackling violence in the workplace involved more than resolving the issue at a local level and complying to set standards – the intention was for TEGH to become a leader in WVP and a champion across the healthcare sector. To facilitate this goal, TEGH identified labour unions as key stakeholders and leveraged their expertise in the area of WVP. ONA especially was willing to support this initiative, and a partnership was created between ONA and TEGH that centered on knowledge transfer and sharing of best practices. To reiterate the importance of WVP across the province, a joint letter written by the CEO of TEGH and the provincial president of ONA was sent to the Minister of Health and Long-Term Care advocating that WVP should be made a component of CEO accountability and a priority for the Local Health Integration Networks (LHINs).

Workplace Violence Prevention Committee and Policies

The first step towards creating a safer work environment was engaging internal and external WVP stakeholders. To gather expertise and recommendations from these stakeholders, the Workplace Violence Prevention Committee (WVPC) was formed, and included the CEO, leaders from ONA, union leaders, staff, management, and JHSC representatives (representing workers from OPSEU, SEIU, and ONA, as well as non-unionized workers). With input from these key stakeholders, the WVPC developed policy measures and procedures to clearly outline TEGH's position with respect to WVP. These policies included provisions against not only physical violence, but also against psychological and emotional threats, which are often over-looked but should be held to the same standard as physical attacks.



Zero Tolerance Signs

To make its workplace violence policy clear to all parties, TEGH developed and posted Zero Tolerance Signs to clearly state the organization's commitment to creating a culture of safety. These signs use bright colours and plain language to ensure that everyone who enters the hospital - including staff, volunteers, patients, and visitors – is familiar with the definition of workplace violence and their individual responsibilities for preventive and corrective action.

Initially, concerns arose that patients and visitors may take offense to the sign's strong wording; however, the Hospital held the position that protecting staff takes precedence over the possibility of offending patients and visitors. These signs were also a public acknowledgement by the Hospital that violence exists in the organization and would not be tolerated, which was a significant step towards combatting the assumption that violence in healthcare is an accepted part of the job.

Risk Assessments

An important component of preventing violence is to proactively identify potential risks across the hospital. Early in the WVP program, external consultants were brought in to conduct an external safety review, in collaboration with members of the WVP Committee. This review identified the Emergency Department (ED) and Mental Health as areas with a high risk for potential violence. Risk assessments in these departments identified numerous process improvements, including better use of name badges, changes to physical space, door security and key control, and an updated security guard role and positioning.

A key component of these risk assessments unique to TEGH is the circulation of a pre-assessment violence awareness survey to front-line staff prior to the assessment. These surveys allow the individuals conducting the assessment to receive feedback regarding staff perceptions of safety in the workplace. The unit manager assists in conducting the assessment and is responsible for presenting an action plan to the WVPC following the assessment to present the resulting short and long-term goals. A copy of the action plan is also sent to the JHSC for review. Recommendations based on the physical environment are included in the assessment, but risks from patient behaviour, acuity, and population are also considered and addressed through the assessment. Risk assessments have become a common practice at TEGH, and are completed regularly on each unit and in each department.

Communication Devices

An innovative approach was taken to protecting worker safety with the introduction of Vocera, a voice-activated communication system implemented hospital-wide. The personal alarm provides two-way communication with all security agents and has reduced code white response time by 60% since its implementation.

Patient Flagging

TEGH was one of the first hospitals to implement a comprehensive patient flagging policy as part of its WVP program. To flag a patient, nursing staff place a blue hospital armband on violent or potentially violent patients and affix a Stop sign to the patient's door to warn the next nurse or caregiver to take precaution. Although this initiative initially faced resistance from front-line staff significant emphasis was placed on change management and conveying a clear message that flagging patients is not meant to carry a negative connotation; rather, it allows a comprehensive individualized care plan to be developed for each patient so that necessary precautions can be taken to avoid incidents or minimize their severity.

Incident Reporting Software

To better capture incidents, TEGH implemented an advanced incident reporting system which helped drive management accountability by accurately recording violence statistics, flagging violent persons, facilitating prevention action planning, and tracking incident history throughout the organization.

Staff Training

Staff education of WVP was vital to changing the culture and helping staff understand the importance of violence prevention, reporting, and investigation. The training program includes both on-line and in-person sessions incorporating practical workshops to teach trigger recognition, non-physical de-escalation techniques, self-defense, and emotional intelligence training to facilitate early recognition of personal triggers.

Security Measures

TEGH has placed a strong emphasis on strengthening security measures across the organization. As an example, an increase in security cameras from 32 to 210 between 2003 and 2008 led to decreased police involvement and physical interventions.

Personal Support

When incidents do occur, the leadership team provides comprehensive support, debriefing with the staff involved, facilitating follow-ups from OHS, and ensuring that on-site crisis counselors are made available. Uniquely, TEGH leadership demonstrates their commitment by initiating a follow up phone call to anyone who experiences an incident of violence. Support from the executive team assures individuals that the incident has been acknowledged and that steps will be taken to prevent this type of incident from occurring again. It also allows the executive team to reiterate their commitment to WVP, and staff are given the opportunity to provide feedback regarding opportunities for improvement.

The Importance of Leadership Engagement

The success of TEGH's WVP program would not have been possible without the engagement of the senior leadership team and key labour union leaders. The presence of hospital leadership on the WVPC and during the

intervention process was crucial to driving cultural change and demonstrating the organization’s commitment to protecting the safety of its staff. Support from ONA’s president was especially influential, and the joint communication from TEGH and ONA sent a strong message to the healthcare sector that staff safety should be a priority for leaders.

Several recommendations for engaging leadership can be taken from TEGH’s journey. First, leaders should be familiar with their responsibilities under OHSA and WVP policies, measures, and procedures. Executives have a legal and moral responsibility to protect the safety of their staff. Reducing violence and working to strengthen safety is the right thing to do, and it is this attitude that will drive a cultural shift towards safety across the organization.

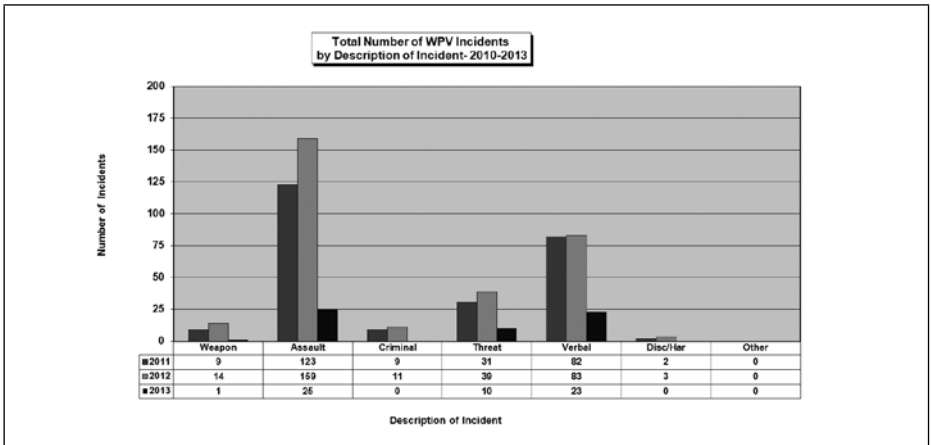
Second, leadership should also be aware of violence statistics within their organization. In some cases, a graphic approach may be required to ensure that senior leaders are informed of the incidents that occur across their organizations. Third, the use of quantitative measurements to frame the issue from a value proposition perspective (for example, in terms of lost time saved) may be beneficial to aid in bringing executives on board. As well, it is important to highlight that violence prevention is not only beneficial for protecting staff, but it will also have a positive effect on patient safety and care.

Finally, ensure that leaders are present at all levels of the program. At TEGH, directors and senior leaders sit on the WVPC and the JHSC, receive reports about incidents that occur across the organization, remain engaged in risk assessments, and debrief and follow up with recommendations when an incident occurs. With guidance from leadership, staff can be challenged to embrace a culture of safety in the workplace. In TEGH’s case, leadership behaviour around WVP permitted staff to challenge the historic acceptance of violence in the healthcare sector, and allowed them to begin thinking differently about WVP and its importance not only to their own safety, but the safety of their patients, as well.

Outcomes

The interventions outlined above resulted in several positive outcomes for TEGH, including an increase in staff satisfaction, a decrease in the frequency and severity of incidents, a change in the culture around workplace violence prevention, and an unexpected financial impact. The 2013 results of a staff engagement survey from National Research Corporation (NRC) Canada show that 71% of TEGH’s staff is satisfied with the organization’s commitment to workplace safety and 63% of staff feel that systems are good at preventing incidents from happening. These scores are well above the average for participating hospitals in Ontario.

Figure 1: Total Number of WPV Incidents by Description of Incident - 2010 - 2013



In 2007, 207 workplace violence incidents were reported at TEGH; by 2008, only 128 incidents were reported. A decrease in incidents was observed for disturbances, criminal offences, and apprehensions, while a slight increase is apparent for patient interaction calls and code whites. This increase is attributed to enhanced incident reporting as a result of violence prevention procedures becoming part of the TEGH culture. The severity of incidents has also decreased; near misses and hazards have become more prevalent since the interventions began, followed by incidents requiring first aid and medical treatment. Since 2011, incidents involving weapons have decreased by 88%; incidents involving assault have decreased by 80%; verbal incidents have decreased by 72%; threats have decreased by 68%; and criminal offenses have decreased by 100%.

Although TEGH has come a long way since 2006, the Hospital, along with ONA, continues to identify and address areas for improvement. TEGH's experience demonstrates that WVP begins at the leadership level, and is best addressed with a collaborative approach to enrich the program, create a culture of knowledge sharing, and promote a strong commitment to worker safety across the healthcare industry.

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Learning objectives

Participants will...

1. Realize that engaged leadership is a key component of implementing successful workplace violence prevention programs.
2. Learn that collaboration with organizations with expertise in the area workplace violence prevention, such as labour unions, will enrich workplace violence prevention programs.

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Men, depression and violence in health and community care services

Paper

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Perspective: Practice

Keywords: Men, depression, masked, violence, sheds, Australia

Introduction

This presentation examines the contentious concept of ‘masked’ or hidden male depression and its links with aggression and violence. It then shows how life transitions for men may trigger depression and the associated hostility and aggression. Key therapeutic, legal and social support strategies that are commonly used with such depressed and angry men are outlined. The presentation critiques aspects of these approaches and offers effective options for alternative services and programs. It concludes with suggestions for those working with men to enable them to ‘walk’ with them through some of these transitions and help these males regain a sense of meaning, direction and purpose by co-creating men friendly places and services.

Body of the Presentation

Much of the overt workplace violence that health care staff experience is perpetrated by male service users. Such expressions of anger and violence may in turn trigger a variety of responses by individual staff and health and community care organisations. Such responses may include refusal or restriction of services, mandated admission to psychiatric services, medication, restraint or involvement of the police and justice systems.

However what is not fully recognised is that this service user anger and violence may in fact sometimes be triggered by undiagnosed, ‘hidden’ or ‘masked’ underlying depression. Brownhill (2005) calls this progression from depression to anger and suicide ‘The Big Build.’ This may progress through five stages as men try to cope with the depression and anger, which may include: 1. Avoiding it, 2. Numbing it, 3. Escaping it, 4. Hating me/ Hurting you and 5. Stepping over the line. In some situations this underlying depression may be a contributing factor to domestic violence in the extreme form of homicide followed by suicide, or ‘death by cop’ in stages four and five of the Big Build.

Addis (2008) notes that the “masked depression framework assumes that many men who present with problems other than depression are actually experiencing an underlying depression that is transformed into other more externalizing symptoms due to proscriptive gender norms.” (p.154). However this concept of masked or hidden depression is a controversial topic that is not readily or equally accepted across the mental health field. To date there is little direct empirical evidence to support this concept per se of men having major depression but being hidden in some way. However Addis and others (Brownhill, 2005; Rabinowitz & Cochran, 2008; Winkler et al, 2005) would claim that there is a range of indirect, observational evidence to support this idea.

Danielson & Johansson (2005), in their study on gender and depression, comment “[w]omen described feelings of overwhelming fatigue ...” while “[m]ost men ... defined their mood as displaying short temper and aggressiveness.” (p.175). They go on to note that they saw a tendency for women to express guilt, something that can more easily be apologized for and repaired while men seem to feel more shame and loss of face in which they may seek suicide as a solution.

Johnson et al (2012) note “The ways in which men embody depression in their everyday lives (such as anger, isolation and autonomy around self management practices, and risky self-care practices such as alcohol and drug use) may lead to symptoms of depression being interpreted as expressions of masculine ideals” (p. 345). Furthermore Ridge et al (2011) note “... some commentators argue that psychiatric classification systems like the Diagnostic and Statistical Manual lead professionals to bias in overlooking expressions of distress among men (e.g. with presentations of hostility, substance use, blaming others) in favour of female presentations (e.g. feelings of guilt and unworthiness). p. 151

In some cases men will willingly seek out appropriate formal and informal help while others will be forced or mandated to do so by the police or mental health services. From my observations as a men’s services coordinator and previous patient advocate in the New South Wales mental health system in Australia, many men experience mainstream health and welfare services as foreign, women and children focused, not men friendly and sometimes humiliating. This can lead to men appearing to be ‘non-compliant’ and uncommunicative as they express frustration and anger while using such services. In these circumstances men soon leave or behave in

ways that has them 'controlled' or ejected. Responses to such violence sometimes leads to 'collateral' damage to the service user, health staff, bystanders and others.

The underlying premise in this paper is that some men depressed by major life transitions may express aspects of this state in irritation, aggression and sometimes violence against themselves or others. Often the aggression and violence is the primary target of health, welfare and judicial responses but not the underlying depressive state itself.

Males in contact with the health and community services are often going through challenging and disorientating planned or un-planned life transitions and may lack a sense of belonging and purpose. Some of these changes include relationship breakdowns, job change or loss and financial difficulties, leaving the military, becoming a carer, ageing and ill health. Oliffe et al (2011) suggest that the death or divorce of a spouse, lost social bonds and related support, declining health and physical limitations as well as financial issues can all be associated with depression in men. Many men are not equipped with the skills or support networks to identify what is happening, express and work through it and when appropriate seek outside help to do so. Such bewildering transitions may trigger depression and anxiety that is sometimes expressed in anger and violence against themselves, others or health workers.

So how should the health and community services respond in the light of this still contested issue of hidden or masked depression sometimes expressing itself in a continuum of aggression from irritation to full blown violence? Firstly, it is crucial to ensure the safety of all those involved. Secondly, we should investigate further and identify what may be the unique or hidden markers of depression in men. Thirdly, we need to develop more men friendly approaches to professional therapy and service delivery. And fourthly, we must find more effective ways for those working with men who are in in-patient and non-institutional settings to 'walk' with them through some of these transitions. This may enable them to regain a sense of meaning, direction and purpose by co-creating men friendly places and services.

As previously indicated any men who come into contact, voluntarily or involuntarily, with health and social services are going through major life changes and life transitions triggered by loss of key supports or resources. What many of these men need is a non-clinical setting where they can gain or regain a sense of control, purpose and direction. Raphael et al (1999) call these the three Bs; Being, Belonging and Becoming. In order to thrive people need a sense of well – being, physically, psychologically and spiritually. They also need a sense of belonging in a physical, social and community context. Finally they need a sense of becoming, that is, ways that help them meet their personal aspirations and foster hope.

Oldenburg (1989) calls these physical and emotional locations where people can experience being, belonging and becoming 'Third Places'. He defines these third places as "public places that host the regular, voluntary, informal and happily anticipated gatherings of individuals beyond the realms of home and work". (p.16) Such informal, voluntary, low cost, easily accessible welcoming spaces seem to be diminishing in much of the Western world, especially for men. However in Australia there has been some successful attempts to create such Third Places for men.

In Australia, the Men's Shed Movement has been an attempt to create viable 'third places' relevant to a wide range of men's needs. Over the last 20 years the number of 'sheds' have expanded from a handful to having one in most major cities and larger towns both urban and rural. Though originally aimed at older men, and this is still their primary membership, they also include younger men and children who can be mentored by the older more experienced men. The focus of the sheds is activity based manual activities around small projects such as restoring furniture, metal work or making children's toys for charities. In some sheds at risk young people, ex prisoners, people with disabilities and school children are encouraged to participate in these activities. This activity focus gives the participants opportunity to mix with and make friends of other participants thus supplying much needed support and direction for those who may be going through challenging life transitions. More recently the Men's Shed Movement has gone on line (www.theshedonline.org.au) providing access to many of the support and information aspects of sheds. Such approaches have proved successful first in Australia and are now developing in the UK, Ireland, parts of Europe and North America.

Recent research (Flood & Blair 2013 pp 2-6) on the health benefits of belonging to a men's shed had the following findings. "Finding # 1. For many, Shed membership comes about following a significant life change; Finding # 2. Men's Sheds are ideally placed to reach some priority populations for health intervention; Finding # 3. There are clear health benefits associated with Men's Sheds, particularly when compared with less socially active men; Finding # 4. Awareness of mental health issues like depression and anxiety is improved through Shed membership." Though not designed as mental health facilities the third place that these men's sheds supply have been shown to have positive mental health benefits especially in the areas of depression and anxiety. Also with the link posited above between depression, aggression and violence it could be expected that such places would also in some instances have a positive impact on lowering the related aggressiveness.

In Australia, alongside of the men's sheds a wider range of support services for men has been developing. These include men's drop in centres, recreational services, education and volunteering programs, job finding services as well as men friendly health and counseling services. Currently these services are fewer, are less integrated

and not as comprehensive as the men's shed movement. It is my 'vision' that future men's services will combine the best aspects of mainstream and community based services that incorporate the 'third place' concept. Such a comprehensive approach could be delivered through men's hubs that enable them to get the appropriate men friendly services they need while also being able to give back to their new friends and the wider community. I have a dream ...'

Conclusion

By understanding the acting out behaviour of some men with depression it is possible to engage such males more successfully with health and community based services. With the development of 'men friendly' places we can help diminish the 'collateral' damage to service users, staff, bystanders and others as a result of working with depressed and angry men. Men's services based around Third Place principles can help provide an environment in which men can feel more comfortable and receive the services and support most useful to them. Thus institutional and community based services in cooperation with these new more informal place based approaches can help improve the being, belonging and becoming of men in transition.

Acknowledgements

Thank you to the many men and women who journeyed with me through my growing understanding of The Big Build' and ways to recognize and manage it.

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Learning objectives

Participants will...

1. acquire knowledge into how health professionals understand the various life transitions that may lead to men becoming depressed and acting out in aggressive and violent ways.
2. realise how such behaviour may be understood and minimized by developing 'men friendly' programs and services.

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Coping with domestic violence against children and adolescents: the nurse's perspective in primary health care

Poster

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Perspective: Research

Background and context

Domestic violence has been consolidated in academic and communication means as a publicly and socially relevant problem. Care delivery to child and adolescent victims of domestic violence has been an increasing challenge for nursing professionals, who find themselves confronted with the difficulties deriving from their professional background and the need to play an increasingly active role in communication with society and in social problems.

Objective

To analyze the actions nurses report in the fight against domestic violence against children and adolescents and their families from a Primary Healthcare perspective.

Methodology

Qualitative study with a social strategic research design. Five semi-structured interviews were held with nurses working at the five Family Health services in the Western district of Ribeirão Preto - São Paulo, Brazil. The data were analyzed by means of thematic content analysis.

Findings

Two themes were evidenced: I- public policies identified by the nurses, II- Actions of the nurses in view of the violence permeated by fears and conflicts.

In the first theme, we identified that most of the nursing professionals are unprepared and uninformed about the public policies to protect children and adolescents. Consequently, they do not notify suspect or confirmed cases of domestic violence.

The second theme shows the nurses' difficulties to cope with domestic violence, ranging from the training process to their activities, highlighting these professionals' fear, insecurity and lack of preparation to address the phenomenon. In one interview, drug traffic was mentioned in the protection of domestic violence victims, which showed that protective means have failed to act.

Implications

The professionals' fear and lack of training to execute actions against domestic violence, such as prevention, notification, forwarding and monitoring of the victims, are factors that hamper the fight against the violence committed against children and adolescents. There is an urgent need to train the nurses in order to further the knowledge about public policies to protect victims of domestic violence and provide support for the safety of these professionals' practice.

Learning objectives

Participants will...

1. Primary Health Care nurses need to be trained to identify public policies to protect victims of domestic violence.
2. Primary Health Care nurses need to be trained to execute actions against domestic violence, such as prevention, notification, forwarding and monitoring of the victims.

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Bad apples of bad barrels? Sense making in the management of violence and the reduction of restrictive practices

Workshop

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Perspective: Organisational

The last two decades have seen rising awareness of the problem of violence to health care workers with research suggesting mental health nurses may be amongst those most at risk (Elston et al. 2006). This has led to demands for action to protect staff from violence and resulted in a series of international and national policy initiatives many grounded in notions of 'Zero Tolerance' of violence towards staff (Paterson et al. 2008). However, over almost the same time period we have also seen the emergence of a new restraint reduction movement culminating in recent demands by the United Nations (UN) Committee for the Prevention of Torture and Inhumane Treatment to eliminate the use of restrictive practices particularly restraint and seclusion from services for people with mental health needs (Mendez 2013).

Given that restraint and seclusion are justified in part by their necessity in order to maintain safe environments these initiatives may appear to represent very different frames. In the Zero Tolerance frame the fundamental problem is of violence by the 'bad' patient directed towards the nurse or other worker. Such violence cannot be tolerated and any patient who wilfully chooses to behave violently towards a practitioner must be criminalised and severely punished if only in order to discourage others (Leadbetter et al. 2005). The injustice of violence against the innocent and vulnerable health care worker is unacceptable and policy makers must therefore act (Paterson et al. 2008).

The concept of 'Zero Tolerance' originates in the US (Sughrue 2003: 240) and an article by Wilson and Kelling (1982) in *Atlantic Monthly* whose focus was on crime reduction in the community. Its later adoption or at least the language associated with it by the New York Police Department became synonymous with a drop in recorded crime although the causal association is disputed (Sampson 1997). The popularity of the approach or at least the language associated with it, whether with members of the public or policy makers across a remarkably diverse range of social issues may though be due to more than simply those New York associations (Gabe and Elston 2008). Snow and Benford (1988) observe that in order for a given construction of a phenomena to be successful it must resonate with the sentiments of the population concerned by chiming with their pre-existing beliefs. Research into the explanations for the violent acts of service users by nurses in mental health has suggested a tendency by mental health nurses to stress aspects of the service users personality or illness (Duxbury 2002). However, service user's explanations for violence in contrast stress the situational dimensions particularly responses to unreasonable controlling behaviour by staff (Hinsby and Baker 2004). The apparent preponderance of individualistic explanations by nursing staff for service users' violence in studies means that the explanation for violence central Zero Tolerance chimed with and perhaps even reinforced what many nurses thought were the main reasons for violence (Duxbury 2002). More worryingly perhaps it may also have chimed with how many felt towards the perpetrators (Paterson et al. 2009).

Mental health practitioners repeatedly exposed to violence may respond with coping strategies characterised by avoidance or counter aggression (Maier 1999). These reflect the emotions of fear and/or anger that may be produced by exposure to violence (Colson et al. 1986). Where the dominant emotional response is of counter aggression their desire for punishment of the service users is legitimated by the rhetoric of Zero Tolerance. Such factors may explain its rapidity of its adoption firstly in the UK and then in multiple countries around the world. This was despite a lack of evidence as to its effectiveness in the UK (Paterson et al. 2007). The national health service in England actually dropped Zero Tolerance as an inappropriate response to violence in mental health services in 2004 (McMillan 2005).

As noted however we have also seen the emergence or more accurately given its historical antecedents the re-emergence of a restraint reduction movement.

Concerns over the potential for physical injury (Paterson et al. 2003), psychological trauma (Frueh et al. 2005) and multiple examples of misuse have led to demands that the use of restrictive interventions be reduced. Such calls have recently reached their Zenith in the recent report by the rapporteur of the UN Committee for the Prevention of Torture and Inhumane and Degrading Treatment (Mendez 2013). This calls not just for the reduction of restrictive interventions but the total elimination of their use.

The UN initiative may seem the polar opposite of Zero Tolerance. In this frame health care workers whose actions have been justified by the discourse of psychiatry and its legitimisation of coercive interventions under the guise of medical necessity become not the victims but the abusers whose persistent misuse of restrictive

interventions should no longer be justifiable under the guise of treatment (Mendez 2013). Coercive interventions regardless of the form they take in this frame represent a form of violence. Such violence ‘precludes therapy and the use of restraint (and seclusion) often constitutes violence’ (Fisher 2003:70). In this frame in order to protect the innocent and vulnerable patient “It is essential that an absolute ban on all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, should apply in all places of deprivation of liberty, including in psychiatric and social care institutions” (Mendez 2013:15).

The attractiveness of these seemingly opposing frames however also stem from the nature of the frame they use to construct the problem whether of violence to staff or the misuse of restraint by staff. Gamson (1992) argued that three kinds of issue frames delineate how problems may be represented. What he terms ‘Aggregate’ frames effectively define putative issues as ‘social problems’ but the burden of responsibility for action to resolve the issue is placed with individuals. ‘Consensus’ frames, in contrast, whilst also defining an issue as a social problem, represent it as one that can be solved only by collective action but leave unspecified who should actually act. ‘Collective action’ frames differ in three key respects from aggregate or consensus action. Firstly, they define the problem as one, which is intrinsically ‘unjust’. Secondly, ‘agency’ i.e. responsibility for the problem is placed with an identifiable actor. Thirdly, and perhaps crucially, the frame establishes an adversarial relationship between ‘us’ in terms of identity as members of the in group and ‘the other’ i.e. whomsoever the imputation suggests is responsible for the problem (Gamson 1992).

In the Zero Tolerance frame the ‘other’ is the ‘bad’ patient. In the UN frame the ‘other’ is the ‘bad’ mental health practitioner. Such views may seem absolutely irreconcilable but they actually share a common element in their focus on ‘the bad apple’ whether the bad patient or the bad nurse that focuses action at the level of the individual. Both therefore share what has been described as the fundamental attribution error in their focus on the decision making and character of the individual as the primary causal factor (Heider 1958). This error typically leads to the exclusion of consideration of influences arising from wider cultural factors whether in the immediate or wider social environment.

Alternative systemic whole organisation (Mckenna and Paterson 2008) approaches to both problems are however based upon the public health model with its emphasis on primary, secondary and tertiary prevention (Sethie et al. 2004). These start from the premise that what we are dealing with is almost invariably a ‘bad barrel’ in the form of a bad organisation or at least one that is not operating at an optimal level (Paterson and Miller 2005). An emphasis is placed on coordinated administrative and clinical interventions based on systematic root cause analysis. Deep change requiring the adoption of alternative care models is often advocated to address what may be unrecognised corrupted cultures (Paterson et al 2013). Specific interventions include strengths based care (Lebel et al. 2004), trauma informed care (Jennings 2004, Murphy Bennington-David 2005) and six core interventions based on trauma informed care (Hucksthorn 2005).

Inpatient mental health settings can trigger fear and negative reactions among individuals with trauma histories sometimes linked to previous incidents of restraint or seclusion (Bonner 2002). In a trauma-informed care system, critical information from individuals’ trauma history is used to develop an individual support plan (including a safety plan for crisis) to enhance emotional self-regulation and enable the staff to respond individually during times of stress without recourse the use of restrictive interventions (Bloom 1997).

What has consistently emerged in the context of research into such systemic transformative initiatives has been evidence that suggests that these approaches are capable of reducing restrictive interventions (Smith et al. 2005). This is significant given long standing recognition that restraint is an intrinsically high risk activity for both patients and staff (Stark and Paterson 1994). However, many studies have also found significant reductions in assaults upon staff are associated with such interventions (Jonikas, et al. 2004). Such approaches must therefore be seen as a critical element of state of the art practice in reducing violence in mental health service whether this takes the form of violence to staff or staff recourse to violence in the form of restrictive interventions (Bowen et al 2011).

In the bad organisation frame both violence to health care workers and violence by health care workers in the form of the misuse of restraint and seclusion are seen as arising from the interactions between individuals operating within complex social systems whose dysfunction provides the sources of the conflicts and the frustration that may give rise to violence in whatever form. In this frame neither the problem of violence to the worker or excessive use of restraint are defined as injustices but as failures by organisations to adequately understand and address their root causes. Restraint is a treatment failure. Pathology in terms of the origins of violence is seen as potentially residing in the staff involved, the organisation, the perpetrator, the pattern of their interactions, which are collectively co-created and even aspects wider societal culture (Bowie 2011). As an approach to violence prevention it asks what ‘kind of human environments we are creating in our workplaces’ (Braverman 1999:4).

Conclusion

Mental health service users enter mental health services in acute distress often frightened and angry sometimes acutely fearful based on their previous experience of restraint What they find on admission though, is not

necessarily an environment that offers temporary sanctuary alongside skilled individualised evidence based treatment. Instead as Bloom (1997:10) observes their experience may be of 'rigid rules, humiliating procedures, conflicting and often disempowering methods, and inconsistent, confusing and judgmental explanatory systems'. Such practice is the result of an agenda of control by means of violence, which does not acknowledge or explicitly promote self-exploration, accountability and personal growth and development in either staff or service users. The underlying frame may ultimately be a very old one, violence in the form of restraint is a form of treatment because those who indulge in madness must be punished back to sanity (Bloom 1997). This is a perversion of any contemporary understanding of the therapeutic ideal and does not work. Violence simply begets violence.

Banning all forms of coercion however tempting in the light of multiple exposes of bad practice ignores the very real risks that mental health practitioners may face. Moreover it removes the option for coercion that may be a necessary last resort in some instances to prevent individuals who extreme crisis may have lost insight into their behaviour from harming themselves or others. The severely depressed and suicidal young mother whose actions may take not only her own life but those of her children, the young university student suffering from drug induced psychosis who threatens those who he falsely believes intend him mortal harm, the military veteran with PTSD who thinks that her symptoms means her life is over may in extremis require coercion to accept support. In such circumstances it would be unethical not to seek to offer and perhaps in extremis even enforce care (Council of Europe's Steering Committee on Bioethics 2011).

Yellowlees an English psychiatrist writing some 150 years ago in the context of an ongoing debate regarding the use of restraint summarised the position with remarkable eloquence in a way that remains wholly pertinent to the contemporary debate. He observed that 'unnecessary restraint cannot be too strongly condemned but to reject its use when necessary for the patient's welfare is to sacrifice the patient to a sentiment, and to degrade "non-restraint" from the expression of a great principle into the tyranny of a mere name' (Yellowlees 1872:881)

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Workshop programme

This highly interactive workshop will:

- Explore the role of 'frames' in shaping policies relating to violence.
- Describe the use of contextual rather individualised frames.
- Apply contextual frames to the understanding and remedy of a number of practice scenarios.
- Participants will understand the role played by frames in policy making relating to the management of violence.

Learning objectives

Participants will...

1. be able to distinguish between contextual frames and singularly located frames of 'bad patient', 'bad nurse' and 'bad organisation'.
2. appreciate how alternative frames can contribute to a more enlightened understanding and effective responding to the problem.

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Moylan's Model for Nurses' Decision Making with the Aggressive Patient: Implications for practice

Poster

Lois Moylan

Molloy College, Rockville Centre, New York, USA

Focus: Practice

Abstract

The Moylan's Model for Nurses' Decision Making with the Aggressive Patient was developed based on theory and tested in 2 research studies which supported the model. A related paper was presented at the conference in Vancouver (2012) in a concurrent session. This poster presents how the model can be applied to practice.

The significance of this model is that it can be applied in the development of effective teaching and training programs by addressing specific areas recognized as impacting decision making. When considering the multiple factors that impact the nurse's decision making with an aggressive patient, it is important to address both the factual components, such as therapeutic communication skills etc, and the affective components of emotional responses and values. It may also be valuable in assessing nurses knowledge concerning approach to aggressive patients and be used in post assault debriefings.

The poster presents a brief discussion of the development of the model and the testing of the model. A schematic of this is included with a discussion of how each of the elements identified in the model contribute to the development of a program where decision making is addressed in a comprehensive and effective manner.

Learning objectives

Participants will...

1. identify factors that influence nurses' decision making with aggressive patients.
2. become better able to effectively intervene with the aggressive patient.
3. become aware of the need to incorporate the principles of the model in designing education and training for nurses in acute care psychiatry.

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Reducing Seclusion and Restraint in Mental Health Settings: A phenomenological study of hospital leaders and staff experiences

Paper

Kevin Ann Huckshorn
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Focus: Research

Abstract

The intent of this study was to explore and describe the experiences of leaders and staff who directed or participated in successfully reducing the use of seclusion and restraint in two US inpatient public mental health hospitals. This study used a phenomenological methodology to capture the lived experiences of 21 study participants that included a mix of senior leaders, middle managers and direct care staff who were interviewed as key informants. Thirty-two themes were extracted, from an original list of 98 themes using kappa coefficient statistics that were then synthesized into five meaning themes. These five meaning themes were then synthesized into six significant findings, including: (a) the critical roles of leadership and staff in successful seclusion and restraint-reduction projects, (b) the ability of leaders and staff to change their beliefs and behaviors throughout the project, (c) the ability of leaders and staff to build a shared vision that worked to reduce the use of seclusion and restraint in inpatient settings, (d) the identification and resolution of key challenges staff and leaders faced on the way to successful reduction efforts, (e) the use of a solid performance improvement lens to direct changes in practices, and (f) important lessons learned.

Learning objectives

Participants will...

1. realize that leaders and staff can prevent the conflict and violence that occurs in inpatient mental health settings.
2. appreciate that the use of dangerous and coercive measures like seclusion, restraint and forced medication can be avoided.

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Prevalence of workplace violence towards nurses at two private and two government healthcare settings in Karachi, Pakistan

Poster

Rozina Somani, Judith Mc Farlane, Nargis Asad, Saima Hirani
Aga Khan University School of Nursing and Midwifery, Karachi, Pakistan

Focus: Practice

Background

Workplace violence towards nurses is a worldwide problem. Among all healthcare workers, nurses are at a greater risk of being subjected to workplace violence. The present study identified the magnitude of the issue of violence towards nurses at the healthcare settings in Pakistan.

Objective

This study aims to identify the prevalence and characteristics of physical and psychological violence experienced by nurses working in all the In-patient units and the Emergency Departments of two private and two government healthcare settings in Karachi, Pakistan.

Method

This Cross-sectional study included 458 nurses from selected healthcare settings in Karachi, Pakistan. A simple random sampling method was used for the study. The instrument used for collecting the data was jointly developed by International Labour Office (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI). The primary investigator and the research assistant interviewed the participants to complete the study tool.

Findings

The present study found that workplace violence was prevalent among 82% of the nurses. The reported prevalence of physical violence was 16.4%, verbal abuse 77.1%, bullying/ mobbing behavior 33.8% and 10% for sexual violence. Prevalence of workplace violence was found to be higher in the private healthcare settings, among young female nurses with less work experience. These nurses specifically belonged to the Medical Surgical units, Intensive Care Units, and Emergency and Psychiatric departments. Most of them were working in shift duties. The most common perpetrators of physical violence towards nurses were found to be patients and their relatives, and for psychological violence it was patients' relatives and healthcare staff.

Conclusion

This pioneer study is an attempt towards the implementation of one of the World Health Organization's (WHO) goals, that is, a violence free healthcare environment. The study also put forward some evidence based recommendations; based on the findings, for the government, the nursing services, nursing educators, and for future research.

Learning objectives

Participants will...

1. Learn of the prevalence of workplace Violence in Pakistan.
2. identify strategies to deal with workplace violence.
3. Be able to future research perspectives in the same dimension.

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Patient perceptions of abuse in the health care system among a population of long-term opioid users

Poster

Heather Palis, Eugenia Oviedo-Joekes
University of British Columbia, Vancouver, BC, Canada

Focus: Research

Background

Opioid dependence, most commonly manifested as heroin dependence, is regarded as a chronic, relapsing disorder. It has been shown that some health care providers (HCP) hold stereotypical views of illicit drug users that likely compromise treatment outcomes and the provision of quality care. Various topics such as stigma, discrimination, and HCP attitudes have been regarded among drug users in terms of implications for treatment outcomes. Abuse in health care (AHC), a new concept relating to this poor patient treatment however, frames the existing literature on patient care from the patient's subjective experience.

Methodology

The Gender Matters (GeMa) study was a descriptive cross-sectional study with mixed quantitative and qualitative methods. The study was aimed at testing gender-specific patterns in drug use, victimization, and access to care among long-term opioid users in the Downtown East Side of Vancouver, British Columbia, Canada. The victimization section of the study explored the concept of AHC using the NorVold Abuse Questionnaire (NorAQ), a tool meant to measure perceived patient experience of AHC, ranging from mild (an offensive or degrading encounter) to severe (a patient's perceived experience of intentional harm from the HCP). Study participants were also asked whether (and why or why not) HCP should inquire about victimization.

Findings

Of all GeMa participants, 55% reported an experience of AHC at some point in their lifetime, this reporting was consistent by gender. The large majority (87%) of participants agreed that HCP should be inquiring about victimization. Qualitative thematic analysis of the reasons HCP should be inquiring about victimization revealed four key themes, each presented with a participant quote.

1. Prevention: "It could help others. I would hate people to go through some of the things I've been through."
2. Improve Patient Care: "so that an informed treatment plan can be made if the 'victim' wishes proper treatment for psychological and physical issues."
3. Understand Patients: "It is important to know the person holistically, including their past to know how they are apt to respond in the present and future."
4. Patient Healing: "There's not always bruises and stuff, people don't always see, so ask. Because if you hide it people don't know what's going on, how is anyone supposed to stop it?"

Implications

To our knowledge, this study was the first application of the NorAQ and investigation of the concept of AHC in a North American context. This investigation focused on long-term opioid users, however is relevant to a range of populations and contexts. Giving value to and recognizing patient experience with HCP will reveal previously unexplored pathways to the improvement of patient treatment and care among long-term opioid dependent men and women, and to other groups to which this investigation is applied.

To determine patient characteristics associated with reported AHC (drug use history, mental health, history of victimization, etc.).

Learning objectives

Participants will...

1. learn and appreciate patient perceptions of abuse in the health care system.
2. be able to determine methods of improving communication between health care providers and patients surrounding victimization.

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Chapter 8 - Other subtheme or main focus, but related the main theme of the conference

Female health care workers experience of training in physical restraint: Why are all the trainers men?

Paper

Brodie Paterson, Bryan Shewry, Vaughan Bowie
CALM TRAINING, Menstrie, Scotland

Perspective: Research

Introduction

The development and dissemination of structured training in restraint in health care has historically been characterised by an overwhelming predominance of men as trainers (Zarola and Leather 2006). This situation appears to be the result of a process that Gruber (1998:302) has termed 'normative dominance'. In this process one gender, in this instance male exerts, greater control and influence over the other in a given area.

Why this has happened in relation to the role of restraint trainer and what the implications of such gendering may be for female participants being trained have to date been unexplored. This paper reports the results of one element of a larger study, which involved semi structured interviews with women who had experience of physical intervention training.

The results of the semi structured interviews are presented here together with some elements of results obtained from the larger study in order to provide context and explain the recruitment process.

Background

Current guidance in many countries now mandates training where restraint is a foreseeable eventuality (Rogers et 2007). However, significant questions remain as to whether skills largely derived from a context of martial arts training can successfully be adapted for use in health settings (Hollins and Paterson 2009).

There is however some evidence from studies indicating that some of the potential benefits of training such as increased confidence may be more marked in women (McKenzie et al. 2004). To interpret such greater confidence as a benefit however may be questionable. Improved confidence may be associated with an increased use of physical interventions by women to restrain men and result in an increase in injuries to female staff (Bowie 1998). Understanding the role that may be played by gender also requires that we reflect upon who restrains whom. Male service users appear from many studies across a number of settings to be restrained more often than women (Ryan and Bowers 2006, Lancaster et al. 2008, Stewart et al. 2009). This results in a dynamic whose implications have to date seemingly been under explored as these male service user may be being restrained by women at least some of the time. In in-patient / residential settings such as mental health male staff are more likely to experience physical assault than women although such differences may indicate working practices involving the disproportionate employment of men in higher risk settings and situations such as restraint. However, common working practices in many settings require an agreed proportion of men are on shift at any given time because of the possibility of restraint. Such practices are perhaps a pragmatic response to risk but they may also serve to frame the task of restraint as predominantly male.

The increased risk experienced by men is not reflected in studies of perceived vulnerability to assault when women consistently report themselves as more at risk (Hatch-Maillette, 2007). However, this perception may reflect not an inaccurate judgment of the possibility of exposure but rather a lack of confidence in their ability to protect themselves from any assault particularly by a male. Both the perception of risk and the nature of violence experienced may therefore be strongly mediated by gender (Seymour 2009).

The origins of such differences may reflect an underlying physiological reality where women typically have 30-50% of the upper body strength and 70% of the lower body strength of a male of similar size (Wilmore 1979). This difference has significant implications for the nature of any training in physical interventions. Adopting a

gender neutral approach to training, that expects all participants irrespective of gender, to perform to the same standards over the same timescale has been associated with a significantly increased risk of injury to women during training in a number of military studies (Bergman and Miller 2001). It is reasonable therefore to suggest that if robust gender neutral simulations where vigorous resistance is encouraged are used during physical intervention training men will be able to use their strength advantage over women to increase the difficulty of the task women face and that the likelihood that women being injured may be increased.

Whilst the majority of staff in front line posts in health, social care and education are women men still dominate many senior positions. The under-representation of women in management and in high status professional groups may mean that women are routinely excluded from the discussions that inform decisions and the process of policy formation particularly around restraint training (Robb 2004:30). Why however might this exclusion matter in relation to decisions around violence and potentially restraint? Campbell and Muncer (1987) found that men in general were more likely than women to describe their aggression as a socially useful means of control. Women in contrast were more likely to see aggression as a loss of self-control and as wrong. Men reported significantly less guilt than women in relation to their use of violence (Campbell and Muncer 1987) and there at least some suggestions that men may have more difficulty in restraining impulsive aggression than women (Driscoll, et al 2006). It can be suggested therefore if only as a generalisation, that men as managers may be less likely to question the use of physical interventions or emphasise the need for training in alternatives approaches, which may in turn influence their decisions regarding commissioning training.

Campbell (2002) has argued that we need to understand that the fundamental source of gender differences in attitudes towards aggression is fear. From the evolutionary viewpoint, in the human species where women are committed to a long period of gestation, lactation and child rearing, an injury or death to the mother as opposed to the father will have more serious consequences for reproductive success. Consequently it is suggested women have evolved to react with greater fear than men to activities that may cause them physical injury.

Gilligan (1982) argue that that "sex differences in aggression are usually interpreted by taking the male response as the norm, such that the absence of aggression in women is identified as the problem to be explained" (Gilligan 1982). If this premise has validity with the 'male model' of aggression management even if only implicitly. seen as the norm, what are the potential consequences for women being trained by men in a system of restraint designed, albeit perhaps unconsciously, primarily to meet the needs of men? At the very least such suggestions raises the possibility that an incongruence between the design and nature of training and the psychology and physiology of women may result in women being judged inadequate if they don't conform to the male model.

Research Questions

Such concerns gave rise to the following research questions:

- What are the characteristics of the women participating in training and what are the implications?
- Are there barriers to participating in participating in restraint instructor training for women?
- Does the dominance of men in the development of training have a negative or positive impact for those women who receive training?
- What is women's experience of training in restraint?

A mixed methods design using both quantitative and qualitative methods was adopted as being most appropriate to meet the aims of the study. Key demographics and relevant findings are given here to provide context for the qualitative element.

Recruitment and Results

The Quantitative element comprised two surveys. A) national online survey of Instructors. Respondents. N=51. 71% of respondents were male and 27% were female (2% chose not to disclose their gender. 80.4% were training in the health sector, sector 19.6% in adult social care 17.6% in Children's social care, 19.6% in Education and 5.9%. Subjects were recruited via -recruited via E-mails to trainers and training organisations, invitations via an online professional forum and an online link distributed via the British Institute of Learning Disabilities. Survey B Comprised a survey of local authority staff working in social care and education settings (adults & young people) post training in CALM. 31 restraint course participants responded. Response rate 38%. Respondents were female n=18 (58.1%) Male n=12 (38.7%) Unidentified gender n=1 (3.2%).

The qualitative element comprised semi structured interviews with 4 women who had experience of physical intervention training and its use. These women were recruited via their expression of a willingness to participate in further research in either the online or paper questionnaire. The interviewees had experience in social care, health care, and education working with both adults and children. Their age range varied from 20+ to 50+ and they had worked from 5 -20+ years in their respective professions. Two of the four women in the qualitative sample interviewed disclosed that they had previously experienced violence and aggression from males in a domestic context and one woman disclosed she had experienced sexual abuse as a child. Only four interviews were conducted because no significant new issues or potential themes were identified as a result of interviews three and four suggesting saturation had been reached. Access to independent counselling was available to all research participants subsequent to their interview.

Where specific reference was made to a physical intervention system this was anonymised in order that participants could speak freely about their experience including models their organisation might still be using. The women interviewed had experience of the use of physical intervention from several standpoints including as senior trainers / training commissioners, as trainer and as course participants. Three participants had experience of being trained in more than one system of violence prevention/ physical intervention. The approach used in data analysis was theoretical rather than inductive as it was informed by the research questions. The six phase process identified by Braun and Clarke (2006) was followed with both coding and the thematic analysis of data undertaken manually.

Results

Theme 1: 'Men and women think about violence differently'

The women interviewed perceived their response to aggression and violence as being qualitatively different from their male colleagues. A respondent drawing the distinction between them suggested:

- *"They framed it different in their heads. I saw it as we were almost taking on the role as assailant; they (Male trainers) saw it as we're actually making a bad situation better by controlling in a different way and reducing the risk of harm".*

The notion of a 'male response' was directly contrasted with that of the female:

- *" what you need to understand is that the people here, if they're properly communicated with in a positive way, if they're given respect, all the things a human being with that value base you should do, you're actually not going to be that much at risk."*

Does the dominance of men in the development of training have a negative or positive impact for those women who receive training?

Theme 2: 'Macho and non Macho Training Programs'

Some training programmes were seen as explicitly promoting a "macho culture" in which restraint was framed as means of intimidating service users thereby dissuading them from future violence:

- *"It was frightening. I felt frightened for myself, for others and the patient"*
- *"I know how intimidated I was when I went into the early stages of it. I felt inadequate"*
- *"surrounded by big burly guys who looked like fire fighters, you know. And the token woman was in there, trainer, because there was only one of her. They were the A-Team, the elitists".*

Theme 3: 'Active and Passive Resistance'

Where the training was inappropriate it was evident that some participants actively resisted using it:

- *"when I did the very first course. I came out of it feeling really uncomfortable." ... "it just didn't sit right with me" ... ". I don't want to and I can't do this to patients. It didn't seem right"*
- *"The first one we had (restrictive physical intervention training) we thought none of those would be any good for our kids they were too severe, too aggressive they would further aggravate the situation".*

Theme 4: 'Training as a positive experience'

The women were not universally negative about their experiences of training in restraint acknowledging that "we need secure minor interventions." but their experience was strongly mediated by the nature of the programme.

- *"I love the fact that [System Z] is the way it is, is completely non - pain compliant - I love the fact that it does not have kids in the prone position".*
- *"I liked the philosophy. It was all about minimising the risk to the patient and the staff equally. The idea was that no-one get hurt, so that was I must admit really reassuring when that happened".*

Discussion

Because of the small sample in the qualitative element of this study the high level of physical and sexual abuse reported cannot be interpreted as representative of the sector and may be an artefact of the recruitment method. However, Bussey (2008) reported high levels of assault, abuse and PTSD in human services students. Trauma may mediate women's experience of training/learning and influence their ability to gain positive outcomes. If unacknowledged the impact of trauma on training in physical interventions may mean that many women "get only a chance to fail, to falsely confirm to themselves that they really cannot learn" (Horsman, 2006:178). We know that restraint may re-traumatise service users with a history of abuse (Gallop 1999, Wynn 2004). The possibility that training in physical interventions may re-traumatise staff who themselves have been abused is perhaps less recognised (Virki 2007).

Course guidance and instructions from trainers may ask participants to discuss any concerns over prior to participation in training. Expecting such disclosure to a stranger in a context in which both time and privacy may be compromised such as at the commencement of a training program is however unrealistic. If the culture of the training program demands that "you are able to "handle yourself" (Hollins & Paterson 2009:377) and reporting abuse potentially conveys vulnerability then the default scenario in most cases may be that women are implicitly required to suppress their experiences of trauma and violence (Lewis,1999:182). This may

increase the risk of trauma during training. Consequently there is a need for restraint instructors to be trained in recognising potential signs of trauma.

For the women involved in the case studies training in and the use of restraint was not always a positive experience. Such results do not mean that men should not be involved in training but that the role played by gender must be explicitly considered (Virkki 2007). Recognising the role played by gender has however implications for men too. Social workers have been suggested to adopt a dichotomous response characterized in their attempts to positively identify with a profession, which like nursing is seen as essentially female (Christie 2006). One strategy was that of the 'heroic man of action' whose violence is framed as 'protective'. This 'embodies the currently most honored way of being a man' defined by hegemonic masculinity (Connell and Messerschmidt 2005:832). The alternative is that of the 'gentle-man' (Christie 2006:399), abiding by a different and higher moral standard than those of other men in which they can be both caring and masculine. The negative consequences of an inappropriate style and approach by a trainer may therefore have detrimental consequence for any course participant no matter their gender. However if the majority of restraint trainers are men then the possibility exists that 'male' attitudes towards the use of force even if these will themselves vary, may unduly influence the experience of course participants.

Further research is required to identify whether female participants on physical intervention training and those in instructor roles are at increased risk of injury. What we presently don't know is whether there is an interaction between a specific training model, gender and the likelihood of injury to staff or service users during attempted restraint and this requires urgent investigation.

Conclusion

The majority of the workforce in most health, social care and education settings are female. This reality must be reflected in the design, delivery and evaluation of training programs in the prevention and safer management of violence, which in some services may incorporate training in restraint. The implications of gender have to date however it would appear to have received insufficient attention.

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Learning objectives

Participants will...

1. understand the significance of gender as an issue for the design, commissioning and delivery of training in physical restraint.
2. recognise and identify how barriers to womens' effective participation in training may be overcome.

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A 10-pronged approach to the prevention of occupational violence against health workers

Paper

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Perspective: Guidance

Keywords: Nursing, systems approach, prevention, risk management

Background

In Victoria, there has been widespread recognition of the issues relating to violence and aggression against nurses and midwives for well over 10 years. In 2001, Australian Nursing Federation (Victorian Branch) (or ANF (Vic Branch), now known as Australian Nursing and Midwifery Federation (Victorian Branch) – ANMF (Vic Branch) first developed and implemented a Zero Tolerance to Occupational Violence and Aggression policy in response to the concerns from our members, the prevalence of violence in the healthcare environment, and the potential for serious, life threatening injuries, and of course, in extreme circumstances, death.

Since this time, there have been many and various ‘projects’ and ‘inquiries’ undertaken, both by the Government of the day, as well as through systems such as Parliamentary Inquiries, all of which make recommendations to address the issues, none of which have been fully implemented, evaluated or funded by the Government, nor the health services where the incidents are occurring.

Further, there has been an Occupational Health and Safety Act since 1985, which was revised in 2004. Consistently, the risk management framework dictated by the legislation requires employers to provide a workplace that is safe and without risk to health for their employees and others. It remains a criminal offence for an employer to fail in this duty, and it continues to be a criminal offence to assault or physically harm another. In this, the legal framework (while perhaps not ideal) is sound.

Yet, the approach is piecemeal, and there is no coordinated means of ensuring that nurses and midwives working throughout the Victorian healthcare system are able to consistently expect that appropriate preventative approaches have been taken at their health service, to ensure a high level of protection against violence and aggression directed towards them.

In order to tackle this violence in a manner which will not just treat some of the symptoms, but will actually address the issues, a coordinated, systems-wide approach is required, which recognises the causes of the violence and aggression, and puts in place a framework which gives those in the health sector a clear set of principles and guidance to implement, and holds them to account for implementation of and compliance with the provided framework.

Pre-conditions

A critical pre-condition for this 10-Pronged Prevention Strategy Framework to be successful is a health system which has a commitment to the prevention of occupational violence... and not just a documented policy stating that, but a commitment which is real and irrefutable. This commitment needs to come from not just the middle management of a facility, but is required from those with the ultimate power in the health system. This commitment must be demonstrated by those in charge and in control, from the Premier and Minister for Health, through to the Department of Health, and then through the health services individually. Validation of the commitment comes in many forms, not the least of which is the recognition of the problem to begin with, and the dedication of resources to implement strategies to prevent and address the systemic issues.

This commitment must then manifest at the Chief Executive Officer and Board of Director level, with again, the acknowledgement of the failure of the system in its current form, and a pledge to address the shortcomings. Such a demonstration should also include a reporting structure which means that each Board of Directors are provided with an in-depth report at each meeting of the number of assaults that have occurred within their hospital network, the details of each assault, the injuries suffered by the staff, and the corrective actions which have been put in place to reduce the risk of recurrence.

Another pre-condition to the Framework is a commitment by those running the health system, as well as organisations, to undertake the ‘Three C’s’ – Communication, Consultation and Collaboration, in relation to occupational violence and aggression, but more broadly as a management imperative. Whilst the Occupational Health and Safety Act 2004 mandates organisations to undertake consultation in relation to matters which affect (or may affect) the health and safety of staff, experience shows that this is rarely undertaken in the

manner in which it is described. Again, this must be demonstrated from those with power, in order to affect change at a local level. Such communication, consultation and collaboration must involve representatives of all stakeholders, including health services, workers, Regulators and consumers. Without the inclusion of all stakeholder groups, it will be unachievable to change a broken system. Moreover, the presence and input at both a strategic and local level into such strategies will allow more robust systems to be developed and implemented, which will lead to wider acceptance, and increased ownership of the system.

Discussion – A 10-Pronged Prevention Strategy Framework

Occupational violence and aggression is a multifactorial problem, and therefore there is not a single solution or factor which will make a significant inroad into the risk on its own. It is inherent in such a scenario that a multifaceted approach will be required in order to even begin to make progress on the prevention of violence. From experience in being involved in the aftermath of incidents, and being involved in the follow up of these, ten key factors, relevant and critical to the prevention of occupational violence and aggression have been identified. The factors are interrelated, and the success of such a strategy relies upon the implementation of and commitment to all of the equally-relevant factors. The strategy should be developed and mandated at a departmental level (i.e. within the Department of Health, who have overall responsibility for the public health system in Victoria), and implemented at a local level, across individual health networks and services. The 10-Pronged Prevention Strategy Framework consists of (in no particular order):

1. **Legislation, policies and procedures, including Code Grey and Code Black** – it is crucial that the policies and procedures are developed in consultation with staff and relevant stakeholders, and that they are not only internally agreed, but that they are implemented (with appropriate resources dedicated and provided), and followed. Whilst in the majority of health services, there is some kind of ‘Prevention of Occupational Violence’ (or similar) policy in place, what is lacking is the interaction with, and consideration of, such a policy in combination with related policies, such as:
 - Escalation policies, where a risk assessment has been undertaken and additional staff may be required
 - Post-incident support policies
 - Training and education policies
 - Security policies
 - Duress alarm policies
 - Minimisation of seclusion and restraint policies
 - Management of clinical aggression policies
 - Observation policies
 - Behavioural contracts and agreements
 - Police liaison and interaction policies etc
 It is rarely recognised that any policy which involves the care of a patient or client, or interaction with the public, should also consider the impacts on the potential exacerbation of, or exposure to a situation which may result in occupational violence. It is of critical importance that these policies are considered as a whole to ensure that a consistent and appropriate approach is clear throughout i.e. that occupational violence is not expected as a part of the work environment, and that it is unpreventable. More specifically, emergency procedures that incorporate a tiered response to situations of identified risk in themselves allow the de-escalation of potentially harmful situations prior to progressing to a physical incident. Code Grey (loosely defined as a hospital-wide internal response to actual or potential aggressive behaviour – usually clinically led) and Code Black (a hospital-wide internal response to actual or potential aggression involving a weapon or serious threat to personal safety – usually security led, often resulting in police attendance), must be consistently defined, and applied to all situations of occupational violence and aggression.
2. **Clinical pre-admission / admission risk assessments for all patients / clients** – if risk factors can be identified prior to a patient or client being admitted to the health care facility, strategies can be implemented to address these even before they get on site in some circumstances. In others, where they may have attended through an Emergency Department or the like through an unplanned admission, these must be undertaken immediately. The completion of such a risk assessment would be expected prior to introduction of new systems of work for staff, and should be treated in the same vein in terms of risk to staff health and safety, and the prevention of any such occurrence. A consistent system which allowed through any admission system the use of a client alert system must also form a key component of such a risk assessment. It is critical that staff are alerted as soon as possible to the risk of occupational violence presented by a patient or client (or even the family members or visitors of the patient or client) each and every time they present. This allows for informed judgements to be made by clinicians as to the appropriate placement and potentially treatment of a presentation such as ensuring that a presentation to an Emergency Department who has a client alert around previous admissions being allocated a cubicle where there is a high level of visibility and assistance, and potentially being nursed in pairs to reduce the risk associated with treatment.
3. **Clinically-based management plans / care plans for patients and clients** – should take into account not just the clinical component of caring for the client / patient, and how such care may affect the client / patient (and whether this in itself may introduce factors which increase the risk of occupational

violence), but also how taking care of that patient may impact on the care staff. Past history, current presentation and known risk factors must be taken into account, and treated as appropriate. It is of vital importance that all management or care plans involve family where able, as the inclusion of family, and the setting of expectations of behaviour and treatment early in the care journey ensures that clear standards are able to be maintained from the beginning. It also allows for consistency of approach amongst health care professionals in their expectations and understanding for each patient or client.

4. **Security** – a baseline standard for security expectations must be developed at a departmental level, taking into account not just security personnel in facilities, but also access to secure areas, Closed Circuit Televisions, personal alarms and searching of personal belongings. This must be followed with regular audits of facilities, and their security measures, with timelines for implementation of the baseline standard. The ongoing, dedicated funding provided to enable health services to comply with such measures will be a demonstration of the departmental commitment to the prevention of occupational violence against health care workers.
5. **Education and training** – This must begin for nurses and midwives at the undergraduate level, continuing through every part of the journey through the health sector, with employer-specific training and education, accredited, standardised training for health workers, as well as security staff, and regular refresher training and updates. This also includes training and education for users of the health care system, particularly in relation to the setting of clear expectations, with associated consequences for failure to comply. Every component of the 10-Pronged Prevention Strategy Framework requires an element of education around what it is and how it fits into the framework.
6. **Cross-disciplinary understanding of the issue, combined with clear communication and a consistent approach when faced with identified risk factors** – it is important that the psychiatrists, doctors, nursing and midwifery staff, occupational therapists, physiotherapists, and anyone else who may come into contact with a patient, their family or visitor during a hospital journey has a consistent understanding and expectation around occupational violence, and that appropriate consideration is given to the reports of inappropriate / adverse behaviour of all involved in the care when making clinical or management decisions. Of importance, this means that communication, consultation and collaboration occurs with each discipline in the development and implementation of any care plans.
7. **Empowered staff** – who are prepared to report incidents and issues, and believe in their right to a workplace that is safe, and does not involve them being exposed to violence and aggression. This is not something that can be changed overnight, nor by issuing an edict. This can only be changed by demonstration of commitment to change by those in control, over a period of time.
8. **Workplace design (Crime Prevention Through Environmental Design)** – the physical environment in which the work is being undertaken (and the violence is occurring) must be considered, with principles of CPTED recognised, and implemented, for all health services - new, old, refurbished, renovated, retrofitted. Appropriate policies and training, and care plans may all be implemented, but if this occurs in a facility which has inherent risk by its design, these may all be to no avail.
9. **Incident reporting, investigation, review and feedback** – In order to turn the culture of non-reporting around, a significant shift is required in the way reports of occupational violence and aggression are dealt with by the Department of Health, and health services. It is not enough to just 'talk the talk'. To encourage reporting, it is critical that there is some reason for reporting, and to build that trust, there must be communication of the outcomes, collaboration and consultation when undertaking incident investigation, and clear and relevant actions implemented to prevent such an issue occurring in the future. Incumbent in the discussion around incident reporting is a system that allows accurate, timely and appropriate recording of information, and is therefore not discouraging in itself of the reporting. Further, it is critical that the Minister for Health, and Boards of Directors are held accountable for these reports, and that rather than being reported statistics (which are not human), they are provided with individual summaries of assaults that have occurred within their health system at each Board meeting, to assist them in comprehending that these are real people experiencing the violence.
10. **Post-incident support** – whilst a system that did not require any post-incident support (due to no incidents having occurred) is clearly the nirvana when it comes to violence in the health sector, this is not going to be achieved in the immediate future. As such, a work environment that is pre-prepared to provide extensive and appropriate post-incident support and care to their workforce is more likely to reduce the long-term health consequences (both physical and psychological) to nurses and midwives who are involved in incidents.

Conclusion

By fully considering and addressing each of the identified factors, and implementing an approach which is consistent and mandated across the Victorian public health sector, nurses and midwives, as well as other health workers, will finally begin to see what it is like to work in a profession where violence is NOT part of the job, it is NOT normal to go to work expecting to be assaulted and it is NOT acceptable to have your life or that of your family threatened.

Learning objectives

Participants will...

1. be able to contextualise the Australian experience on violence in the health sector.
2. gain insight into a strategy to enable violence in the health sector to be addressed from a multi-factorial, multi-faceted prevention perspective.
3. learn that reinforcement of the prevention of violence is achievable, in bite-sized pieces.

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Working towards a definition of workplace violence actions

Workshop

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Perspective: Guidance

Keywords: Workplace violence, bullying, sexual harassment, sexual assault, intimidation, physical violence

Background

Workplace violence has been well documented and researched internationally. This has resulted in the repeated acknowledgement of various definitions of workplace violence actions. Even the way in which violence in the workplace or workplace violence is termed has various demarcations. In effect this creates a workplace violence research environment that can be unhinged by conflicting rational and meaning. The aim of this literature review and proposed workshop is to work collaboratively with leading researchers to clarify and identify definitions for the actions of workplace violence. From this consultation it is proposed that the proceedings will be published as a guide for future researchers, policy makers and businesses alike. Ultimately this would eliminate the current state of confusion surrounding the unparalleled definitions of workplace violence.

Due to the multifaceted nature of the workplace violence, defining prominent key terms is seen as a necessity for the advancement of workplace violence research in the health sector. From this workshop it is anticipated that researchers from around the globe will discuss and collaborate in working towards some consistency for workplace violence definitions for the health sector.

Methodology

Literature Search

A literature search was conducted using the medical electronic databases of Ovid MEDLINE, CINAHL, EMBASE, and PsycINFO from their beginning until the end of February 2014. MeSH headings and keywords used include: aggression, violence workplace, bullying, sexual harassment, rape, sex offence and intimidation. MeSH headings and keywords were used both individually and combined. Articles of any study type were included if their main purpose was to define the actions of workplace violence. Articles were excluded if they were not written in English. The reference lists of the retrieved articles were also examined.

Findings

A total of 2,177 articles were identified with eight articles meeting the inclusion criteria and two articles excluded as they did not report definitions relating to workplace violence, leaving six articles for further review. No articles were located following the review of reference lists. Four of the articles identified had different definitions of bullying. This varied from a two part, objective (the identification of the activity) and subjective (the person's perception) definition of bullying to a "lay" definition of bullying which included two of the recognised definitional criteria. It would appear there are various definitions of bullying across the business, scientific and legal domains with a lack of commonality in each of the definitions. One article reasoned it was better to describe bullying rather than define it. Another article attempted to define sexual harassment using rape myth research as the template for the definition development.

Discussion

The discussion and debate surrounding attempts to justify defining terms of workplace violence actions is nothing new. This lack of agreement regarding the definitions leads to significant challenges for any researcher attempting to draw parallels. When specifically looking at the health sector there is the highest appreciation and analysis surrounding the existing body of research. All of which significantly impacts the ability to define and delimit specific workplace violence terms in the future. Currently around the globe there are numerous terms often used interchangeably to describe negative workplace behaviours, experiences and actions. With some terms only used in specific countries or arenas. For the purpose of this conference workshop proceeding the over arching definitions; workplace, violence and workplace violence are adopted from major international organisations.

In the health arena there have been considerable international research efforts to hone in on workplace violence. In 2000 a joint programme was launched by the International Labour Office (ILO), World Health Organisation (WHO), International Council of Nurses (ICN) and Public Services International (PSI). The task was to examine the current state of violence in the health sector on a global scale. This resulted in several key findings and a

suite of publications. The chief report was delivered in 2002 titled the Framework Guidelines for addressing workplace violence in the health sector, where this multifaceted problem was researched and prominent definitions published.

Workplace Definition

Within the Framework Guidelines for addressing workplace violence in the health sector a workplace was defined as;

“Any health care facility, whatever the size, location (urban or rural) and the types of service(s) provided, including major referral hospitals of large cities, regional and district hospitals, health care centres, clinics, community health posts, rehabilitation centres, long-term care facilities, general practitioners’ offices, other independent health care professionals. In the case of services provided outside the health care facility, such as ambulance services or home care, any place where such services are performed will be considered a workplace.” (1)

Another consideration to contemplate is the continual upsurging of technological advancements in the workplace. This is not referring to social media but the increase of non-traditional workplaces such as homes and other mobile locations. The concept of telework is part of a broader workplace trend: flexible work practices (2). It has been reported that this transition to non-traditional workplaces may impact the prevalence of workplace violence (3).

Violence Definition

Violence is defined as: “The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, community, which either results in or has a high likelihood of resulting in injury, death, physiological harm, maldevelopment, or deprivation.” (1)

Violence in the Workplace or Workplace Violence Nomenclature

When examining the literature it is apparent that the nomenclature of both violence in the workplace and workplace violence are used interchangeably. This could possibly be due to the historical expansion and elaboration on what acts of violence are represented. For example, acts of terrorism in someone’s workplace would be considered violence in the workplace. However in general terms if we were asked to describe negative workplace behaviours, experiences and actions some might assume that we would list terms such as bullying and harassment. Therefore this may be an issue that could be discussed further at the workshop.

Violence in The Workplace or Workplace Violence Definitions

The first collaborative effort to develop a common understanding of violence in the workplace was scheduled by the European Commission in 1994. From this expert meeting a widely recognised definition of violence in the workplace: “Incidents where persons are abused, threatened or assaulted in circumstances related to their work, involving an explicit or implicit challenge to their safety, well-being and health.” (4-6)

Building on from this definition and adapting the definition proposed in the Framework Guidelines for addressing workplace violence in the health sector the ILO and WHO have joined forces to publish a newly revised definition of workplace violence: “Workplace violence covers a spectrum of unacceptable behaviours. It includes incidents where staff are abused, threatened, discriminated against or assaulted in circumstances related to their work, including commuting to and from work, and which represent a threat to their safety, health, and well-being.” (7) This definition of workplace violence recognises the commute to and from work, an aspect that was not included in the earlier workplace definition. For the purpose of future discussions this most recent definition of workplace violence will be accepted.

Cultural and Linguistic Differences

Prominent researchers Chappell and Di Martino reported in 2006 that a common definition of violence at work has yet to be agreed upon in the international realm (6). In spite of this lack of a definition several country case studies were conducted as part of joint programme by ILO, WHO, ICN and PSI and a common understanding of workplace violence were identified. The countries included in the study were from the industrial world and developing. Countries included were Brazil, Bulgaria, Lebanon, Portugal, South Africa, Thailand and Australia. In addition to this appreciation of a common understanding the Synthesis Report went on to identify the cultural and linguistic differences in action and that this needs to be rectified (8).

Chappell and Martino (2006) then went on to provided more insight into these cultural findings and the impact that this has on research in the book *Violence at Work*. They stated, “Different sensitivities in diverse contexts and cultures also contribute to the variations in the reporting of violence at work, so that comparative data have to be used and interpreted with great caution” (6). Ultimately the cultural and linguistic differences need to be

considered as this can heavily sway the perception of workplace violence. Hence when attempting to create definitions for workplace violence actions they unmistakably need to be adaptable across various domains.

Workshop Presentation

The participants will be divide into small groups and given some opening definitions of various actions of workplace violence, e.g. bullying. The whole group will reconvene to open the floor to a highly anticipated discussion and debate where the participants will be asked to come to an agreement on the definitions. The aim is that the proceedings will be published as a guide for future researchers, policy makers and businesses alike. Ultimately this would result in the elimination of the current state of confusion surrounding the unparalleled definitions associated with workplace violence.

Workplace Violence Terms for Discussion and Deliberation

For the purpose of this workshop a list of common negative behaviours, experiences and action terms are listed below in Table 1.

Table 1: Workplace violence terms for discussion and deliberation

Terms:		
Aggression	Violence	Workplace
Bullying	Sexual harassment	Intimidation
Rape	Sex offence	Vertical violence
Horizontal Violence	Mobbing	Emotional abuse
Workplace victimisation	Internal violence	External violence
Physical violence	Sexual assault	Verbal abuse

The Challenges that Surround the Definition of Workplace Violence Terms/Actions

Largely the biggest challenge that faces workplace violence researchers worldwide is the interchangeability of common workplace violence terms such as “Mobbing”, “Bullying”, “Harassment” and “Aggression” which has been widely recognised in the literature (1, 9-14).

More specifically in the health sector, researchers have used terms such as vertical violence and horizontal violence in international studies of workplace violence; however, there is no agreed definition internationally to what these terms actually means. Obviously this in turn creates a research environment where comparatives and firm conclusions are unobtainable. In addition to this further research has noted that a uniform definition will aid the development of strategies to address workplace violence (12). Likewise, from a legal perspective standardised definitions will assist the quantification of such acts (12, 15).

Considerations for the Workshop Deliberation and Debate

Currently there are several approaches to defining and delimiting workplace violence actions. One study conducted by Saunders et al compared workplace bullying definitions of researcher, practitioner and legal definitions with lay definitions. A total of 1,095 definitions were then analysed and categorised into essential and non-essential defining criteria (12). Whilst other researchers go on to rework existing definitions with evidence-based practice to justify slight modifications (1, 7, 15).

For the purpose of the discussion and to ensure a consistent approach in the workshop what constitutes a definition will be adopted from Agervold who states that a definition consist of two parts; an objective and subjective measure. The objective identification consists of activities that are previously recognised. The subjective identification signifies the persons’ perception of the activities (11).

Implications

The outcome of the workshop will be a set of definitions that will ensures consistency across the local and international domains that will enable better comparison of studies.

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Learning objectives

Participants will...

1. be able to identify the current definitions of violence associated with the workplace.
2. be able to synthesise the definitions.
3. be able to compile definitions of common workplace violence acts by consensus.

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Prevalence of sexual harassment towards nurses working at private and public healthcare settings of Karachi, Pakistan

Paper

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Perspective: Practice

Background and context

Sexual harassment towards nurses has negative consequences, both for the nurses and for the health care organizations. Female nurses are more at risk for sexual violence because their caring attitude is misperceived by male patients as sexual signals. This study aimed to explore the prevalence of sexual harassment towards nurses.

Methodology

A descriptive Cross-sectional study was conducted with 458 registered nurses from all the In-patient units and the Emergency departments of two government and two private healthcare settings in Karachi, Pakistan. The data was collected through a tool known as “workplace violence in the health sector country case studies research instrument” (2003).

Findings

The study found 10 % prevalence of sexual harassment. Sexual harassment was almost the same at both the government and private healthcare settings. The common perpetrators were found to be patients’ relatives (47.8%) and the staff members (32.6%). Nurses, who were between 19 and 29 years of age, were mostly the victims of sexual harassment.

Implications

Considering the study findings, it is recommended that acceptable and non-acceptable behaviors for patients and their relatives must be communicated very clearly in the hospitals, so that they may get aware of and practice acceptable behaviors. Moreover, a structured reporting system should be formulated in the private and government health care organizations.

Learning objectives

Participants will...

1. have a basic understanding of sexual harassment towards nurses.
2. be able to know the magnitude of this problem in Pakistani healthcare settings.
3. be able to know the perpetrators and significant contributing factors for sexual harassment in Pakistani healthcare settings.
4. be able to identify some evidence based recommendations to deal with sexual harassment.

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The Babel of human services: Common language, definitions, and data collection to support safety

Paper

Aaryce Hayes

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Perspective: Policy

Background and context

Despite over 40 years of attention to the issues surrounding workplace violence, the prevalence and impact of workplace violence continues to escalate. There are no common definitions of workplace violence, and there are competing taxonomies (Cal-OSHA, Bowie, ANSI) of workplace violence. Given this state of affairs, using data to inform practice, build better practices, and share those practices across health care settings in different regional, national, and international venues should become a priority for all health care professionals.

Methodology

A meta-analysis of definitions of workplace violence in the United States, Canada, Australia, the United Kingdom, Hong Kong, and the European Union will be shared with participants. A common set of definitions and data collection has been proposed by.

Findings

The lack of common definitions has led to isolated projects that have, in their own ways, achieved success in supporting organizations to move towards safety and security for all people. However, that isolated success has not resulted in a broad move towards safety as evidenced by data from the Bureau of Labor Statistics (Janocha & Smith, 2011) showing that there was a decrease in workplace violence in all American labor sectors, except in health care, where there was an approximately 10% increase in injuries to staff in health care settings.

Implications

Implications for practice: Common definitions of workplace violence will increase the fidelity of data collection systems, and will also increase communication across health care sectors of approaches that do, or do not, achieve increases in safety and security for all people.

Implications for training: There are literally hundreds of training programs addressing workplace violence in health care settings. Having one set of definitions of what workplace violence is, as well as what safety and security are will give all these training programs the ability to use their unique approaches to safety and security in ways that can be compared, contrasted, and used to improve safety. Health and Safety committees within hospitals, mental health centers, and other health care settings can also provide more effective training through the use of common definitions and data collection methodologies.

Implications for policy: Policy makers often use definitions unique to their state, region, or country. By having a common set of definitions policies and procedures can become standardized and accessible to all people.

Learning objectives

Participants will...

1. Be able to articulate the need for common definitions.
2. Identify the impact of common definitions on data collection.

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Validating a French version of the Perception of Prevalence of Aggression Scale – learning objectives

Poster

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Focus: Research

Background

The POPAS (Perception of Prevalence of Aggression Scale; Oud, 2001) is a 16 items self-report questionnaire that measures aggressive behaviors from patients experienced by workers in the healthcare sector. This instrument combines a Likert scale and an estimated number of times workers have been victims of or witnesses to 15 different types of aggression in the past year. Providing definitions for each type of aggression, the POPAS gives a detailed profile of victimization frequency. With all these features and its focus on perceptions, the instrument offers a different outlook than is provided by official data on worker victimization.

Context

The POPAS has been mainly used in mental health sectors to measure the prevalence of aggression against staff. Even though this instrument presents good internal consistency in these settings (Gale & al., 2009; Jonker & al., 2008; Nijman & al., 2005), it has yet to be fully validated. The aim of this study is to validate a French-Canadian version of the POPAS in a child protection worker population.

Methodology

A randomized sample stratified by gender comprised of 310 child protection workers in Quebec, Canada (women = 262) was used to achieve the purpose of this study. Exploratory factorial analyses were conducted to identify principal components. Cronbach's alphas were calculated for the 15-item scale. Correlations were computed with global score to assess convergent and discriminant validity with the Posttraumatic stress Disorder Checklist (PCL) and the Perceived Accountability Scale (PAS), respectively. T-tests according to work environment (internship vs externship) were used to evaluate discriminative validity. Finally, all statistical analyses were rerun in a split-half sample.

Findings

Factorial analysis structured the items into 4 principal components (eigenvalues > 1). Even so, only one factor showed good internal consistency. Moreover, these components were not comprehensible.

Internal consistency of the global scale in the full sample and split-half sample were good (Alpha = 0.85; Alpha = 0.85).

Convergent validity with the PCL ($r = .47$; $p < .01$; $r = .50$; $p < .001$), discriminant validity with the PAS ($r = -0.01$; $p > .05$; $r = 0.00$; $p > .05$) and differences observed in work environment ($t = 16,02$, $ddl = 259.21$; $p < .001$; $t = 10.34$; $ddl = 140$; $p = .001$) validated the instrument.

Implications

The POPAS-FRC (French-Canadian) is a validated instrument to assess perception of workplace aggressions. Exploratory analysis showed that the POPAS is comprised of one factor and the global score of this instrument should be used in future research. Finally, the POPAS is a reliable tool to assess subjective frequency of different types of workplace aggression among child protection workers. The POPAS may therefore be a good alternative to official data, which suffer from under-reporting in healthcare services.

Learning objectives

Participants will...

1. be aware of the advantages of using the Perception Of Prevalence of Aggression Scale to measure workplace aggression.
2. be acquainted of the psychometric properties of the POPAS.

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Violence towards healthcare workers in Turkey: A literature review

Poster

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Focus: Research

Background

In recent years, health professionals have been suffering from widespread violence in Turkey as well as in the world. Violence is one of the most dangerous occupational hazards facing healthcare workers in today's healthcare environment and violence leads to decreasing well-being and job satisfaction among healthcare workers. The aim of this literature review is to examine violence towards healthcare workers studies in Turkey, and to determine the requirements and priorities of research in this area.

Methodology

In this literature analysis, ULAKBİM Turkish Medical Literature, google academic, psychiatry index, YOK theses search, pubmed, google scholar, Ebsco HOST were scanned. A combination of key words such as "sađlýk çalıřpanları", "biddet", "Türkiye", "healthcare workers", "violence" and "Turkey" along with the preferred time limit of "2005 onwards" were used to search the literature. The results of 54 national and international publications suitable for the purposes of this analysis were included.

Findings

The majority of studies were found to be descriptive. Healthcare workers in emergency departments were at high risk for violence. Physicians and nurses were the main risk groups of being subjected to violence. Patients and their relatives have been reported to expose violence. Violence towards healthcare workers is under-reported. It has also been reported that only attacks resulting in serious injuries have been considered as incidents of violence and other violence attempts are inclined not to be reported to legal authorities resulting in a much lower official rates.

Violence risk factors include patient, environmental and personnel factors. Patient risk factors include educational level, communication problems, previous legal problems, firearms, substance abuse and patients' emotions, such as fear, anxiety and anger. Environmental risk factors include working directly with potentially poor security, delays in service, longer duration of treatment, crowding and uncomfortable surroundings. Personnel risk factors include a lack of training, inadequate staffing, extended working hours, crowded patient areas.

Healthcare workers are not effectively attempting to stop the process of violence. Both rapid changes in health care services, facilities and shortcomings in legal regulations cause gaps in violence prevention and employing safety issues in workplace. Healthcare workers exposed to violence have emotional, physiological, and psychiatric problems, and their work performance and social relationships are damaged. Health care workers are not sufficiently trained about how to cope with acute and chronic effects of violent behavior.

Conclusions

The incidence of healthcare violence is not well documented in Turkey. On the other hand, the topic has come increasingly into public and scientific attention in Turkey. In spite of the increased scientific attention to the problem, there are very few violence prevention intervention studies on how to prevent violence toward health care workers. Studies in this area need to be further enhanced.

Learning objectives

Participants will...

1. have an understanding of the studies conducted on violence towards healthcare workers in Turkey.
2. be aware of the requirements and priorities of research in this area.

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Perceptions of nursing and vocational health high school students towards violence

Poster

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Focus: Research

Background

Violence is an important and a common community health problem in all cultures around the world. Besides being a serious community problem, violence leads to mental, social, and health damages in people exposed to the violence. The priority in fighting violence is to make sure all healthcare staff are aware of the problem. Early diagnosis and intervention are needed to minimize the more destructive and irreversible effects of violence. In the framework of especially nurses and paramedics which have the chance to observe and influence the people directly, has opportunities to take violence into careful consideration. In addition, the perceptions of the healthcare staff who will identify and find out the violence are important. Because perception of behaviors related to violence is affected from value judgment of person.

Objectives

The aim of the study was to determine the perceptions and ideas of nursing and paramedic students towards violence.

Methods

This descriptive study was carried out between January-February 2012. The questionnaire was applied to a total of 636 students including 408 nurses and 228 paramedics. Data were obtained using the Descriptive Information Questionnaire. The questionnaire consists of 10 questions which covers socio-demographic features and 5 propositions to determine the perceptions and ideas of students against violence. The SPSS 15.0 software package was used for statistical analysis. The distribution of the data was expressed as counts and percentages. The chi-square test was used for statistical analyses.

Results

In this study, the sample was 64.2% female and 35.8% male. 68.6% of the students evaluated their families as protectors. Most of them pointed out that arguments were being lived in between their partners.

96.8% of nursing students and 75.0% of paramedic students disagree that men are justified in exerting physical violence to their partner due to certain reasons such as neglect of child care, unnecessary expense, protest against partner. But 25.0% of paramedic students are agreed that men are justified in exerting physical violence to their partner. All of them are male. It was identified that paramedic students have more traditional views on violence against partner ($p < 0.001$). Students witnessed violence at the family believe that it's appropriate the partner to expose to violence ($p < 0.05$).

There are significant statistically between attitude of family and propositions which perceptions against violence. Students, who think that behave democratically of their families are certainly protest against violence ($p < 0.05$).

Conclusion

This study shows that male and paramedic students have more traditional perceptions on violence. Besides, attitude of family and arguments between partners are affected the perceptions of students towards violence. Permanent measures should be taken to stop violence. In order for such efforts to be effective, accurate and realistic determinations must be made. The students in health sector must be aware of the effects of violence. For this reason, to remove personal comprehension differences about violence, this matter must be handed in health education.

Learning objectives

Participants will...

1. have an understanding of the perceptions of nursing and paramedic students towards violence.
2. learn that factors affecting perceptions of nursing and paramedic students towards violence.

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Psychopathology and crime: Research on patients of a Northern Italian Criminal Psychiatric Hospital

Poster

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Focus: Research

Background

There are over 10 million prisoners worldwide. It has been reported that prisoners have elevated rates of psychiatric disorders. Methodological problems associated with criminological and psychiatric research were addressed in relation to the exploration of whether these people are more dangerous or violent if compared to other people. In this context, we would like to give the Italian perspective with a descriptive analysis of the population of one of six existing Criminal Psychiatric Hospitals (CPH) in Italy, accommodating 2000 patients.

Methodology

We reviewed the admission forms and the main clinical and demographic data, from medical records and Court files. We interviewed the patients and administered SCID-I and II.

Findings

We evaluated 123 male inpatients, mean age 43.3 years; 96 (78.05%) unmarried. 93 (75.61%) had low education, 83 (67.48%) had low economic status and 22 (17.89%) had a job. The diagnoses were grouped into four categories (with or without an alcohol/drugs addiction). Table 1 shows the distribution of alcohol/drugs misuse across the four different diagnostic categories. 71 (57.72%) patients showed previous alcohol/drugs misuse, in particular those affected by a PD (81.82%).

Table 1: Distribution of addiction (alcohol/drugs misuse) across psychiatric diagnoses

Diagnosis	N (%) without addiction	N (%) with addiction	Proportion without vs with addiction	Total N (%)
Organic Disorder (ORG)	6 (11.5)	3 (4.23)	66.7: 33	9 (100)
Psychosis (PSY)	33 (63.5)	28 (39.4)	54.1: 45.9	61 (100)
Mood Disorder (MD)	5 (9.6)	4 (5.6)	55.6: 44.4	9 (100)
Personality Disorder (PD)	8 (15.4)	36 (50.7)	18.2: 81.8	44 (100)
Total	52 (100)	71 (100)		123

We grouped all the crimes into four categories. Table 2 shows the distribution of each diagnostic category within the four different types of crime. The proportion identifies the distribution of the different types of crime according to the specific diagnoses as a percentage.

Table 2: Distribution of crimes

	Murder	Crimes against persons	Property crimes	Public order crimes	Total
Organic Disorder (ORG)	0 (0%)	6 (9.1%)	2 (15.4%)	1 (3.9%)	9 (24.8%)
Proportion ORG	0%	66.7%	22.2%	11.1%	100%
Psychosis (PSY)	13 (76.5%)	30 (45.5%)	3 (23.1%)	14 (53.9%)	60 (153.1%)
Proportion PSY	21.8%		5%	23.3%	100%
Mood Disorder (MD)	0 (0%)	6 (9.1%)	2 (15.4%)	1 (3.9%)	9 (24.8%)
Proportion MD	0%	66.7%	22.2%	11.1%	100%
Personality Disorder (PD)	4 (23.5%)	24 (36.4%)	6 (46.1%)	10 (38.5%)	44 (144.5%)
Proportion PD	9.1%	54.6%	13.6%	22.7%	100%
Total	17 (100)	66 (100)	13 (100)	26 (100)	122

Of the murders 76% were committed by PSY while 46% of property crimes were committed by PDs. There is a trend of correlation between crimes against the person (included murder) and PSY, and between property crimes and PD (chi-square 2.42; $p=0.11$). If we take into account patients with a cognitive organic impairment this result raises. However the % of violent crimes among PD is high, probably due to the effects of drug addiction. MD show low rate of criminal conduct, none for murder or attempted murder.

Implications

The association between violence and diagnosis remain controversial. In other studies, violence was not associated with the neuropsychological domain. In our sample PD is associated with substance addiction: the criminal conduct may be forced by drugs. Future research could compare risk and protective factors for violence between different psychiatric diagnoses, particularly in high risk groups such as those diagnosed with personality disorder or substance misuse. Previous reviews on risk and protective factors for violence in PSY have produced contrasting findings.

Learning objectives

Participants will...

1. be able to analyze the different clinical and demographic profiles of a population of patients of a criminal psychiatric hospital.
2. be able to compare and discuss which factors could explain violent behaviors.

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The effects of music and movement on violence in adults with mental health disorders

Poster

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Perspective: Research

Keywords: aggression, violence, mood, music, movement, suicide, mental health

Background and Context:

Mood disorders affect more than 350 million people worldwide, negatively impacting quality of life and increasing a person's potential for mental health hospitalization (Ren, J., & Xia, J., 2013; Helgason, C., & Sarris, J., 2013). Despite the importance of regular exercise and movement, the Centers for Disease Control (CDC) reported in meeting the Healthy People 2010 initiatives that approximately 25% of Georgians had no planned active movement during their leisure time (U.S. Department of Health and Human Services [USDHHS], 2010). Lack of physical activity, exercise, or movement has been associated with health issues such as obesity, cardiac disorders, and diabetes, reducing quality of life and dramatically increasing the cost of health care (Centers for Disease Control and Prevention [CDC], (2013).

Music, as a complementary therapeutic intervention, has been shown to improve the mental health patient's mood and reduce aggressive negative behaviors towards self, others, and property (Hsu W., & Lai H., 2004). Movement, in the form of exercise, has also been shown to improve the mood of mental health patients in the community (Knubben, K., Reischies, F. M., Adli, M., Schlattmann, P., Bauer, M., Dimeo, F. 2007). Combining music and movement together as a therapeutic intervention may minimize aggressive behaviors, reduce hospitalization time and recidivism, and ultimately lower health care costs more effectively than each therapy alone (Sylvia, L. G., Friedman, E.S., Kocsis, J.H., Bernstein, E. E., Brody, B. D., Kinrys, G., ... & Nierenberg, A. A. 2013; Roberts, S., & Bailey, J. 2011). However, this investigator has been aware of very little research that exists that demonstrates the effectiveness of a music-plus-movement (MPM) complementary intervention for adult mental health patients diagnosed with mood disorders, and those with high risk for negative mood-related behaviors such as those with schizophrenia. Indications from what does exist regarding outpatients is encouraging (Park, A., McDaid, D., Weiser, P., Von Gottberg, C., Becker, T., Kilian, R. 2013).

The combination of music with movement to improve mood to reduce negative mood-related behaviors in hospitalized mental health patients is a new approach that changes how clinical mental health practice is performed on a daily basis, as this combination has not been researched with this population. Therefore, this literature review seeks to investigate further the published research information regarding the effects of a MPM intervention on adult inpatients diagnosed with mood disorders at a mental health hospital, as further described in the poster presentation.

Methodology, findings, implications: Literature review of dance interventions, aerobics, or physical activity in outpatients has positive implications for reducing cortisol, and improving self-reported mood state, although few very high quality studies have been found as of this time, particularly with the most acute cases in mental health facilities. More studies are indicated with high quality controls. It is suggested that similar studies be carried out in broader environments in the health sector and broader geographical locations.

Abstract

Adult mental health has become one of the top three health concerns in the world. Documentation has widely indicated that many people suffer from mood disorders worldwide, which is commonly displayed by negative mood related behaviors of aggression and violence. These negative mood-related behaviors impact the individuals' quality of life and increase their potential for being admitted to a mental health hospital. The negative effects of mood disorders are not only an international problem, but also affect locally hospitalized individuals who lead sedentary lifestyles as well, who may also have difficulty in caring for themselves. Research in other fields such as psychology and psychiatry indicate that controlling negative mood-related behaviors is an ongoing and perplexing problem for which we do not yet have an adequate solution. Literature review of the effects of music plus movement on mood in adults with mental health disorders has been encouraging for its positive effects, but inconclusive. A call to nurses for further research has been made. The purpose of this proposed project is to implement a complementary music plus movement program that will help to reduce negative mood related behaviors and help individuals better cope with their propensity towards aggressive behavior towards self, others, or property. We are in a time when care of mental health is becoming critical, and increasing healthcare costs have a profound impact, so low cost, complementary interventions are of high importance. The proposed methods include intervention of music plus movement in a 30-minute display of a

musical DVD, encouraging movements of choice with cortisol and mood states testing immediately before and after the intervention. This intervention is intended to be implemented in a Georgia, United States mental health facility, which is the first in the United States to partner with a research University for a psychological dedicated educational unit, with the goal of improving care for individuals with persistent mental illness. This poster will summarize recent literature results, describing the positive preliminary effects on individuals in the community with similar interventions, while addressing a gap in the literature in quality studies. Improving mood and decreasing incidents of negative mood-related behaviors with this novel intervention would reduce healthcare costs, hospitalization time, readmission rates for aggressive mentally-ill individuals diagnosed with mood disorders such as major depression, potentially saving lives from suicide, and generally reducing violence in the health sector.

Fit of abstract with conference theme / Subtheme: Main Focus is on "Safety"

With examples of initiatives that have enhanced cultures of safety, including: Aggression and violence minimization initiatives

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Learning Objectives

Participants will learn that:

- 1) Both Music and Movement are indicated to have a positive effect on mood which reduces aggression and violence
- 2) The combination of Music and Movement in a mental health setting of the most acute cases of violence may decrease the frequency of these behaviors.

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The effects of culturally relevant music on aggressive mental health patients

Poster

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Perspective: Research

Keywords: aggression, violence, Axis I, mental health, therapeutic, cognizant, psychology, music, validation, genre, facilitator, physiological, soothing

Background and Context

Serious and persistent mental illnesses affect nearly 400 million people worldwide. Many of these people with such illnesses present behaviors that are directly affected by symptoms that demonstrate aggression and violence in the health sector. Behaviors can be the result of paranoia, resurfacing of previous traumatic experiences, or poor judgment as a result of medication non-compliance, substance withdrawal, or adverse interpersonal exchange among patients or between service recipient and service provider.

The application of culturally relevant music should be considered from two main perspectives. Consideration of the physiological effects of music would involve assessing the expected outcomes of mood regulation along with improvement in cognizance and present mental status. Secondly, the psychological effects of culturally relevant lyrics and melodies of music awaken a stronger sense of self-pride as well as belonging and validation. The mental health population represents the most acute and frequent scenarios of aggression and violence, and therefore; should be strongly considered for cost efficient, harmless, and enjoyable treatment solutions. By integrating the expected psychological outcomes, physiological consequences, and relevant counseling techniques, one can offer an approach that is stimulating, therapeutic, mood regulating, and soothing.

Methodology, findings, implications

A review of literature yields that music has been incorporated in curriculum for anger management groups, substance abuse groups, psycho-educational groups, and inpatient therapy groups. Findings, as revealed through patient and consumer surveys convey that applications that incorporate music are more popular and attended in comparison to other modalities. Implications include a gap in literature involving genres, training and experience of the facilitator, and age range of the mental health service consumer.

Abstract

Aggression and violence among patients who receive services from outpatient and inpatient mental health service providers has been identified as a major problem regarding morale, safety, and well-being, and can be transferred into a concern in all industries. These recipients of services generally have diagnoses of Axis I categorizations such as Bipolar I, Schizophrenia, and Substance induced Mood Disorders. These diagnoses are characterized by symptoms that contribute to aggression between residents as well as patient aggression toward the care providers. Literature review has revealed that symptoms including disorientation, paranoia, hallucinations, and agitation have been chronicled as major factors when assessing and probing for the root cause of aggression. Current literature offers major parallels that reflect the popularity and efficacy of music with regard to addressing and soothing aggression among mental health patients. While a comprehensive review of literature fails to yield a conclusive answer to the phenomena of a music based approach, one can establish a conceptual framework to provide effective methods that can be built upon for a purpose of presenting a concrete methodology. Proposed methods to address how music affects aggression includes informal interviewing and assessment. Within such form of probing, relevant and individualized inquiry through surveys, Likert scales, and open discussion will allow the patient to identify with self, culture, and a support system that will be reintroduced in the most positive manner, through the musical and psychological therapeutic application. The gathering of information proves to be critical and lends itself to conveying equity, respect, and concern through a group formatted approach or an individualized session. After the assessment process has been conducted, the application of folk music, world music, and other genres can be communicated in a live setting in which the patient serves as the audience, the producer, or collaborative partner of the clinician providing the service. Preliminary results from current literature are encouraging, and application in this population is recommended. Conclusions from preliminary studies with music and therapeutic application indicate a positive mood change, and that further, high quality studies should be performed.

Fit of abstract with conference theme / Subtheme: Main Focus is on "Safety"

With examples of initiatives that have enhanced cultures of safety, including: Aggression and violence minimization initiatives

Learning Objectives

Participants will learn that:

- 1) A strategic application of music and counseling provide a soothing, motivational, and therapeutic approach to diminishing aggression and violence in the health-sector.
- 2) Live, interactive musical engagement offers several therapeutic components that aid the delivery of medication in a more sustaining manner.

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Forum Theatre and Mindful Learning: an approach to develop key skills for dealing with violence

Workshop

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Perspective: Education and Training

Keywords: mindful learning, active learning, student nurses, forum theatre, aggression, mental health

Abstract

Forum Theatre and Mindful Learning in the Pre-Registration Nursing Curriculum: Supporting student nurses in the development of key skills that prevent and resolve the rise of verbal aggression in mental health settings.

Combining forum theatre with mindfulness, as an approach to facilitate active learning for nursing students, is at an early stage of development. Initial evaluation from a current pilot group, with 'verbal aggression' as the main theme of the workshop, indicates early promise with positive feedback and encouraging results. The pilot group provided a unique opportunity for genuine interprofessional learning within the university: The College of Nursing, Midwifery and Healthcare working with the College of Music.

Trainee actors, nursing students and facilitators participated in forum theatre actively learning together: exchanging knowledge, understanding, attitudes and skills. Forum theatre is used as a method of learning skills in a safe environment to assess risk, to develop therapeutic relationships, and to communicate observations appropriately. Key principles of mindful practice are applied to create a stimulating learning environment and enhance the learning opportunity and experience. This approach to teaching within practice development days for nursing students, offers a valuable platform for using live simulation as an experiential tool to reflect in, and on, action. This approach is versatile and can be adapted for any situation, with all professions, at any level.

Forum theatre scenarios are designed to stimulate audience participation through discussion, interactive role-playing and shared experience, (Boal, 2000). In terms of working with conflict (in particular verbal aggression) it enables the creation of a safe environment allowing participants to examine their beliefs and challenge perceptions leading to educated decisions that can be translated into the real world; give the participants the chance to make informed choices to ensure they feel empowered to challenge and change their own reality; create positive challenges instead of negative enforcements to empower the participants to grow; motivate learning by ensuring that participants experience and explore issues in a 'real life' context; empower and inspire the participants to be active and not passive. Blended with this active learning, mindful practice involves the creation of a culture of caring and compassion: crucial to the future of health and social care as highlighted in the recent, high profile, public inquiry report (Francis, 2013).

Mindfulness can be complimentary to a constructivist approach, in the context of teaching and learning with nursing students, and has characteristics that can stand the test of time regardless of changes in the health and social care environment (Langer, 2003). Characteristics include openness towards new information; acceptance of more than one view; and, a focus on process before outcome. Mindful learning enhances personal and professional development and is linked with reaching academic and personal goals.

Mindful practice is a skill which fits well with the concept that learning is a lifelong and life-wide activity: a concept that is promoted and seen as paramount to current nurse education (Department of Health (DH), 2006; Nursing and Midwifery Council, 2010).

Facilitators of the workshops can create stimulating learning environments by utilizing forum theatre, whilst emphasizing mindful practice. The goals of this approach are for students to:

- use mindfulness skills to develop life skills and essential nursing qualities, enhancing individual and shared learning experience
- reflect on practice to increase self-awareness, empathy and compassion, develop and enhance interpersonal skills, and promote personal and professional growth
- use mindful practice to enhance their capability in developing resilience and openness to change for managing their future challenges in practice and adaptation to change

Therefore students find that they feel better equipped and more confident when faced with conflictive situations that may have typically led to a more serious incident.

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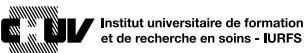
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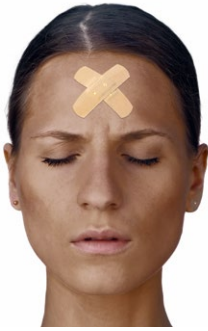
Announcement

**The Fifth International Conference on
Violence in the Health Sector
will be held on the 26th till the 28th of
October 2016 in Dublin, Ireland.**

The call for abstracts will be issued at the end of October or beginning of November 2015 on the conference website www.oudconsultancy.nl.

Please reserve these important dates in your agenda.

Looking forward to meet you in Dublin, Ireland in 2016.



Towards safety, security and wellbeing for all

The World Health Organization reports that 1.6 million people worldwide lose their lives annually to violence and the channelling and management of violent behaviour a major challenge to all societies. Violence is an intrinsic characteristic of the conditio humana and thus an “anthropological constant”.

Health care institutions are created to tend to patients’ needs and challenges in a caring way. Health sector institutions are created to tend to patients’ needs and challenges in a caring way. When entering the health care system patients trust they will be in safe hands and expect safety, security and optimum wellbeing. However, as the general societal situation is reflected in the health sector it is not surprising that abuse, aggression and physical violence are present and a critical issue for care institutions.

This book of conference proceedings summarizes topical writing and reports from the five continents pertaining to the following aspects of violence:

- Evidence of threats to safety and security,
- Examples of collaborative working toward aggression and violence free environments,
- Examples of initiatives which enhance cultures of safety and security,
- Strategies which enhance cultures of safety and security,
- Examples of initiatives which promote and preserve wellness in environments of potential aggression and violence.

Thanks to the dedicated work of the conference presenters and participants the initiatives shared and exchanged do help raise awareness and lead to sustainable action creating a health care environment and workplace characterized by safety, security and wellbeing for all.

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